

# OCCUPATIONAL THERAPY PRACTICE FRAMEWORK: *Domain & Process* 3rd Edition

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## PREFACE

The *Occupational Therapy Practice Framework: Domain and Process*, 3rd edition (hereinafter referred to as “the *Framework*”), is an official document of the American Occupational Therapy Association (AOTA). Intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, and consumers, the *Framework* presents a summary of interrelated constructs that describe occupational therapy practice.

### Definitions

Within the *Framework*, *occupational therapy* is defined as the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings. Occupational therapy practitioners use their knowledge of the transactional relationship among the person, his or her engagement in valuable occupations, and the context to design occupation-based intervention plans that facilitate change or growth in client factors (body functions, body structures, values, beliefs, and spirituality) and skills (motor, process, and social interaction) needed for successful participation. Occupational therapy practitioners are concerned with the end result of participation and thus enable engagement through adaptations and modifications to the environment or objects within the environment when needed. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs. These services include acquisition and preservation of occupational identity for those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. (adapted from AOTA, 2011; see Appendix A for additional definitions in a glossary)

When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006). Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2009). Additional information about the preparation and qualifications of occupational therapists and occupational therapy assistants can be found in Appendix B.

## Evolution of This Document

The *Framework* was originally developed to articulate occupational therapy's distinct perspective and contribution to promoting the health and participation of persons, groups, and populations through engagement in occupation. The first edition of the *Framework* emerged from an examination of documents related to the *Occupational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services* (AOTA, 1979). Originally a document that responded to a federal requirement to develop a uniform reporting system, the text gradually shifted to describing and outlining the domains of concern of occupational therapy.

The second edition of *Uniform Terminology for Occupational Therapy* (AOTA, 1989) was adopted by the AOTA Representative Assembly (RA) and published in 1989. The document focused on delineating and defining only the occupational performance areas and occupational performance components that are addressed in occupational therapy direct services. The third and final revision of *Uniform Terminology for Occupational Therapy* (AOTA, 1994) was adopted by the RA in 1994 and was "expanded to reflect current practice and to incorporate contextual aspects of performance" (p. 1047). Each revision reflected changes in practice and provided consistent terminology for use by the profession.

In Fall 1998, the AOTA Commission on Practice (COP) embarked on the journey that culminated in the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002b). At that time, AOTA also published *The Guide to Occupational Therapy Practice* (Moyers, 1999), which outlined contemporary practice for the profession. Using this document and the feedback received during the review process for the third edition of *Uniform Terminology for Occupational Therapy*, the COP proceeded to develop a document that more fully articulated occupational therapy.

The *Framework* is an ever-evolving document. As an official AOTA document, it is reviewed on a 5-year cycle for usefulness and the potential need for further refinements or changes. During the review period, the COP collects feedback from members, scholars, authors, practitioners, and other stakeholders. The revision process ensures that the *Framework* maintains its integrity while responding to internal and external influences that should be reflected in emerging concepts and advances in occupational therapy.

The *Framework* was first revised and approved by the RA in 2008. Changes to the document included

refinement of the writing and the addition of emerging concepts and changes in occupational therapy. The rationale for specific changes can be found in Table 11 of the second edition of the *Framework* (AOTA, 2008, pp. 665–667).

In 2012, the process of review and revision of the *Framework* was initiated again. Following member review and feedback, several modifications were made to improve flow, usability, and parallelism of concepts within the document. The following major revisions were made and approved by the RA in the Fall 2013 meeting:

- The overarching statement describing occupational therapy's domain is now stated as "achieving health, well-being, and participation in life through engagement in occupation" to encompass both domain and process.
- *Clients* are now defined as persons, groups, and populations.
- The relationship of occupational therapy to organizations has been further defined.
- *Activity demands* has been removed from the domain and placed in the overview of the process to augment the discussion of the occupational therapy practitioner's basic skill of activity analysis.
- *Areas of occupation* are now called *occupations*.
- *Performance skills* have been redefined, and Table 3 has been revised accordingly.
- The following changes have been made to the interventions table (Table 6):
  - *Consultation* has been removed and has been infused throughout the document as a method of service delivery.
  - Additional intervention methods used in practice have been added, and a clearer distinction is made among the interventions of *occupations*, *activities*, and *preparatory methods and tasks*.
  - *Self-advocacy* and *group interventions* have been added.
  - *Therapeutic use of self* has been moved to the process overview to ensure the understanding that use of the self as a therapeutic agent is integral to the practice of occupational therapy and is used in all interactions with all clients.
- Several additional, yet minor, changes have been made, including the creation of a preface, reorganization for flow of content, and modifications to several definitions. These changes reflect feedback received from AOTA members, educators, and other stakeholders.

## Vision for This Work

Although this revision of the *Framework* represents the latest in the profession's efforts to clearly articulate the occupational therapy domain and process, it builds on a set of values that the profession has held since its founding in 1917. This founding vision had at its center a profound belief in the value of therapeutic occupations as a way to remediate illness and maintain health (Slagle, 1924). The founders emphasized the importance of

establishing a therapeutic relationship with each client and designing a treatment plan based on knowledge about the client's environment, values, goals, and desires (Meyer, 1922). They advocated for scientific practice based on systematic observation and treatment (Dunton, 1934). Paraphrased using today's lexicon, the founders proposed a vision that was occupation based, client centered, contextual, and evidence based—the vision articulated in the *Framework*.

## INTRODUCTION

The purpose of a *framework* is to provide a structure or base on which to build a system or a concept (*American Heritage Dictionary of the English Language*, 2003). The *Occupational Therapy Practice Framework: Domain and Process* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and vision of the profession. The *Framework* does not serve as a taxonomy, theory, or model of occupational therapy.

By design, the *Framework* must be used to guide occupational therapy practice in conjunction with the knowledge and evidence relevant to occupation and occupational therapy within the identified areas of practice and with the appropriate clients. Embedded in this document is the profession's core belief in the positive relationship between occupation and health and its view of people as occupational beings. Occupational therapy practice emphasizes the occupational nature of humans and the importance of occupational identity (Unruh, 2004) to healthful, productive, and satisfying living. As Hooper and Wood (2014) stated,

A core philosophical assumption of the profession, therefore, is that by virtue of our biological endowment, people of all ages and abilities require occupation to grow and thrive; in pursuing occupation, humans express the totality of their being, a mind–body–spirit union. Because human existence could not otherwise be, humankind is, in essence, occupational by nature. (p. 38)

The clients of occupational therapy are typically classified as *persons* (including those involved in care of a client), *groups* (collectives of individuals, e.g., families, workers, students, communities), and *populations* (collectives of groups of individuals living in a similar locale—e.g., city, state, or country—or sharing the same or like characteristics or concerns). Services are pro-

vided directly to clients using a collaborative approach or indirectly on behalf of clients through advocacy or consultation processes.

Organization- or systems-level practice is a valid and important part of occupational therapy for several reasons. First, organizations serve as a mechanism through which occupational therapy practitioners provide interventions to support participation of those who are members of or served by the organization (e.g., falls prevention programming in a skilled nursing facility, ergonomic changes to an assembly line to reduce cumulative trauma disorders). Second, organizations support occupational therapy practice and occupational therapy practitioners as stakeholders in carrying out the mission of the organization. It is the fiduciary responsibility of practitioners to ensure that services provided to organizational stakeholders (e.g., third-party payers, employers) are of high quality and delivered in an efficient and efficacious manner. Finally, organizations employ occupational therapy practitioners in roles in which they use their knowledge of occupation and the profession of occupational therapy indirectly. For example, practitioners can serve in positions such as dean, administrator, and corporate leader; in these positions, practitioners support and enhance the organization but do not provide client care in the traditional sense.

The *Framework* is divided into two major sections: (1) the *domain*, which outlines the profession's purview and the areas in which its members have an established body of knowledge and expertise, and (2) the *process*, which describes the actions practitioners take when providing services that are client centered and focused on engagement in occupations. The profession's understanding of the domain and process of occupational therapy guides practitioners as they seek to support clients' participation in daily living that results from the dynamic intersection of clients, their desired engagements, and the context and environment (Christiansen

& Baum, 1997; Christiansen, Baum, & Bass-Haugen, 2005; Law, Baum, & Dunn, 2005).

Although the domain and process are described separately, in actuality they are linked inextricably in a transactional relationship. The aspects that constitute the domain and those that constitute the process exist in constant interaction with one another during the delivery of occupational therapy services. In other words, it is through simultaneous attention to the client's body functions and structures, skills, roles, habits, routines, and context—combined with a focus on the client as an occupational being and the practitioner's knowledge of the health- and performance-enhancing effects of occupational engagements—that outcomes such as occupational performance, role competence, and participation in daily life are produced.

*Achieving health, well-being, and participation in life through engagement in occupation* is the overarching statement that describes the domain and process of occupational therapy in its fullest sense. This statement acknowledges the profession's belief that active engagement in occupation promotes, facilitates, supports, and maintains health and participation. These interrelated concepts include

- *Health*—"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organization [WHO], 2006, p. 1).
- *Well-being*—"a general term encompassing the total universe of human life domains, including physical, mental, and social aspects" (WHO, 2006, p. 211).
- *Participation*—"involvement in a life situation" (WHO, 2001, p. 10). Participation naturally occurs when clients are actively involved in carrying out occupations or daily life activities they find purposeful and meaningful. More specific outcomes of

occupational therapy intervention are multidimensional and support the end result of participation.

- *Engagement in occupation*—performance of occupations as the result of choice, motivation, and meaning within a supportive context and environment. Engagement includes objective and subjective aspects of clients' experiences and involves the transactional interaction of the mind, body, and spirit. Occupational therapy intervention focuses on creating or facilitating opportunities to engage in occupations that lead to participation in desired life situations (AOTA, 2008).

## Domain

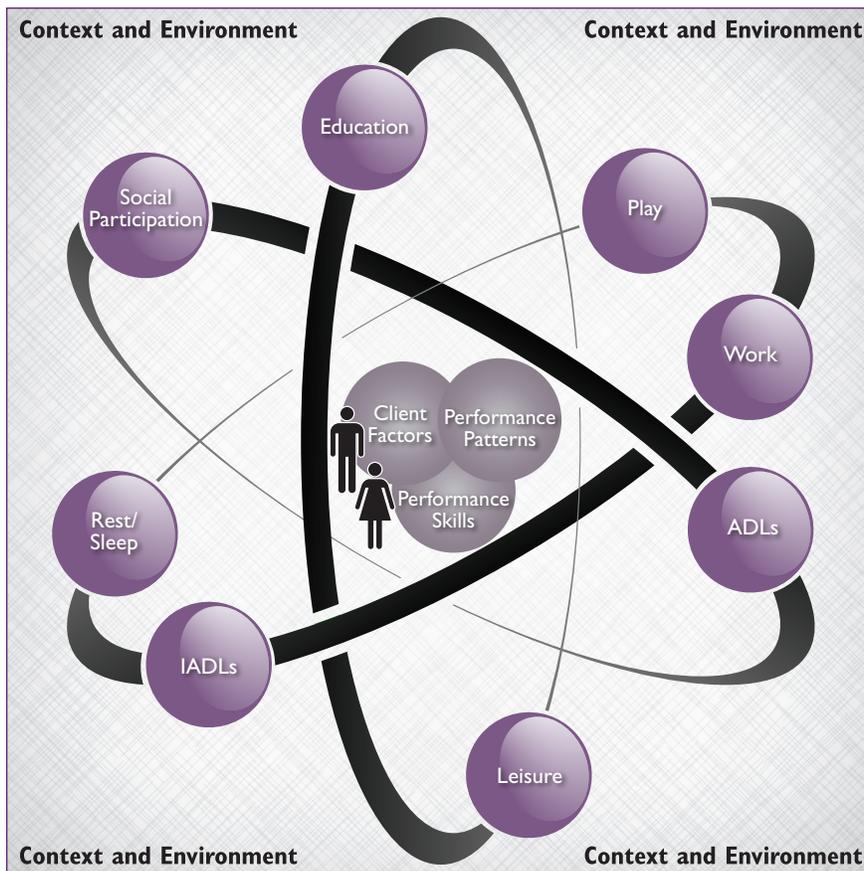
Exhibit 1 identifies the aspects of the domain, and Figure 1 illustrates the dynamic interrelatedness among them. All aspects of the domain, including occupations, client factors, performance skills, performance patterns, and context and environment, are of equal value, and together they interact to affect the client's occupational identity, health, well-being, and participation in life.

Occupational therapists are skilled in evaluating all aspects of the domain, their interrelationships, and the client within his or her contexts and environments. In addition, occupational therapy practitioners recognize the importance and impact of the mind–body–spirit connection as the client participates in daily life. Knowledge of the transactional relationship and the significance of meaningful and productive occupations form the basis for the use of occupations as both the means and the ends of interventions (Trombly, 1995). This knowledge sets occupational therapy apart as a distinct and valuable service (Hildenbrand & Lamb, 2013) for which a focus on the whole is considered stronger than a focus on isolated aspects of human function.

<b>OCCUPATIONS</b>	<b>CLIENT FACTORS</b>	<b>PERFORMANCE SKILLS</b>	<b>PERFORMANCE PATTERNS</b>	<b>CONTEXTS AND ENVIRONMENTS</b>
Activities of daily living (ADLs)*	Values, beliefs, and spirituality	Motor skills	Habits	Cultural
Instrumental activities of daily living (IADLs)	Body functions	Process skills	Routines	Personal
Rest and sleep	Body structures	Social interaction skills	Rituals	Physical
Education			Roles	Social
Work				Temporal
Play				Virtual
Leisure				
Social participation				

\*Also referred to as *basic activities of daily living (BADLs)* or *personal activities of daily living (PADLs)*.

**Exhibit 1. Aspects of the domain of occupational therapy.** All aspects of the domain transact to support engagement, participation, and health. This exhibit does not imply a hierarchy.



**Figure 1. Occupational therapy's domain.**

*Note.* ADLs = activities of daily living; IADLs = instrumental activities of daily living.

The discussion that follows provides a brief explanation of each aspect of the domain. Tables included at the end of the document provide full descriptions and definitions of terms.

### Occupations

Occupations are central to a client's (person's, group's, or population's) identity and sense of competence and have particular meaning and value to that client. Several definitions of *occupation* are described in the literature and can add to an understanding of this core concept:

- “Goal-directed pursuits that typically extend over time, have meaning to the performance, and involve multiple tasks” (Christiansen et al., 2005, p. 548).
- “The things that people do that occupy their time and attention; meaningful, purposeful activity; the personal activities that individuals choose or need to engage in and the ways in which each individual actually experiences them” (Boyt Schell, Gillen, & Scaffa, 2014a, p. 1237).
- “When a person engages in purposeful activities out of personal choice and they are valued, these clusters of purposeful activities form occupations

(Hinojosa, Kramer, Royeen, & Luebben, 2003). Thus, occupations are unique to each individual and provide personal satisfaction and fulfillment as a result of engaging in them (AOTA, 2002b; Pierce, 2001)” (Hinojosa & Blount, 2009, pp. 1–2).

- “In occupational therapy, occupations refer to the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do” (World Federation of Occupational Therapists, 2012).
- “Activities . . . of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves . . . enjoying life . . . and contributing to the social and economic fabric of their communities” (Law, Polatajko, Baptiste, & Townsend, 1997, p. 32).
- “A dynamic relationship among an occupational form, a person with a unique developmental structure, subjective meanings and purpose, and the

resulting occupational performance” (Nelson & Jepson-Thomas, 2003, p. 90).

- “Occupation is used to mean all the things people want, need, or have to do, whether of physical, mental, social, sexual, political, or spiritual nature and is inclusive of sleep and rest. It refers to all aspects of actual human doing, being, becoming, and belonging. The practical, everyday medium of self-expression or of making or experiencing meaning, occupation is the activist element of human existence whether occupations are contemplative, reflective, and meditative or action based” (Wilcock & Townsend, 2014, p. 542).

The term *occupation*, as it is used in the *Framework*, refers to the daily life activities in which people engage. Occupations occur in context and are influenced by the interplay among client factors, performance skills, and performance patterns. Occupations occur over time; have purpose, meaning, and perceived utility to the client; and can be observed by others (e.g., preparing a meal) or be known only to the person involved (e.g., learning through reading a textbook). Occupations can involve the execution of multiple activities for completion and can result in various outcomes. The *Framework* identifies a broad range of occupations categorized as activities of daily living (ADLs), instrumental activities of daily living (IADLs), rest and sleep, education, work, play, leisure, and social participation (Table 1).

When occupational therapy practitioners work with clients, they identify the many types of occupations clients engage in while alone or with others. Differences among persons and the occupations they engage in are complex and multidimensional. The client’s perspective on how an occupation is categorized varies depending on that client’s needs and interests as well as the context. For example, one person may perceive doing laundry as work, whereas another may consider it an IADL. One group may engage in a quiz game and view their participation as play, but another group may engage in the same quiz game and view it as education.

The ways in which clients prioritize engagement in selected occupations may vary at different times. For example, clients in a community psychiatric rehabilitation setting may prioritize registering to vote during an election season and food preparation during holidays. The unique features of occupations are noted and analyzed by occupational therapy practitioners, who consider all components of the engagement and use them effectively as both a therapeutic tool and a way to achieve the targeted outcomes of intervention.

The extent to which a person is involved in a particular occupational engagement is also important. Occupations

can contribute to a well-balanced and fully functional lifestyle or to a lifestyle that is out of balance and characterized by occupational dysfunction. For example, excessive work without sufficient regard for other aspects of life, such as sleep or relationships, places clients at risk for health problems (Hakansson, Dahlin-Ivanoff, & Sonn, 2006).

Sometimes occupational therapy practitioners use the terms *occupation* and *activity* interchangeably to describe participation in daily life pursuits. Some scholars have proposed that the two terms are different (Christiansen & Townsend, 2010; Pierce, 2001; Reed, 2005). In the *Framework*, the term *occupation* denotes life engagements that are constructed of multiple activities. Both occupations and activities are used as interventions by practitioners. Participation in occupations is considered the end result of interventions, and practitioners use occupations during the intervention process as the means to the end.

Occupations often are shared and done with others. Those that implicitly involve two or more individuals may be termed *co-occupations* (Zemke & Clark, 1996). Caregiving is a co-occupation that involves active participation on the part of both the caregiver and the recipient of care. For example, the co-occupations required during parenting, such as the socially interactive routines of eating, feeding, and comforting, may involve the parent, a partner, the child, and significant others (Olson, 2004); the activities inherent in this social interaction are reciprocal, interactive, and nested co-occupations (Dunlea, 1996; Esdaile & Olson, 2004). Consideration of co-occupations supports an integrated view of the client’s engagement in context in relationship to significant others.

Occupational participation occurs individually or with others. It is important to acknowledge that clients can be independent in living regardless of the amount of assistance they receive while completing activities. Clients may be considered independent when they perform or direct the actions necessary to participate, regardless of the amount or kind of assistance required, if they are satisfied with their performance. In contrast with definitions of independence that imply a level of physical interaction with the environment or objects within the environment, occupational therapy practitioners consider clients to be independent whether they perform the component activities by themselves, perform the occupation in an adapted or modified environment, use various devices or alternative strategies, or oversee activity completion by others (AOTA, 2002a). For example, people with a spinal cord injury who direct a personal care assistant to assist them with their ADLs are demonstrating independence in this essential aspect of their lives.

Occupational therapy practitioners recognize that health is supported and maintained when clients are able to engage in home, school, workplace, and community life. Thus, practitioners are concerned not only with occupations but also with the variety of factors that empower and make possible clients' engagement and participation in positive health-promoting occupations (Wilcock & Townsend, 2014).

### *Client Factors*

*Client factors* are specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations (Table 2). Client factors are affected by the presence or absence of illness, disease, deprivation, disability, and life experiences. Although client factors are not to be confused with performance skills, client factors can affect performance skills. Thus, client factors may need to be present in whole or in part for a person to complete an action (skill) used in the execution of an occupation. In addition, client factors are affected by performance skills, performance patterns, contexts and environments, and performance and participation in activities and occupations. It is through this cyclical relationship that preparatory methods, activities, and occupations can be used to affect client factors and vice versa.

Values, beliefs, and spirituality influence a person's motivation to engage in occupations and give his or her life meaning. *Values* are principles, standards, or qualities considered worthwhile by the client who holds them. *Beliefs* are cognitive content held as true (Moyers & Dale, 2007). *Spirituality* is "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al., 2009, p. 887).

*Body functions* and *body structures* refer to the "physiological function of body systems (including psychological functions) and anatomical parts of the body such as organs, limbs, and their components," respectively (WHO, 2001, p. 10). Examples of body functions include sensory, musculoskeletal, mental (affective, cognitive, perceptual), cardiovascular, respiratory, and endocrine functions. Examples of body structures include the heart and blood vessels that support cardiovascular function (for additional examples, see Table 2). Body structures and body functions are interrelated, and occupational therapy practitioners must consider them when seeking to promote clients' ability to engage in desired occupations.

Moreover, occupational therapy practitioners understand that, despite their importance, the presence,

absence, or limitation of specific body functions and body structures does not necessarily ensure a client's success or difficulty with daily life occupations. Occupational performance and various types of client factors may benefit from supports in the physical or social environment that enhance or allow participation. It is through the process of observing clients engaging in occupations and activities that occupational therapy practitioners are able to determine the transaction between client factors and performance and to then create adaptations and modifications and select activities that best promote enhanced participation.

Client factors can also be understood as pertaining to individuals at the group and population level. Although client factors may be described differently when applied to a group or population, the underlying tenets do not change substantively.

### *Performance Skills*

Various approaches have been used to describe and categorize performance skills. The occupational therapy literature from research and practice offers multiple perspectives on the complexity and types of skills used during performance.

*Performance skills* are goal-directed actions that are observable as small units of engagement in daily life occupations. They are learned and developed over time and are situated in specific contexts and environments (Fisher & Griswold, 2014). Fisher and Griswold (2014) categorized performance skills as motor skills, process skills, and social interaction skills (Table 3). Various body structures, as well as personal and environmental contexts, converge and emerge as occupational performance skills. In addition, body functions, such as mental, sensory, neuromuscular, and movement-related functions, are identified as the capacities that reside within the person and also converge with structures and environmental contexts to emerge as performance skills. This description is consistent with WHO's (2001) *International Classification of Functioning, Disability and Health*.

Performance skills are the client's demonstrated abilities. For example, praxis capacities, such as imitating, sequencing, and constructing, affect a client's motor performance skills. Cognitive capacities, such as perception, affect a client's process performance skills and ability to organize actions in a timely and safe manner. Emotional regulation capacities can affect a client's ability to effectively respond to the demands of occupation with a range of emotions. It is important to remember that many body functions underlie each performance skill.

Performance skills are also closely linked and are used in combination with one another as a client engages in an occupation. A change in one performance skill can affect other performance skills. Occupational therapy practitioners observe and analyze performance skills to understand the transactions among client factors, context and environment, and activity or occupational demands, which support or hinder performance skills and occupational performance (Chisholm & Boyt Schell, 2014; Hagedorn, 2000).

In practice and in some literature, underlying body functions are labeled as *performance skills* and are seen in various combinations such as perceptual–motor skills and social–emotional skills. Although practitioners may focus on underlying capacities such as cognition, body structures, and emotional regulation, the *Framework* defines performance skills as those that are observable and that are key aspects of successful occupational participation. Table 3 provides definitions of the various skills in each category.

Resources informing occupational therapy practice related to performance skills include Fisher (2006); Polatajko, Mandich, and Martini (2000); and Fisher and Griswold (2014). Detailed information about the ways performance skills are used in occupational therapy practice may be found in the literature on specific theories and models such as the Model of Human Occupation (Kielhofner, 2008), the Cognitive Orientation to Daily Occupational Performance (Polatajko & Mandich, 2004), the Occupational Therapy Intervention Process Model (Fisher, 2009), sensory integration theory (Ayres, 1972, 2005), and motor learning and motor control theory (Shumway-Cook & Woollacott, 2007).

### *Performance Patterns*

*Performance patterns* are the habits, routines, roles, and rituals used in the process of engaging in occupations or activities that can support or hinder occupational performance. *Habits* refers to specific, automatic behaviors; they may be useful, dominating, or impoverished (Boyt Schell, Gillen, & Scaffa, 2014b; Clark, 2000; Dunn, 2000). *Routines* are established sequences of occupations or activities that provide a structure for daily life; routines also can promote or damage health (Fiese, 2007; Koome, Hocking, & Sutton, 2012; Segal, 2004).

*Roles* are sets of behaviors expected by society and shaped by culture and context; they may be further conceptualized and defined by a client (person, group, or population). Roles can provide guidance in selecting occupations or can be used to identify activities connected with certain occupations in which a client engages.

When considering roles, occupational therapy practitioners are concerned with how clients construct their occupations to fulfill their perceived roles and identity and whether their roles reinforce their values and beliefs. Some roles lead to stereotyping and restricted engagement patterns. Jackson (1998a, 1998b) cautioned that describing people by their roles can be limiting and can promote segmented rather than enfolded occupations.

*Rituals* are symbolic actions with spiritual, cultural, or social meaning. Rituals contribute to a client's identity and reinforce the client's values and beliefs (Fiese, 2007; Segal, 2004).

Performance patterns develop over time and are influenced by all other aspects of the occupational therapy domain. Practitioners who consider clients' performance patterns are better able to understand the frequency and manner in which performance skills and occupations are integrated into clients' lives. Although clients may have the ability to engage in skilled performance, if they do not embed essential skills in a productive set of engagement patterns, their health, well-being, and participation may be negatively affected. For example, a client who has the skills and resources to engage in appropriate grooming, bathing, and meal preparation but does not embed them into a consistent routine may struggle with poor nutrition and social isolation. Table 4 provides examples of performance patterns for persons and groups or populations.

### *Context and Environment*

Engagement and participation in occupation take place within the social and physical environment situated within context. In the literature, the terms *environment* and *context* often are used interchangeably. In the *Framework*, both terms are used to reflect the importance of considering the wide array of interrelated variables that influence performance. Understanding the environments and contexts in which occupations can and do occur provides practitioners with insights into their overarching, underlying, and embedded influences on engagement.

The *physical environment* refers to the natural (e.g., geographic terrain, plants) and built (e.g., buildings, furniture) surroundings in which daily life occupations occur. Physical environments can either support or present barriers to participation in meaningful occupations. Examples of barriers include doorway widths that do not allow for wheelchair passage or absence of healthy social opportunities for people abstaining from alcohol use. Conversely, environments can provide supports and resources for service delivery

(e.g., community, health care facility, home). The *social environment* consists of the presence of, relationships with, and expectations of persons, groups, and populations with whom clients have contact (e.g., availability and expectations of significant individuals, such as spouse, friends, and caregivers).

The term *context* refers to elements within and surrounding a client that are often less tangible than physical and social environments but nonetheless exert a strong influence on performance. Contexts, as described in the *Framework*, are cultural, personal, temporal, and virtual.

The *cultural context* includes customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society of which a client is a member. The cultural context influences the client's identity and activity choices, and practitioners must be aware, for example, of norms related to eating or deference to medical professionals when working with someone from another culture and of socioeconomic status when providing a discharge plan for a young child and family. *Personal context* refers to demographic features of the individual, such as age, gender, socioeconomic status, and educational level, that are not part of a health condition (WHO, 2001). *Temporal context* includes stage of life, time of day or year, duration or rhythm of activity, and history.

Finally, *virtual context* refers to interactions that occur in simulated, real-time, or near-time situations absent of physical contact. The virtual context is becoming increasingly important for clients as well as occupational therapy practitioners and other health care providers. Clients may require access to and the ability to use technology such as cell or smartphones, computers or tablets, and videogame consoles to carry out their daily routines and occupations.

Contexts and environments affect a client's access to occupations and influence the quality of and satisfaction with performance. A client who has difficulty performing effectively in one environment or context may be successful when the environment or context is changed. The context within which the engagement in occupations occurs is specific for each client. Some contexts are external to clients (e.g., virtual), some are internal to clients (e.g., personal), and some have both external features and internalized beliefs and values (e.g., cultural).

Occupational therapy practitioners recognize that for clients to truly achieve an existence of full participation, meaning, and purpose, clients must not only function but also engage comfortably with their world, which consists of a unique combination of contexts and environments (Table 5).

Interwoven throughout all contexts and environments is the concept of *occupational justice*, defined as "a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (Nilsson & Townsend, 2010, p. 58). Occupational justice describes the concern that occupational therapy practitioners have with the ethical, moral, and civic aspects of clients' environments and contexts. As part of the occupational therapy domain, practitioners consider how these aspects can affect the implementation of occupational therapy and the target outcome of participation.

Several environments and contexts can present occupational justice issues. For example, an alternative school placement for children with psychiatric disabilities could provide academic support and counseling but limit opportunity for participation in sports, music programs, and organized social activities. A residential facility could offer safety and medical support but provide little opportunity for engagement in the role-related activities that were once a source of meaning for residents. Poor communities that lack accessibility and resources make participation especially difficult and dangerous for people with disabilities. Occupational therapy practitioners may recognize areas of occupational injustice and work to support policies, actions, and laws that allow people to engage in occupations that provide purpose and meaning in their lives.

By understanding and addressing the specific justice issues within a client's discharge environment, occupational therapy practitioners promote therapy outcomes that address empowerment and self-advocacy. Occupational therapy's focus on engagement in occupations and occupational justice complements WHO's (2001) perspective on health. In an effort to broaden the understanding of the effects of disease and disability on health, WHO recognized that health can be affected by the inability to carry out activities and participate in life situations caused both by environmental barriers and by problems that exist in body structures and body functions. The *Framework* identifies occupational justice as both an aspect of contexts and environments and an outcome of intervention.

## Process

This section operationalizes the process undertaken by occupational therapy practitioners when providing services to clients. Exhibit 2 identifies the aspects of the process, and Figure 2 illustrates the dynamic interrelatedness among them. The *occupational therapy process* is

### Evaluation

*Occupational profile*—The initial step in the evaluation process, which provides an understanding of the client's occupational history and experiences, patterns of daily living, interests, values, and needs. The client's reasons for seeking services, strengths and concerns in relation to performing occupations and daily life activities, areas of potential occupational disruption, supports and barriers, and priorities are also identified.

*Analysis of occupational performance*—The step in the evaluation process during which the client's assets and problems or potential problems are more specifically identified. Actual performance is often observed in context to identify supports for and barriers to the client's performance. Performance skills, performance patterns, context or environment, client factors, and activity demands are all considered, but only selected aspects may be specifically assessed. Targeted outcomes are identified.

### Intervention

*Intervention plan*—The plan that will guide actions taken and that is developed in collaboration with the client. It is based on selected theories, frames of reference, and evidence. Outcomes to be targeted are confirmed.

*Intervention implementation*—Ongoing actions taken to influence and support improved client performance and participation. Interventions are directed at identified outcomes. The client's response is monitored and documented.

*Intervention review*—Review of the intervention plan and progress toward targeted outcomes.

### Targeting of Outcomes

*Outcomes*—Determinants of success in reaching the desired end result of the occupational therapy process. Outcome assessment information is used to plan future actions with the client and to evaluate the service program (i.e., program evaluation).

#### Exhibit 2. Process of occupational therapy service delivery.

The process of service delivery is applied within the profession's domain to support the client's health and participation.

the client-centered delivery of occupational therapy services. The process includes evaluation and intervention to achieve targeted outcomes, occurs within the purview of the occupational therapy domain, and is facilitated by the distinct perspective of occupational therapy practitioners when engaging in clinical reasoning, analyzing activities and occupations, and collaborating with clients. This section is organized into four broad areas: (1)

an overview of the process as it is applied within the profession's domain, (2) the evaluation process, (3) the intervention process, and (4) the process of targeting outcomes.

#### Overview of the Occupational Therapy Process

Many professions use a similar process of evaluating, intervening, and targeting intervention outcomes. However,

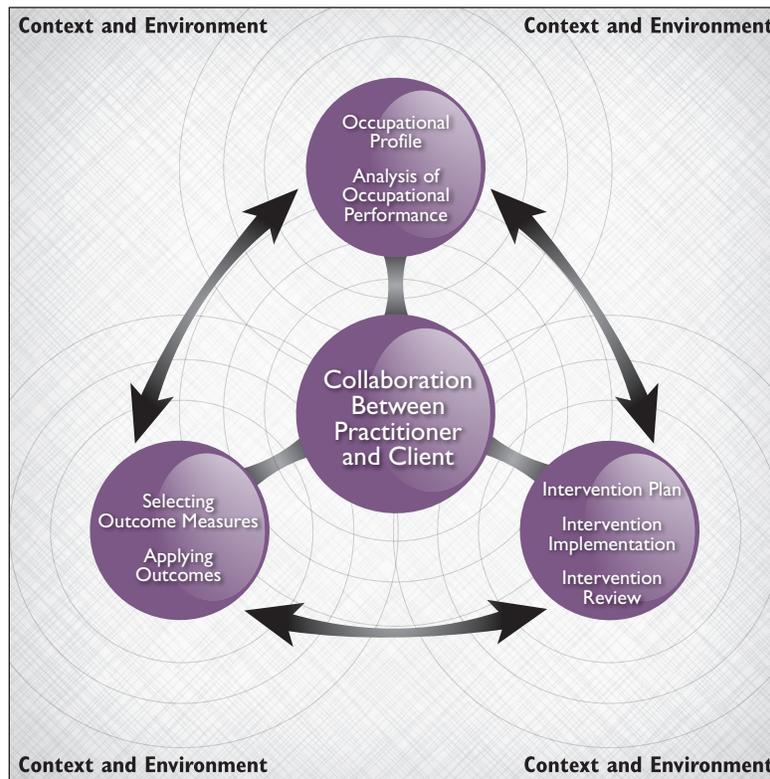


Figure 2. Occupational therapy's process.

only occupational therapy practitioners focus on the use of occupations to promote health, well-being, and participation in life. Occupational therapy practitioners use therapeutically selected occupations and activities as primary methods of intervention throughout the process (Table 6).

To help clients achieve desired outcomes, occupational therapy practitioners facilitate interactions among the client, his or her environments and contexts, and the occupations in which he or she engages. This perspective is based on the theories, knowledge, and skills generated and used by the profession and informed by available evidence (Clark et al., 2012; Davidson, Shahar, Lawless, Sells, & Tondora, 2006; Glass, de Leon, Marottoli, & Berkman, 1999; Jackson, Carlson, Mandel, Zemke, & Clark, 1998; Sandqvist, Akesson, & Eklund, 2005).

Analyzing occupational performance requires an understanding of the complex and dynamic interaction among client factors, performance skills, performance patterns, and contexts and environments, along with the activity demands of the occupation being performed. Occupational therapy practitioners attend to each aspect and gauge the influence of each on the others, individually and collectively. By understanding how these aspects influence each other, practitioners can better evaluate how each aspect contributes to clients' performance-related concerns and potentially contributes to interventions that support occupational performance.

For ease of explanation, the *Framework* describes the occupational therapy process as being linear. In reality, the process does not occur in a sequenced, step-by-step fashion. Rather, it is fluid and dynamic, allowing occupational therapy practitioners and clients to maintain their focus on the identified outcomes while continually reflecting on and changing the overall plan to accommodate new developments and insights along the way.

The broader definition of *client* included in this document is indicative of the profession's increasing involvement in providing services not only to a person but also to groups and populations. When working with a group or population, occupational therapy practitioners consider the collective occupational performance abilities of the members. Whether the client is a person, group, or population, information about the client's wants, needs, strengths, limitations, and occupational risks is gathered, synthesized, and framed from an occupational perspective.

### *Service Delivery Models*

Occupational therapy practitioners provide services to clients directly, in settings such as hospitals, clinics, industry, schools, homes, and communities, and indi-

rectly on behalf of clients through consultation. Direct services include interventions completed when in direct contact with the individual or group of clients. These interventions are completed through various mechanisms such as meeting in person with a client, leading a group session, or interacting with clients and families through telehealth systems (AOTA, 2013c).

When providing services to clients indirectly on their behalf, practitioners provide consultation to entities such as teachers, multidisciplinary teams, and community planning agencies. Occupational therapy practitioners also provide consultation to community organizations such as park districts and civic organizations that may or may not include people with disabilities. In addition, practitioners consult with businesses regarding the work environment, ergonomic modifications, and compliance with the Americans With Disabilities Act of 1990 (Pub. L. 101–336).

Occupational therapy practitioners can indirectly affect the lives of clients through advocacy. Common examples of advocacy include talking to legislators about improving transportation for older adults or improving services for people with mental or physical disabilities to support their living and working in the community of their choice.

Regardless of the service delivery model, the individual client may not be the exclusive focus of the intervention. For example, the needs of an at-risk infant may be the initial impetus for intervention, but the concerns and priorities of the parents, extended family, and funding agencies are also considered. Occupational therapy practitioners understand and focus intervention to include the issues and concerns surrounding the complex dynamics among the client, caregiver, and family. Similarly, services addressing independent living skills for adults coping with serious and persistent mental illness may also address the needs and expectations of state and local services agencies and of potential employers.

### *Clinical Reasoning*

Throughout the process, occupational therapy practitioners are continually engaged in clinical reasoning about a client's occupational performance. Clinical reasoning enables practitioners to

- Identify the multiple demands, required skills, and potential meanings of the activities and occupations and
- Gain a deeper understanding of the interrelationships between aspects of the domain that affect performance and that support client-centered interventions and outcomes.

Occupational therapy practitioners use theoretical principles and models, knowledge about the effects of conditions on participation, and available evidence of the effectiveness of intervention to guide their reasoning. Clinical reasoning ensures the accurate selection and application of evaluations, interventions, and client-centered outcome measures. Practitioners also apply their knowledge and skills to enhance clients' participation in occupations and promote their health and well-being regardless of the effects of disease, disability, and occupational disruption or deprivation.

### *Therapeutic Use of Self*

An integral part of the occupational therapy process is *therapeutic use of self*, which allows occupational therapy practitioners to develop and manage their therapeutic relationship with clients by using narrative and clinical reasoning; empathy; and a client-centered, collaborative approach to service delivery (Taylor & Van Puymbroeck, 2013). *Empathy* is the emotional exchange between occupational therapy practitioners and clients that allows more open communication, ensuring that practitioners connect with clients at an emotional level to assist them with their current life situation.

Occupational therapy practitioners use narrative and clinical reasoning to help clients make sense of the information they are receiving in the intervention process, to discover meaning, and to build hope (Peloquin, 2003; Taylor & Van Puymbroeck, 2013). Clients have identified the therapeutic relationship as critical to the outcome of occupational therapy intervention (Cole & McLean, 2003).

Occupational therapy practitioners develop a collaborative relationship with clients to understand their experiences and desires for intervention. The collaborative approach used throughout the process honors the contributions of clients along with practitioners. Through the use of interpersonal communication skills, occupational therapy practitioners shift the power of the relationship to allow clients more control in decision making and problem solving, which is essential to effective intervention.

Clients bring to the occupational therapy process their knowledge about their life experiences and their hopes and dreams for the future. They identify and share their needs and priorities. Occupational therapy practitioners bring their knowledge about how engagement in occupation affects health, well-being, and participation; they use this information, coupled with theoretical perspectives and clinical reasoning, to critically observe, analyze, describe, and interpret human performance. Practitioners and clients, together with caregivers, family members, community members, and other

stakeholders (as appropriate), identify and prioritize the focus of the intervention plan.

### *Activity Analysis*

Activity analysis is an important process occupational therapy practitioners use to understand the demands a specific activity places on a client:

*Activity analysis* addresses the typical demands of an activity, the range of skills involved in its performance, and the various cultural meanings that might be ascribed to it. . . . Occupation-based activity analysis places the person in the foreground. It takes into account the particular person's interests, goals, abilities, and contexts, as well as the demands of the activity itself. These considerations shape the practitioner's efforts to help the . . . person reach his/her goals through carefully designed evaluation and intervention. (Crepeau, 2003, pp. 192–193)

Occupational therapy practitioners analyze the demands of an activity or occupation to understand the specific body structures, body functions, performance skills, and performance patterns that are required and to determine the generic demands the activity or occupation makes on the client.

*Activity and occupational demands* are the specific features of an activity and occupation that influence its meaning for the client and the type and amount of effort required to engage in it. Activity and occupational demands include the following (see Table 7 for definitions and examples):

- *The tools and resources needed to engage in the activity*—What specific objects are used in the activity? What are their properties, and what transportation, money, or other resources are needed to participate in the activity?
- *Where and with whom the activity takes place*—What are the physical space requirements of the activity, and what are the social interaction demands?
- *How the activity is accomplished*—What process is used in carrying out the activity, including the sequence and timing of the steps and necessary procedures and rules?
- *How the activity challenges the client's capacities*—What actions, performance skills, body functions, and body structures are the individual, group, or population required to use during the performance of the activity?
- *The meaning the client derives from the activity*—What potential symbolic, unconscious, and metaphorical meanings does the individual attach to the activity (e.g., driving a car equates with independence, preparing a holiday meal connects with family tradition, voting is a rite of passage to adulthood)?

Activity and occupational demands are specific to each activity. A change in one feature of an activity may change the extent of the demand in another feature. For example, an increase in the number or sequence of steps in an activity increases the demand on attention skills.

### *Evaluation Process*

The evaluation process is focused on finding out what a client wants and needs to do; determining what a client can do and has done; and identifying supports and barriers to health, well-being, and participation. Evaluation occurs during the initial and all subsequent interactions with a client. The type and focus of the evaluation differ depending on the practice setting.

The evaluation consists of the occupational profile and an analysis of occupational performance. The occupational profile includes information about the client's needs, problems, and concerns about performance in occupations. The analysis of occupational performance focuses on collecting and interpreting information to more specifically identify supports and barriers related to occupational performance and identify targeted outcomes.

Although the *Framework* describes the components of the evaluation process separately and sequentially, the exact manner in which occupational therapists collect client information is influenced by client needs, practice settings, and therapists' frames of reference or practice models. Information related to the occupational profile is gathered throughout the occupational therapy process.

### *Occupational Profile*

The *occupational profile* is a summary of a client's occupational history and experiences, patterns of daily living, interests, values, and needs. Developing the occupational profile provides the occupational therapy practitioner with an understanding of a client's perspective and background.

Using a client-centered approach, the practitioner gathers information to understand what is currently important and meaningful to the client (i.e., what he or she wants and needs to do) and to identify past experiences and interests that may assist in the understanding of current issues and problems. During the process of collecting this information, the client, with the assistance of the occupational therapy practitioner, identifies priorities and desired targeted outcomes that will lead to the client's engagement in occupations that support participation in life. Only clients can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting clients' input, practitioners help foster their involvement and can more efficiently guide interventions.

Occupational therapy practitioners collect information for the occupational profile at the beginning of contact with clients to establish client-centered outcomes. Over time, practitioners collect additional information, refine the profile, and ensure that the additional information is reflected in changes subsequently made to targeted outcomes. The process of completing and refining the occupational profile varies by setting and client. The information gathered in the profile may be completed in one session or over a longer period while working with a client. For clients who are unable to participate in this process, their profiles may be compiled through interaction with family members or other significant people in their lives.

Obtaining information for the occupational profile through both formal interview techniques and casual conversation is a way to establish a therapeutic relationship with clients and their support network. The information obtained through the occupational profile leads to an individualized approach in the evaluation, intervention planning, and intervention implementation stages. Information is collected in the following areas:

- Why is the client seeking service, and what are the client's current concerns relative to engaging in occupations and in daily life activities?
- In what occupations does the client feel successful, and what barriers are affecting his or her success?
- What aspects of his or her environments or contexts does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement?
- What is the client's occupational history (i.e., life experiences)?
- What are the client's values and interests?
- What are the client's daily life roles?
- What are the client's patterns of engagement in occupations, and how have they changed over time?
- What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, participation, role competence, health and wellness, quality of life, well-being, and occupational justice?

After collecting profile data, occupational therapists view the information and develop a working hypothesis regarding possible reasons for the identified problems and concerns. Reasons could include impairments in client factors, performance skills, and performance patterns or barriers within the context and environment. Therapists then work with clients to establish preliminary goals and outcome measures. In addition,

therapists note strengths and supports within all areas because these can inform the intervention plan and affect future outcomes.

### *Analysis of Occupational Performance*

*Occupational performance* is the accomplishment of the selected occupation resulting from the dynamic transaction among the client, the context and environment, and the activity or occupation. In the *analysis of occupational performance*, the client's assets and problems or potential problems are more specifically identified through assessment tools designed to observe, measure, and inquire about factors that support or hinder occupational performance. Targeted outcomes also are identified. The analysis of occupational performance involves one or more of the following activities:

- Synthesizing information from the occupational profile to focus on specific occupations and contexts that need to be addressed
- Observing a client's performance during activities relevant to desired occupations, noting effectiveness of performance skills and performance patterns
- Selecting and using specific assessments to measure performance skills and performance patterns, as appropriate
- Selecting and administering assessments, as needed, to identify and measure more specifically the contexts or environments, activity demands, and client factors that influence performance skills and performance patterns
- Selecting outcome measures
- Interpreting the assessment data to identify supports and hindrances to performance
- Developing and refining hypotheses about the client's occupational performance strengths and limitations
- Creating goals in collaboration with the client that address the desired outcomes
- Determining procedures to measure the outcomes of intervention
- Delineating a potential intervention approach or approaches based on best practices and available evidence.

Multiple methods often are used during the evaluation process to assess client, environment or context, occupation or activity, and occupational performance. Methods may include an interview with the client and significant others, observation of performance and context, record review, and direct assessment of specific aspects of performance. Formal and informal, struc-

ured and unstructured, and standardized criterion- or norm-referenced assessment tools can be used. Standardized assessments are preferred, when available, to provide objective data about various aspects of the domain influencing engagement and performance. The use of valid and reliable assessments for obtaining trustworthy information can also help support and justify the need for occupational therapy services (Doucet & Gutman, 2013; Gutman, Mortera, Hinojosa, & Kramer, 2007).

Implicit in any outcome assessment used by occupational therapy practitioners are clients' belief systems and underlying assumptions regarding their desired occupational performance. Occupational therapists select outcome assessments pertinent to clients' needs and goals, congruent with the practitioner's theoretical model of practice and based on knowledge of the psychometric properties of standardized measures or the rationale and protocols of nonstandardized yet structured measures and the available evidence. In addition, clients' perception of success in engaging in desired occupations is vital to any outcomes assessment (Bandura, 1986).

### *Intervention Process*

The intervention process consists of the skilled services provided by occupational therapy practitioners in collaboration with clients to facilitate engagement in occupation related to health, well-being, and participation. Practitioners use the information about clients gathered during the evaluation and theoretical principles to direct occupation-centered interventions. Intervention is then provided to assist clients in reaching a state of physical, mental, and social well-being; identifying and realizing aspirations; satisfying needs; and changing or coping with the environment. Types of occupational therapy interventions are discussed in Table 6.

Intervention is intended to promote health, well-being, and participation. *Health promotion* is "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). Wilcock (2006) stated,

Following an occupation-focused health promotion approach to well-being embraces a belief that the potential range of what people can do, be, and strive to become is the primary concern, and that health is a by-product. A varied and full occupational lifestyle will coincidentally maintain and improve health and well-being if it enables people to be creative and adventurous physically, mentally, and socially. (p. 315)

Interventions vary depending on the client—person, group, or population—and the context of service deliv-

ery (Moyers & Dale, 2007). The actual term used for clients or groups of clients receiving occupational therapy varies among practice settings and delivery models. For example, when working in a hospital, the person or group might be referred to as a *patient* or *patients*, and in a school, the clients might be *students*. When providing consultation to an organization, clients may be called *consumers* or *members*. The term *person* includes others who may help or be served indirectly, such as caregiver, teacher, parent, employer, or spouse.

Interventions provided to groups and populations are directed to all the members collectively rather than individualized to specific people within the group. Practitioners direct their interventions toward current or potential disabling conditions with the goal of enhancing the health, well-being, and participation of all group members collectively. The intervention focus often is on health promotion activities, self-management, educational services, and environmental modification. For instance, occupational therapy practitioners may provide education on falls prevention and the impact of fear of falling to a group of residents in an assisted living center or provide support to people with psychiatric disability as they learn to use the Internet to identify and coordinate community resources that meet their needs. Practitioners may work with a wide variety of populations experiencing difficulty in accessing and engaging in healthy occupations because of conditions such as poverty, homelessness, and discrimination.

The intervention process is divided into three steps: (1) intervention plan, (2) intervention implementation, and (3) intervention review. During the intervention process, information from the evaluation is integrated with theory, practice models, frames of reference, and evidence. This information guides occupational therapy practitioners' clinical reasoning in the development, implementation, and review of the intervention plan.

### *Intervention Plan*

The *intervention plan*, which directs the actions of occupational therapy practitioners, describes selected occupational therapy approaches and types of interventions to be used in reaching clients' identified outcomes. The intervention plan is developed collaboratively with clients or their proxies and is directed by

- Client goals, values, beliefs, and occupational needs;
- Client health and well-being;
- Client performance skills and performance patterns;
- Collective influence of the context and environment, activity demands, and client factors on the client;

- Context of service delivery in which the intervention is provided; and
- Best available evidence.

The selection and design of the intervention plan and goals are directed toward addressing clients' current and potential situation related to engagement in occupations or activities. Intervention planning includes the following steps:

1. Developing the plan, which involves selecting
  - Objective and measurable occupation-focused goals and related time frames;
  - The occupational therapy intervention approach or approaches, such as create or promote, establish or restore, maintain, modify, and prevent (Table 8); and
  - Methods for service delivery, including who will provide the intervention, types of interventions, and service delivery models to be used.
2. Considering potential discharge needs and plans.
3. Making recommendations or referrals to other professionals as needed.

### *Intervention Implementation*

*Intervention implementation* is the process of putting the intervention plan into action. Interventions may focus on a single aspect of the domain, such as a specific occupation, or on several aspects of the domain, such as context and environment, performance patterns, and performance skills.

Given that aspects of the domain are interrelated and influence one another in a continuous, dynamic process, occupational therapy practitioners expect that a client's ability to adapt, change, and develop in one area will affect other areas. Because of this dynamic interrelationship, evaluation and intervention planning continue throughout the implementation process.

Intervention implementation includes the following steps:

1. Determining and carrying out the occupational therapy intervention or interventions to be used (see Table 6), which may include the following:
  - Therapeutic use of occupations and activities
  - Preparatory methods (e.g., splinting, assistive technology, wheeled mobility) and preparatory tasks
  - Education and training
  - Advocacy (e.g., advocacy, self-advocacy)
  - Group interventions.
2. Monitoring a client's response to specific interventions on the basis of ongoing evaluation and reevaluation of his or her progress toward goals.

## Intervention Review

*Intervention review* is the continuous process of reevaluating and reviewing the intervention plan, the effectiveness of its delivery, and progress toward outcomes. As during intervention planning, this process includes collaboration with the client on the basis of identified goals and progress toward the associated outcomes. Reevaluation and review may lead to change in the intervention plan.

The intervention review includes the following steps:

1. Reevaluating the plan and how it is implemented relative to achieving outcomes
2. Modifying the plan as needed
3. Determining the need for continuation or discontinuation of occupational therapy services and for referral to other services.

## Targeting of Outcomes

*Outcomes* are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention. The benefits of occupational therapy are multifaceted and may occur in all aspects of the domain of concern. Outcomes are directly related to the interventions provided and to the occupations, client factors, performance skills, performance patterns, and contexts and environments targeted. Outcomes may also be traced to the improved transactional relationship among the areas of the domain that result in clients' ability to engage in desired occupations secondary to improved abilities at the client factor and performance skill level (Table 9).

In addition, outcomes may relate to clients' subjective impressions regarding goal attainment, such as improved outlook, confidence, hope, playfulness, self-efficacy, sustainability of valued occupations, resilience, and perceived well-being. An example of a subjective outcome of intervention is parents' greater perceived efficacy about their parenting through a new understanding of their child's behavior after receiving occupational therapy services (Cohn, 2001; Cohn, Miller, & Tickle-Degnen, 2000; Graham, Rodger, & Ziviani, 2013).

Interventions can also be designed for caregivers of people with dementia to improve quality of life for both care recipient and caregiver. Caregivers who received intervention reported fewer declines in occupational performance, enhanced mastery and skill, improved sense of self-efficacy and well-being, and less need for help with care recipients (Gitlin & Corcoran, 2005; Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001; Gitlin et al., 2003, 2008; Graff et al., 2007).

Outcomes for groups may include improved social interaction, increased self-awareness through peer support, a larger social network, or increased workplace productivity with fewer injuries. Outcomes for populations may include health promotion, occupational justice and self-advocacy, and access to services. The impact of outcomes and the way they are defined are specific to clients and to other stakeholders such as payers and regulators. Specific outcomes and documentation of those outcomes vary by practice setting and are influenced by the stakeholders in each setting.

The focus on outcomes is woven throughout the process of occupational therapy. Occupational therapists and clients collaborate during evaluation to identify initial client outcomes related to engagement in valued occupations or daily life activities. During intervention implementation and reevaluation, clients, occupational therapists, and, when appropriate, occupational therapy assistants may modify outcomes to accommodate changing needs, contexts, and performance abilities. As further analysis of occupational performance and the development of the intervention plan occur, therapists and clients may redefine the desired outcomes.

Implementation of the outcomes process includes the following steps:

1. Selecting types of outcomes and measures, including but not limited to occupational performance, prevention, health and wellness, quality of life, participation, role competence, well-being, and occupational justice (see Table 9). Outcome measures are
  - Selected early in the intervention process (see "Evaluation Process" section);
  - Valid, reliable, and appropriately sensitive to change in clients' occupational performance;
  - Consistent with targeted outcomes;
  - Congruent with clients' goals; and
  - Selected on the basis of their actual or purported ability to predict future outcomes.
2. Using outcomes to measure progress and adjust goals and interventions by
  - Comparing progress toward goal achievement to outcomes throughout the intervention process and
  - Assessing outcome use and results to make decisions about the future direction of intervention (e.g., continue intervention, modify intervention, discontinue intervention, provide follow-up, refer for other services).

Outcomes and the other aspects of the occupational therapy process are summarized in Exhibit 3.

Evaluation		Intervention			Targeting of Outcomes
Occupational Profile	Analysis of Occupational Performance	Intervention Plan	Intervention Implementation	Intervention Review	Outcomes
<p>Identify the following:</p> <ul style="list-style-type: none"> <li>• Why is the client seeking service, and what are the client's current concerns relative to engaging in activities and occupations?</li> <li>• In what occupations does the client feel successful, and what barriers are affecting his or her success?</li> <li>• What aspects of the contexts or environments does the client see as supporting and as inhibiting engagement in desired occupations?</li> <li>• What is the client's occupational history?</li> <li>• What are the client's values and interests?</li> <li>• What are the client's daily life roles?</li> <li>• What are the client's patterns of engagement in occupations, and how have they changed over time?</li> <li>• What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, participation, role competence, health and wellness, quality of life, well-being, and occupational justice?</li> </ul>	<ul style="list-style-type: none"> <li>• Synthesize information from the occupational profile to focus on specific occupations and contexts.</li> <li>• Observe the client's performance during activities relevant to desired occupations.</li> <li>• Select and use specific assessments to identify and measure contexts or environments, activity and occupational demands, client factors, and performance skills and patterns.</li> <li>• Select outcome measures.</li> <li>• Interpret assessment data to identify supports for and hindrances to performance.</li> <li>• Develop and refine hypotheses about the client's occupational performance strengths and limitations.</li> <li>• Create goals in collaboration with the client that address desired outcomes.</li> <li>• Determine procedures to measure the outcomes of intervention.</li> <li>• Delineate a potential intervention based on best practices and available evidence.</li> </ul>	<ol style="list-style-type: none"> <li>1. Develop the plan, which involves selecting <ul style="list-style-type: none"> <li>• Objective and measurable occupation-focused goals and related time frames;</li> <li>• Occupational therapy intervention approach or approaches, such as create or promote, establish or restore, maintain, modify, or prevent; and</li> <li>• Methods for service delivery, including who will provide the intervention, types of intervention, and service delivery models.</li> </ul> </li> <li>2. Consider potential discharge needs and plans.</li> <li>3. Recommend or refer to other professionals as needed.</li> </ol>	<ol style="list-style-type: none"> <li>1. Determine and carry out occupational therapy intervention or interventions, which may include the following: <ul style="list-style-type: none"> <li>• Therapeutic use of occupations and activities</li> <li>• Preparatory methods and tasks</li> <li>• Education and training</li> <li>• Advocacy</li> <li>• Group interventions</li> </ul> </li> <li>2. Monitor the client's response through ongoing evaluation and reevaluation.</li> </ol>	<ol style="list-style-type: none"> <li>1. Reevaluate the plan and implementation relative to achieving outcomes.</li> <li>2. Modify the plan as needed.</li> <li>3. Determine the need for continuation or discontinuation of occupational therapy services and for referral.</li> </ol>	<ol style="list-style-type: none"> <li>1. Early in the intervention process, select outcomes and measures that are <ul style="list-style-type: none"> <li>• Valid, reliable, sensitive to change, and consistent with outcomes</li> <li>• Congruent with client goals</li> <li>• Based on their actual or purported ability to predict future outcomes</li> </ul> </li> <li>2. Apply outcomes to measure progress and adjust goals and interventions. <ul style="list-style-type: none"> <li>• Compare progress toward goal achievement to outcomes throughout the intervention process.</li> <li>• Assess outcome use and results to make decisions about the future direction of intervention.</li> </ul> </li> </ol>
<p>←—————Ongoing interaction among evaluation, intervention, and outcomes occurs throughout the process.—————→</p> <p>←—————Continue to renegotiate intervention plans and targeted outcomes.—————→</p>					

**Exhibit 3. Operationalizing the occupational therapy process.**

## Conclusion

The *Framework* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and distinct contribution of the profession. The occupational therapy domain and process are linked inextricably in a transactional relationship, as illustrated in Figure 3. An understanding of this relationship supports and

guides the complex decision making required in the daily practice of occupational therapy and enhances practitioners' ability to define the reasons for and direct interventions to clients (persons, groups, and populations), family members, team members, payers, and policymakers. The *Framework* highlights the distinct value of occupation and occupational therapy in contributing to client health, well-being, and participation in life.

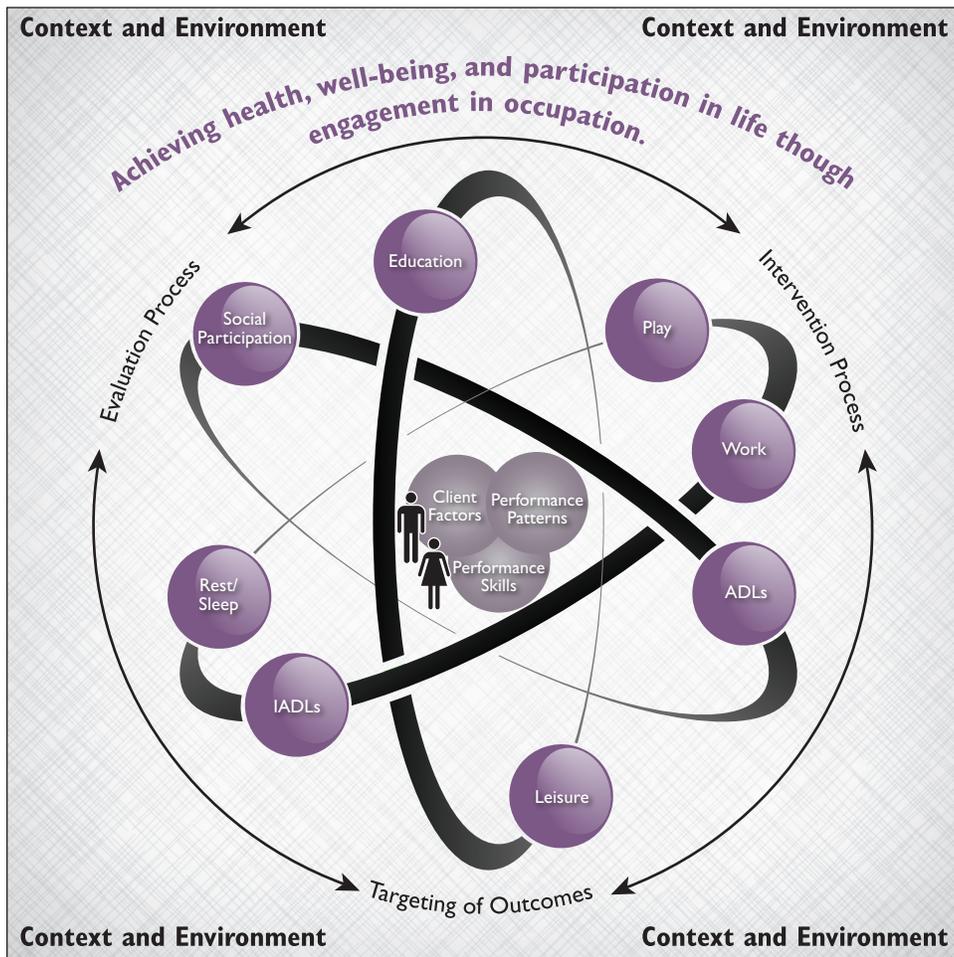


Figure 3. Occupational therapy domain and process.

**TABLE 1. OCCUPATIONS**

Occupations are various kinds of life activities in which individuals, groups, or populations engage, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation.

Category	Description
<p>■ <b>ACTIVITIES OF DAILY LIVING (ADLs)</b>—Activities oriented toward taking care of one's own body (adapted from Rogers &amp; Holm, 1994). ADLs also are referred to as <i>basic activities of daily living (BADLs)</i> and <i>personal activities of daily living (PADLs)</i>. These activities are "fundamental to living in a social world; they enable basic survival and well-being" (Christiansen &amp; Hammecker, 2001, p. 156).</p>	
<b>Bathing, showering</b>	Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; and transferring to and from bathing positions
<b>Toileting and toilet hygiene</b>	Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, and caring for menstrual and continence needs (including catheter, colostomy, and suppository management), as well as completing intentional control of bowel movements and urination and, if necessary, using equipment or agents for bladder control (Uniform Data System for Medical Rehabilitation, 1996, pp. III-20, III-24)
<b>Dressing</b>	Selecting clothing and accessories appropriate to time of day, weather, and occasion; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; and applying and removing personal devices, prosthetic devices, or splints
<b>Swallowing/eating</b>	Keeping and manipulating food or fluid in the mouth and swallowing it; <i>swallowing</i> is moving food from the mouth to the stomach
<b>Feeding</b>	Setting up, arranging, and bringing food [or fluid] from the plate or cup to the mouth; sometimes called <i>self-feeding</i>
<b>Functional mobility</b>	Moving from one position or place to another (during performance of everyday activities), such as in-bed mobility, wheelchair mobility, and transfers (e.g., wheelchair, bed, car, shower, tub, toilet, chair, floor). Includes functional ambulation and transportation of objects.
<b>Personal device care</b>	Using, cleaning, and maintaining personal care items, such as hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, glucometers, and contraceptive and sexual devices
<b>Personal hygiene and grooming</b>	Obtaining and using supplies; removing body hair (e.g., using razor, tweezers, lotion); applying and removing cosmetics; washing, drying, combing, styling, brushing, and trimming hair; caring for nails (hands and feet); caring for skin, ears, eyes, and nose; applying deodorant; cleaning mouth; brushing and flossing teeth; and removing, cleaning, and reinserting dental orthotics and prosthetics
<b>Sexual activity</b>	Engaging in activities that result in sexual satisfaction and/or meet relational or reproductive needs
<p>■ <b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)</b>—Activities to support daily life within the home and community that often require more complex interactions than those used in ADLs.</p>	
<b>Care of others (including selecting and supervising caregivers)</b>	Arranging, supervising, or providing care for others
<b>Care of pets</b>	Arranging, supervising, or providing care for pets and service animals
<b>Child rearing</b>	Providing care and supervision to support the developmental needs of a child
<b>Communication management</b>	Sending, receiving, and interpreting information using a variety of systems and equipment, including writing tools, telephones (cell phones or smartphones), keyboards, audiovisual recorders, computers or tablets, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for deaf people, augmentative communication systems, and personal digital assistants
<b>Driving and community mobility</b>	Planning and moving around in the community and using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, or other transportation systems
<b>Financial management</b>	Using fiscal resources, including alternate methods of financial transaction, and planning and using finances with long-term and short-term goals
<b>Health management and maintenance</b>	Developing, managing, and maintaining routines for health and wellness promotion, such as physical fitness, nutrition, decreased health risk behaviors, and medication routines
<b>Home establishment and management</b>	Obtaining and maintaining personal and household possessions and environment (e.g., home, yard, garden, appliances, vehicles), including maintaining and repairing personal possessions (e.g., clothing, household items) and knowing how to seek help or whom to contact

(Continued)

**TABLE 1. OCCUPATIONS***(Continued)*

<b>Category</b>	<b>Description</b>
<b>Meal preparation and cleanup</b>	Planning, preparing, and serving well-balanced, nutritious meals and cleaning up food and utensils after meals
<b>Religious and spiritual activities and expression</b>	Participating in <i>religion</i> , “an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent” (Moreira-Almeida & Koenig, 2006, p. 844), and engaging in activities that allow a sense of connectedness to something larger than oneself or that are especially meaningful, such as taking time out to play with a child, engaging in activities in nature, and helping others in need (Spencer, Davidson, & White, 1997)
<b>Safety and emergency maintenance</b>	Knowing and performing preventive procedures to maintain a safe environment; recognizing sudden, unexpected hazardous situations; and initiating emergency action to reduce the threat to health and safety; examples include ensuring safety when entering and exiting the home, identifying emergency contact numbers, and replacing items such as batteries in smoke alarms and light bulbs
<b>Shopping</b>	Preparing shopping lists (grocery and other); selecting, purchasing, and transporting items; selecting method of payment; and completing money transactions; included are Internet shopping and related use of electronic devices such as computers, cell phones, and tablets
■ <b>REST AND SLEEP</b> —Activities related to obtaining restorative rest and sleep to support healthy, active engagement in other occupations.	
<b>Rest</b>	Engaging in quiet and effortless actions that interrupt physical and mental activity, resulting in a relaxed state (Nurit & Michal, 2003, p. 227); included are identifying the need to relax; reducing involvement in taxing physical, mental, or social activities; and engaging in relaxation or other endeavors that restore energy and calm and renew interest in engagement
<b>Sleep preparation</b>	(1) Engaging in routines that prepare the self for a comfortable rest, such as grooming and undressing, reading or listening to music to fall asleep, saying goodnight to others, and engaging in meditation or prayers; determining the time of day and length of time desired for sleeping and the time needed to wake; and establishing sleep patterns that support growth and health (patterns are often personally and culturally determined). (2) Preparing the physical environment for periods of unconsciousness, such as making the bed or space on which to sleep; ensuring warmth or coolness and protection; setting an alarm clock; securing the home, such as locking doors or closing windows or curtains; and turning off electronics or lights.
<b>Sleep participation</b>	Taking care of personal needs for sleep, such as ceasing activities to ensure onset of sleep, napping, and dreaming; sustaining a sleep state without disruption; and performing nighttime care of toileting needs and hydration; also includes negotiating the needs and requirements of and interacting with others within the social environment such as children or partners, including providing nighttime caregiving such as breastfeeding and monitoring the comfort and safety of others who are sleeping
■ <b>EDUCATION</b> —Activities needed for learning and participating in the educational environment.	
Formal educational participation	Participating in academic (e.g., math, reading, degree coursework), nonacademic (e.g., recess, lunchroom, hallway), extracurricular (e.g., sports, band, cheerleading, dances), and vocational (prevocational and vocational) educational activities
Informal personal educational needs or interests exploration (beyond formal education)	Identifying topics and methods for obtaining topic-related information or skills
Informal personal education participation	Participating in informal classes, programs, and activities that provide instruction or training in identified areas of interest
■ <b>WORK</b> —“Labor or exertion; to make, construct, manufacture, form, fashion, or shape objects; to organize, plan, or evaluate services or processes of living or governing; committed occupations that are performed with or without financial reward” (Christiansen & Townsend, 2010, p. 423).	
<b>Employment interests and pursuits</b>	Identifying and selecting work opportunities based on assets, limitations, likes, and dislikes relative to work (adapted from Mosey, 1996, p. 342)
<b>Employment seeking and acquisition</b>	Advocating for oneself; completing, submitting, and reviewing appropriate application materials; preparing for interviews; participating in interviews and following up afterward; discussing job benefits; and finalizing negotiations
<b>Job performance</b>	Performing the requirements of a job, including work skills and patterns; time management; relationships with coworkers, managers, and customers; leadership and supervision; creation, production, and distribution of products and services; initiation, sustainment, and completion of work; and compliance with work norms and procedures
<b>Retirement preparation and adjustment</b>	Determining aptitudes, developing interests and skills, selecting appropriate avocational pursuits, and adjusting lifestyle in the absence of the worker role

*(Continued)*

**TABLE 1. OCCUPATIONS***(Continued)*

Category	Description
<b>Volunteer exploration</b>	Determining community causes, organizations, or opportunities for unpaid work in relationship to personal skills, interests, location, and time available
<b>Volunteer participation</b>	Performing unpaid work activities for the benefit of selected causes, organizations, or facilities
■ <b>PLAY</b> —“Any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion” (Parham & Fazio, 1997, p. 252).	
<b>Play exploration</b>	Identifying appropriate play activities, including exploration play, practice play, pretend play, games with rules, constructive play, and symbolic play (adapted from Bergen, 1988, pp. 64–65)
<b>Play participation</b>	Participating in play; maintaining a balance of play with other occupations; and obtaining, using, and maintaining toys, equipment, and supplies appropriately
■ <b>LEISURE</b> —“Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep” (Parham & Fazio, 1997, p. 250).	
<b>Leisure exploration</b>	Identifying interests, skills, opportunities, and appropriate leisure activities
<b>Leisure participation</b>	Planning and participating in appropriate leisure activities; maintaining a balance of leisure activities with other occupations; and obtaining, using, and maintaining equipment and supplies as appropriate
■ <b>SOCIAL PARTICIPATION</b> —“The interweaving of occupations to support desired engagement in community and family activities as well as those involving peers and friends” (Gillen & Boyt Schell, 2014, p. 607); involvement in a subset of activities that involve social situations with others (Bedell, 2012) and that support social interdependence (Magasi & Hammel, 2004). Social participation can occur in person or through remote technologies such as telephone calls, computer interaction, and video conferencing.	
<b>Community</b>	Engaging in activities that result in successful interaction at the community level (e.g., neighborhood, organization, workplace, school, religious or spiritual group)
<b>Family</b>	Engaging in activities that result in “successful interaction in specific required and/or desired familial roles” (Mosey, 1996, p. 340)
<b>Peer, friend</b>	Engaging in activities at different levels of interaction and intimacy, including engaging in desired sexual activity

**TABLE 2. CLIENT FACTORS**

Client factors include (1) values, beliefs, and spirituality; (2) body functions; and (3) body structures that reside within the client that influence the client's performance in occupations.

<p>■ <b>VALUES, BELIEFS, AND SPIRITUALITY</b>—Clients' perceptions, motivations, and related meaning that influence or are influenced by engagement in occupations.</p>	
Category and Definition	Examples
<p><b>Values</b>—Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008)</p>	<p><i>Person:</i></p> <ul style="list-style-type: none"> <li>• Honesty with self and others</li> <li>• Commitment to family</li> </ul> <p><i>Group:</i></p> <ul style="list-style-type: none"> <li>• Obligation to provide a service</li> <li>• Fairness</li> </ul> <p><i>Population:</i></p> <ul style="list-style-type: none"> <li>• Freedom of speech</li> <li>• Equal opportunities for all</li> <li>• Tolerance toward others</li> </ul>
<p><b>Beliefs</b>—Cognitive content held as true by or about the client</p>	<p><i>Person:</i></p> <ul style="list-style-type: none"> <li>• One is powerless to influence others.</li> <li>• Hard work pays off.</li> </ul> <p><i>Group and population:</i></p> <ul style="list-style-type: none"> <li>• Some personal rights are worth fighting for.</li> <li>• A new health care policy, as yet untried, will positively affect society.</li> </ul>
<p><b>Spirituality</b>—“The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (Puchalski et al., 2009, p. 887)</p>	<p><i>Person:</i></p> <ul style="list-style-type: none"> <li>• Daily search for purpose and meaning in one's life</li> <li>• Guidance of actions by a sense of value beyond the personal acquisition of wealth or fame</li> </ul> <p><i>Group and population:</i></p> <ul style="list-style-type: none"> <li>• Common search for purpose and meaning in life</li> <li>• Guidance of actions by values agreed on by the collective</li> </ul>
<p>■ <b>BODY FUNCTIONS</b>—“The physiological functions of body systems (including psychological functions)” (WHO, 2001, p. 10). This section of the table is organized according to the classifications of the <i>International Classification of Functioning, Disability and Health (ICF)</i>; for fuller descriptions and definitions, refer to WHO (2001).</p>	
Category	Description (not an all-inclusive list)
<b>Mental functions</b> (affective, cognitive, perceptual)	
<b>Specific mental functions</b>	
Higher-level cognitive	Judgment, concept formation, metacognition, executive functions, praxis, cognitive flexibility, insight
Attention	Sustained shifting and divided attention, concentration, distractibility
Memory	Short-term, long-term, and working memory
Perception	Discrimination of sensations (e.g., auditory, tactile, visual, olfactory, gustatory, vestibular, proprioceptive)
Thought	Control and content of thought, awareness of reality vs. delusions, logical and coherent thought
Mental functions of sequencing complex movement	Mental functions that regulate the speed, response, quality, and time of motor production, such as restlessness, toe tapping, or hand wringing, in response to inner tension
Emotional	Regulation and range of emotions; appropriateness of emotions, including anger, love, tension, and anxiety; lability of emotions
Experience of self and time	Awareness of one's identity, body, and position in the reality of one's environment and of time
<b>Global mental functions</b>	
Consciousness	State of awareness and alertness, including the clarity and continuity of the wakeful state
Orientation	Orientation to person, place, time, self, and others
Temperament and personality	Extroversion, introversion, agreeableness, conscientiousness, emotional stability, openness to experience, self-control, self-expression, confidence, motivation, impulse control, appetite

(Continued)

**TABLE 2. CLIENT FACTORS***(Continued)*

<b>Category</b>	<b>Description (not an all-inclusive list)</b>
Energy and drive	Energy level, motivation, appetite, craving, impulse control
Sleep	Physiological process, quality of sleep
<b>Sensory functions</b>	
Visual functions	Quality of vision, visual acuity, visual stability, and visual field functions to promote visual awareness of environment at various distances for functioning
Hearing functions	Sound detection and discrimination; awareness of location and distance of sounds
Vestibular functions	Sensation related to position, balance, and secure movement against gravity
Taste functions	Association of taste qualities of bitterness, sweetness, sourness, and saltiness
Smell functions	Sensing odors and smells
Proprioceptive functions	Awareness of body position and space
Touch functions	Feeling of being touched by others or touching various textures, such as those of food; presence of numbness, paresthesia, hyperesthesia
Pain (e.g., diffuse, dull, sharp, phantom)	Unpleasant feeling indicating potential or actual damage to some body structure; sensations of generalized or localized pain (e.g., diffuse, dull, sharp, phantom)
Sensitivity to temperature and pressure	Thermal awareness (hot and cold), sense of force applied to skin
<b>Neuromusculoskeletal and movement-related functions</b>	
Functions of joints and bones	
Joint mobility	Joint range of motion
Joint stability	Maintenance of structural integrity of joints throughout the body; physiological stability of joints related to structural integrity
<b>Muscle functions</b>	
Muscle power	Strength
Muscle tone	Degree of muscle tension (e.g., flaccidity, spasticity, fluctuation)
Muscle endurance	Sustaining muscle contraction
<b>Movement functions</b>	
Motor reflexes	Involuntary contraction of muscles automatically induced by specific stimuli (e.g., stretch, asymmetrical tonic neck, symmetrical tonic neck)
Involuntary movement reactions	Postural reactions, body adjustment reactions, supporting reactions
Control of voluntary movement	Eye–hand and eye–foot coordination, bilateral integration, crossing of the midline, fine and gross motor control, and oculomotor function (e.g., saccades, pursuits, accommodation, binocularity)
Gait patterns	Gait and mobility considered in relation to how they affect ability to engage in occupations in daily life activities; for example, walking patterns and impairments, asymmetric gait, stiff gait
<b>Cardiovascular, hematological, immunological, and respiratory system functions</b>	
<i>(Note. Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)</i>	
Cardiovascular system functions	Maintenance of blood pressure functions (hypertension, hypotension, postural hypotension), heart rate and rhythm
Hematological and immunological system functions	
Respiratory system functions	Rate, rhythm, and depth of respiration
Additional functions and sensations of the cardiovascular and respiratory systems	Physical endurance, aerobic capacity, stamina, fatigability
<b>Voice and speech functions; digestive, metabolic, and endocrine system functions; genitourinary and reproductive functions</b>	
<i>(Note. Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)</i>	
Voice and speech functions	Fluency and rhythm, alternative vocalization functions

*(Continued)*

**TABLE 2. CLIENT FACTORS***(Continued)*

Category	Description (not an all-inclusive list)
Digestive, metabolic, and endocrine system functions	Digestive system functions, metabolic system and endocrine system functions
Genitourinary and reproductive functions	Urinary functions, genital and reproductive functions
<b>Skin and related structure functions</b>	
<i>(Note. Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)</i>	
Skin functions	Protection (presence or absence of wounds, cuts, or abrasions), repair (wound healing)
Hair and nail functions	
■ <b>BODY STRUCTURES:</b> “Anatomical parts of the body, such as organs, limbs, and their components” that support body function (WHO, 2001, p. 10). The “Body Structures” section of the table is organized according to the <i>ICF</i> classifications; for fuller descriptions and definitions, refer to WHO (2001).	
Category	Examples not delineated in the “Body Structure” section of this table
<b>Structure of the nervous system</b> <b>Eyes, ear, and related structures</b> <b>Structures involved in voice and speech</b> <b>Structures of the cardiovascular, immunological, and respiratory systems</b> <b>Structures related to the digestive, metabolic, and endocrine systems</b> <b>Structures related to the genitourinary and reproductive systems</b> <b>Structures related to movement</b> <b>Skin and related structures</b>	<i>(Note. Occupational therapy practitioners have knowledge of body structures and understand broadly the interaction that occurs between these structures to support health, well-being, and participation in life through engagement in occupation.)</i>

*Note.* The categorization of body function and body structure client factors outlined in Table 2 is based on the *ICF* proposed by WHO (2001). The classification was selected because it has received wide exposure and presents a language that is understood by external audiences. WHO = World Health Organization.

**TABLE 3. PERFORMANCE SKILLS**

Performance skills *are observable elements of action that have an implicit functional purpose; skills are considered a classification of actions, encompassing multiple capacities (body functions and body structures) and, when combined, underlie the ability to participate in desired occupations and activities. This list is not all inclusive and may not include all possible skills addressed during occupational therapy interventions.*

Skill	Definition
■ <b>MOTOR SKILLS</b> —“Occupational performance skills observed as the person interacts with and moves task objects and self around the task environment” (e.g., activity of daily living [ADL] motor skills, school motor skills; Boyt Schell, Gillen, & Scaffa, 2014a, p. 1237).	
<b>Aligns</b>	Interacts with task objects without evidence of persistent propping or persistent leaning
<b>Stabilizes</b>	Moves through task environment and interacts with task objects without momentary propping or loss of balance
<b>Positions</b>	Positions self an effective distance from task objects and without evidence of awkward body positioning
<b>Reaches</b>	Effectively extends the arm and, when appropriate, bends the trunk to effectively grasp or place task objects that are out of reach
<b>Bends</b>	Flexes or rotates the trunk as appropriate to the task to grasp or place task objects out of reach or when sitting down
<b>Grips</b>	Effectively pinches or grasps task objects such that the objects do not slip (e.g., from the person’s fingers, between teeth)
<b>Manipulates</b>	Uses dexterous finger movements, without evidence of fumbling, when manipulating task objects (e.g., manipulating buttons when buttoning)
<b>Coordinates</b>	Uses two or more body parts together to manipulate, hold, and/or stabilize task objects without evidence of fumbling task objects or slipping from one’s grasp
<b>Moves</b>	Effectively pushes or pulls task objects along a supporting surface, pulls to open or pushes to close doors and drawers, or pushes on wheels to propel a wheelchair
<b>Lifts</b>	Effectively raises or lifts task objects without evidence of increased effort
<b>Walks</b>	During task performance, ambulates on level surfaces without shuffling the feet, becoming unstable, propping, or using assistive devices
<b>Transports</b>	Carries task objects from one place to another while walking or moving in a wheelchair
<b>Calibrates</b>	Uses movements of appropriate force, speed, or extent when interacting with task objects (e.g., not crushing objects, pushing a door with enough force that it closes)
<b>Flows</b>	Uses smooth and fluid arm and wrist movements when interacting with task objects
<b>Endures</b>	Persists and completes the task without showing obvious evidence of physical fatigue, pausing to rest, or stopping to catch one’s breath
<b>Paces</b>	Maintains a consistent and effective rate or tempo of performance throughout the entire task
■ <b>PROCESS SKILLS</b> —“Occupational performance skills [e.g., ADL process skills, school process skills] observed as a person (1) selects, interacts with, and uses task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered” (Boyt Schell et al., 2014a, p. 1239).	
<b>Paces</b>	Maintains a consistent and effective rate or tempo of performance throughout the entire task
<b>Attends</b>	Does not look away from what he or she is doing, interrupting the ongoing task progression
<b>Heeds</b>	Carries out and completes the task originally agreed on or specified by another
<b>Chooses</b>	Selects necessary and appropriate type and number of tools and materials for the task, including the tools and materials that the person was directed to use or specified he or she would use
<b>Uses</b>	Applies tools and materials as they are intended (e.g., uses a pencil sharpener to sharpen a pencil but not to sharpen a crayon) and in a hygienic fashion
<b>Handles</b>	Supports or stabilizes tools and materials in an appropriate manner, protecting them from being damaged, slipping, moving, and falling
<b>Inquires</b>	(1) Seeks needed verbal or written information by asking questions or reading directions or labels and (2) does not ask for information when he or she was fully oriented to the task and environment and had immediate prior awareness of the answer
<b>Initiates</b>	Starts or begins the next action or step without hesitation
<b>Continues</b>	Performs single actions or steps without interruptions such that once an action or task is initiated, the person continues without pauses or delays until the action or step is completed
<b>Sequences</b>	Performs steps in an effective or logical order and with an absence of (1) randomness or lack of logic in the ordering and (2) inappropriate repetition of steps
<b>Terminates</b>	Brings to completion single actions or single steps without inappropriate persistence or premature cessation
<b>Searches/locates</b>	Looks for and locates tools and materials in a logical manner, both within and beyond the immediate environment
<b>Gathers</b>	Collects related tools and materials into the same work space and regathers tools or materials that have spilled, fallen, or been misplaced

(Continued)

**TABLE 3. PERFORMANCE SKILLS***(Continued)*

<b>Skill</b>	<b>Definition</b>
<b>Organizes</b>	Logically positions or spatially arranges tools and materials in an orderly fashion within a single work space and between multiple appropriate work spaces such that the work space is not too spread out or too crowded
<b>Restores</b>	Puts away tools and materials in appropriate places and ensures that the immediate work space is restored to its original condition
<b>Navigates</b>	Moves the arm, body, or wheelchair without bumping into obstacles when moving in the task environment or interacting with task objects
<b>Notices/responds</b>	Responds appropriately to (1) nonverbal task-related cues (e.g., heat, movement), (2) the spatial arrangement and alignment of task objects to one another, and (3) cupboard doors and drawers that have been left open during task performance
<b>Adjusts</b>	Effectively (1) goes to new work spaces; (2) moves tools and materials out of the current work space; and (3) adjusts knobs, dials, or water taps to overcome problems with ongoing task performance
<b>Accommodates</b>	Prevents ineffective task performance
<b>Benefits</b>	Prevents problems with task performance from recurring or persisting
<b>■ SOCIAL INTERACTION SKILLS</b> —"Occupational performance skills observed during the ongoing stream of a social exchange" (Boyt Schell et al., 2014a, p. 1241).	
<b>Approaches/starts</b>	Approaches or initiates interaction with the social partner in a manner that is socially appropriate
<b>Concludes/disengages</b>	Effectively terminates the conversation or social interaction, brings to closure the topic under discussion, and disengages or says good-bye
<b>Produces speech</b>	Produces spoken, signed, or augmentative (i.e., computer-generated) messages that are audible and clearly articulated
<b>Gesticulates</b>	Uses socially appropriate gestures to communicate or support a message
<b>Speaks fluently</b>	Speaks in a fluent and continuous manner, with an even pace (not too fast, not too slow) and without pauses or delays during the message being sent
<b>Turns toward</b>	Actively positions or turns the body and face toward the social partner or person who is speaking
<b>Looks</b>	Makes eye contact with the social partner
<b>Places self</b>	Positions self at an appropriate distance from the social partner during the social interaction
<b>Touches</b>	Responds to and uses touch or bodily contact with the social partner in a manner that is socially appropriate
<b>Regulates</b>	Does not demonstrate irrelevant, repetitive, or impulsive behaviors that are not part of social interaction
<b>Questions</b>	Requests relevant facts and information and asks questions that support the intended purpose of the social interaction
<b>Replies</b>	Keeps conversation going by replying appropriately to question and comments
<b>Discloses</b>	Reveals opinions, feelings, and private information about self or others in a manner that is socially appropriate
<b>Expresses emotion</b>	Displays affect and emotions in a way that is socially appropriate
<b>Disagrees</b>	Expresses differences of opinion in a socially appropriate manner
<b>Thanks</b>	Uses appropriate words and gestures to acknowledge receipt of services, gifts, or compliments
<b>Transitions</b>	Handles transitions in the conversation smoothly or changes the topic without disrupting the ongoing conversation
<b>Times response</b>	Replies to social messages without delay or hesitation and without interrupting the social partner
<b>Times duration</b>	Speaks for reasonable periods given the complexity of the message sent
<b>Takes turns</b>	Takes his or her turn and gives the social partner the freedom to take his or her turn
<b>Matches language</b>	Uses a tone of voice, dialect, and level of language that are socially appropriate and matched to the social partner's abilities and level of understanding
<b>Clarifies</b>	Responds to gestures or verbal messages signaling that the social partner does not comprehend or understand a message and ensures that the social partner is following the conversation
<b>Acknowledges and encourages</b>	Acknowledges receipt of messages, encourages the social partner to continue interaction, and encourages all social partners to participate in social interaction
<b>Empathizes</b>	Expresses a supportive attitude toward the social partner by agreeing with, empathizing with, or expressing understanding of the social partner's feelings and experiences
<b>Heeds</b>	Uses goal-directed social interactions focused on carrying out and completing the intended purpose of the social interaction
<b>Accommodates</b>	Prevents ineffective or socially inappropriate social interaction
<b>Benefits</b>	Prevents problems with ineffective or socially inappropriate social interaction from recurring or persisting

Source. From "Performance Skills: Implementing Performance Analyses to Evaluate Quality of Occupational Performance," by A. G. Fisher and L. A. Griswold, in *Willard and Spackman's Occupational Therapy* (12th ed., pp. 252–254), by B. A. B. Schell, G. Gillen, M. E. Scaffa, and E. S. Cohn (Eds.), 2014, Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins; <http://lww.com>. Copyright © 2014 by Wolters Kluwer/Lippincott Williams & Wilkins. Adapted with permission.

**TABLE 4. PERFORMANCE PATTERNS**

Performance patterns are the habits, routines, roles, and rituals used in the process of engaging in occupations or activities; these patterns can support or hinder occupational performance.

Category	Description	Examples
<b>■ PERSON</b>		
<b>Habits</b>	“Acquired tendencies to respond and perform in certain consistent ways in familiar environments or situations; specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation” (Boyt Schell, Gillen, & Scaffa, 2014a, p. 1234). Habits can be useful, dominating, or impoverished and can either support or interfere with performance in occupations (Dunn, 2000).	<ul style="list-style-type: none"> <li>• Automatically puts car keys in the same place</li> <li>• Spontaneously looks both ways before crossing the street</li> <li>• Always turns off the stove burner before removing a cooking pot</li> <li>• Activates the alarm system before leaving the home</li> </ul>
<b>Routines</b>	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese, 2007; Segal, 2004).	<ul style="list-style-type: none"> <li>• Follows a morning sequence to complete toileting, bathing, hygiene, and dressing</li> <li>• Follows the sequence of steps involved in meal preparation</li> <li>• Follows a daily routine of dropping children off at school, going to work, picking children up from school, doing homework, and making dinner</li> </ul>
<b>Rituals</b>	Symbolic actions with spiritual, cultural, or social meaning contributing to the client’s identity and reinforcing values and beliefs. Rituals have a strong affective component and consist of a collection of events (Fiese, 2007; Fiese et al., 2002; Segal, 2004).	<ul style="list-style-type: none"> <li>• Uses an inherited antique hairbrush to brush hair 100 strokes nightly as her mother had done</li> <li>• Prepares holiday meals with favorite or traditional accoutrements using designated dishware</li> <li>• Kisses a sacred book before opening the pages to read</li> <li>• Attends a spiritual gathering on a particular day</li> </ul>
<b>Roles</b>	Sets of behaviors expected by society and shaped by culture and context that may be further conceptualized and defined by the client.	<ul style="list-style-type: none"> <li>• Mother of an adolescent with developmental disabilities</li> <li>• Student with a learning disability studying computer technology</li> <li>• Corporate executive returning to work after a stroke</li> </ul>
<b>■ GROUP OR POPULATION</b>		
<b>Routines</b>	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Segal, 2004).	<ul style="list-style-type: none"> <li>• Follows health practices, such as scheduled immunizations for children and yearly health screenings for adults</li> <li>• Follows business practices, such as provision of services for disadvantaged populations (e.g., loans to underrepresented groups)</li> <li>• Follows legislative procedures, such as those associated with the Individuals With Disabilities Education Improvement Act of 2004 (Pub. L. 108–446) or Medicare</li> <li>• Follows social customs for greeting</li> </ul>
<b>Rituals</b>	Shared social actions with traditional, emotional, purposive, and technological meaning contributing to values and beliefs within the group or population.	<ul style="list-style-type: none"> <li>• Holds cultural celebrations</li> <li>• Has parades or demonstrations</li> <li>• Shows national affiliations or allegiances</li> <li>• Follows religious, spiritual, and cultural practices, such as touching the mezuzah or using holy water when leaving and entering or praying while facing Mecca</li> </ul>
<b>Roles</b>	Sets of behaviors by the group or population expected by society and shaped by culture and context that may be further conceptualized and defined by the group or population.	<ul style="list-style-type: none"> <li>• Nonprofit civic group providing housing for people with mental illness</li> <li>• Humanitarian group distributing food and clothing donations to refugees</li> <li>• Student organization in a university educating elementary school children about preventing bullying</li> </ul>

**TABLE 5. CONTEXT AND ENVIRONMENT**

Context refers to a variety of interrelated conditions that are within and surrounding the client. Contexts include cultural, personal, temporal, and virtual. The term environment refers to the external physical and social conditions that surround the client and in which the client's daily life occupations occur.

Category	Definition	Examples
<b>CONTEXTS</b>		
<b>Cultural</b>	Customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society of which a client is a member. The cultural context influences the client's identity and activity choices.	<ul style="list-style-type: none"> <li>• <i>Person:</i> A person delivering Thanksgiving meals to home-bound individuals</li> <li>• <i>Group:</i> Employees marking the end of the work week with casual dress on Friday</li> <li>• <i>Population:</i> People engaging in an afternoon siesta or high tea</li> </ul>
<b>Personal</b>	"Features of the individual that are not part of a health condition or health status" (WHO, 2001, p. 17). The personal context includes age, gender, socioeconomic status, and educational status and can also include group membership (e.g., volunteers, employees) and population membership (e.g., members of society).	<ul style="list-style-type: none"> <li>• <i>Person:</i> A 25-year-old unemployed man with a high school diploma</li> <li>• <i>Group:</i> Volunteers working in a homeless shelter</li> <li>• <i>Population:</i> Older drivers learning about community mobility options</li> </ul>
<b>Temporal</b>	The experience of time as shaped by engagement in occupations; the temporal aspects of occupation that "contribute to the patterns of daily occupations" include "rhythm . . . tempo . . . synchronization . . . duration . . . and sequence" (Larson & Zemke, 2003, p. 82; Zemke, 2004, p. 610). The temporal context includes stage of life, time of day or year, duration and rhythm of activity, and history.	<ul style="list-style-type: none"> <li>• <i>Person:</i> A person retired from work for 10 years</li> <li>• <i>Group:</i> A community organization's annual fundraising campaign</li> <li>• <i>Population:</i> People celebrating Independence Day on July 4</li> </ul>
<b>Virtual</b>	Environment in which communication occurs by means of airwaves or computers and in the absence of physical contact. The virtual context includes simulated, real-time, or near-time environments such as chat rooms, email, video conferencing, or radio transmissions; remote monitoring via wireless sensors; or computer-based data collection.	<ul style="list-style-type: none"> <li>• <i>Person:</i> Friends who text message each other</li> <li>• <i>Group:</i> Members who participate in a video conference, telephone conference call, instant message, or interactive white board use</li> <li>• <i>Population:</i> Virtual community of gamers</li> </ul>
<b>ENVIRONMENTS</b>		
<b>Physical</b>	Natural and built nonhuman surroundings and the objects in them. The natural environment includes geographic terrain, plants, and animals, as well as the sensory qualities of the surroundings. The built environment includes buildings, furniture, tools, and devices.	<ul style="list-style-type: none"> <li>• <i>Person:</i> Individual's house or apartment</li> <li>• <i>Group:</i> Office building or factory</li> <li>• <i>Population:</i> Transportation system</li> </ul>
<b>Social</b>	Presence of, relationships with, and expectations of persons, groups, or populations with whom clients have contact. The social environment includes availability and expectations of significant individuals, such as spouse, friends, and caregivers; relationships with individuals, groups, or populations; and relationships with systems (e.g., political, legal, economic, institutional) that influence norms, role expectations, and social routines.	<ul style="list-style-type: none"> <li>• <i>Person:</i> Friends, colleagues</li> <li>• <i>Group:</i> Occupational therapy students conducting a class get-together</li> <li>• <i>Population:</i> People influenced by a city government</li> </ul>

Note. WHO = World Health Organization.

**TABLE 6. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS**

Occupational therapy interventions include the use of occupations and activities, preparatory methods and tasks, education and training, advocacy, and group interventions to facilitate engagement in occupations to promote health and participation. The examples provided illustrate the types of interventions occupational therapy practitioners provide and are not intended to be all inclusive.

Category	Description	Examples
<p>■ <b>OCCUPATIONS AND ACTIVITIES</b>—Occupations and activities selected as interventions for specific clients and designed to meet therapeutic goals and address the underlying needs of the mind, body, and spirit of the client. To use occupations and activities therapeutically, the practitioner considers activity demands and client factors in relation to the client's therapeutic goals, contexts, and environments.</p>		
<b>Occupations</b>	Client-directed daily life activities that match and support or address identified participation goals.	<p>The client</p> <ul style="list-style-type: none"> <li>• Completes morning dressing and hygiene using adaptive devices</li> <li>• Purchases groceries and prepares a meal</li> <li>• Visits a friend using public transportation independently</li> <li>• Applies for a job in the retail industry</li> <li>• Plays on a playground with children and adults</li> <li>• Participates in a community festival by setting up a booth to sell baked goods</li> <li>• Engages in a pattern of self-care and relaxation activities in preparation for sleep</li> <li>• Engages in a statewide advocacy program to improve services to people with mental illness</li> </ul>
<b>Activities</b>	Actions designed and selected to support the development of performance skills and performance patterns to enhance occupational engagement. Activities often are components of occupations and always hold meaning, relevance, and perceived utility for clients at their level of interest and motivation.	<p>The client</p> <ul style="list-style-type: none"> <li>• Selects clothing and manipulates clothing fasteners in advance of dressing</li> <li>• Practices safe ways to get into and out of the bathtub</li> <li>• Prepares a food list and practices using cooking appliances</li> <li>• Reviews how to use a map and transportation schedule</li> <li>• Writes answers on an application form</li> <li>• Climbs on and off playground and recreation equipment</li> <li>• Greets people and initiates conversation in a role-play situation</li> <li>• Develops a weekly schedule to manage time and organize daily and weekly responsibilities required to live independently</li> <li>• Uses adaptive switches to operate the home environmental control system</li> <li>• Completes a desired expressive activity (e.g., art, craft, dance) that is not otherwise classified</li> <li>• Plays a desired game either as a solo player or in competition with others</li> </ul>
<p>■ <b>PREPARATORY METHODS AND TASKS</b>—Methods and tasks that prepare the client for occupational performance, used as <i>part of a treatment session</i> in preparation for or concurrently with occupations and activities or provided to a client as a home-based engagement to support daily occupational performance.</p>		
<b>Preparatory methods</b>	Modalities, devices, and techniques to prepare the client for occupational performance. Often preparatory methods are interventions that are “done to” the client without the client's active participation.	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Administers physical agent modalities to decrease pain, assist with wound healing or edema control, or prepare muscles for movement</li> <li>• Provides massage</li> <li>• Performs manual lymphatic drainage techniques</li> <li>• Performs wound care techniques, including dressing changes</li> </ul>
<b>Splints</b>	Construction and use of devices to mobilize, immobilize, and support body structures to enhance participation in occupations.	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Fabricates and issues a splint or orthotic to support a weakened hand and decrease pain</li> <li>• Fabricates and issues a wrist splint to facilitate movement and enhance participation in household activities</li> </ul>
<b>Assistive technology and environmental modifications</b>	Identification and use of assistive technologies (high and low tech), application of universal design principles, and recommends changes to the environment or activity to support the client's ability to engage in occupations. This preparatory method includes assessment, selection, provision, and education and training in use of devices.	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Provides a pencil grip and slant board</li> <li>• Provides electronic books with text-to-speech software</li> <li>• Recommends visual supports (e.g., a social story) to guide behavior</li> <li>• Recommends replacing steps with an appropriately graded ramp</li> <li>• Recommends universally designed curriculum materials</li> </ul>
<b>Wheeled mobility</b>	Use of products and technologies that facilitate a client's ability to maneuver through space, including seating and positioning, and that improve mobility, enhance participation in desired daily occupations, and reduce risk for complications such as skin breakdown or limb contractures.	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Recommends, in conjunction with the wheelchair team, a sip-and-puff switch to allow the client to maneuver the power wheelchair independently and interface with an environmental control unit in the home</li> </ul>

(Continued)

**TABLE 6. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS***(Continued)*

Category	Description	Examples
<b>Preparatory tasks</b>	Actions selected and provided to the client to target specific client factors or performance skills. Tasks involve active participation of the client and sometimes comprise engagements that use various materials to simulate activities or components of occupations. Preparatory tasks themselves may not hold inherent meaning, relevance, or perceived utility as stand-alone entities.	<p>The client</p> <ul style="list-style-type: none"> <li>• Refolds towels taken from a clean linen cart to address shoulder range of motion</li> <li>• Participates in fabricated sensory environment (e.g., through movement, tactile sensations, scents) to promote alertness</li> <li>• Uses visual imagery and rhythmic breathing to promote rest and relaxation</li> <li>• Performs a home-based conditioning regimen using free weights</li> <li>• Does hand-strengthening exercises using therapy putty, exercise bands, grippers, and clothespins</li> <li>• Participates in an assertiveness training program to prepare for self-advocacy</li> </ul>
<b>■ EDUCATION AND TRAINING</b>		
<b>Education</b>	Imparting of knowledge and information about occupation, health, well-being, and participation that enables the client to acquire helpful behaviors, habits, and routines that may or may not require application at the time of the intervention session	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Provides education regarding home and activity modifications to the spouse or family member of a person with dementia to support maximum independence</li> <li>• Educates town officials about the value of and strategies for making walking and biking paths accessible for all community members</li> <li>• Educates providers of care for people who have experienced trauma on the use of sensory strategies</li> <li>• Provides education to people with mental health issues and their families on the psychological and social factors that influence engagement in occupation</li> </ul>
<b>Training</b>	Facilitation of the acquisition of concrete skills for meeting specific goals in a real-life, applied situation. In this case, <i>skills</i> refers to measurable components of function that enable mastery. Training is differentiated from education by its goal of enhanced performance as opposed to enhanced understanding, although these goals often go hand in hand (Collins & O'Brien, 2003).	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Instructs the client in how to operate a universal control device to manage household appliances</li> <li>• Instructs family members in the use and maintenance of the father's power wheelchair</li> <li>• Instructs the client in the use of self range of motion as a preparatory technique to avoid joint contracture of wrist</li> <li>• Instructs the client in the use of a handheld electronic device and applications to recall and manage weekly activities and medications</li> <li>• Instructs the client in how to direct a personal care attendant in assisting with self-care activities</li> <li>• Trains parents and teachers to focus on a child's strengths to foster positive behaviors</li> </ul>
<b>■ ADVOCACY</b> —Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in daily life occupations. The outcomes of advocacy and self-advocacy support health, well-being, and occupational participation at the individual or systems level.		
<b>Advocacy</b>	Advocacy efforts undertaken by the practitioner.	<p>The practitioner</p> <ul style="list-style-type: none"> <li>• Collaborates with a person to procure reasonable accommodations at a work site</li> <li>• Serves on the policy board of an organization to procure supportive housing accommodations for people with disabilities</li> <li>• Serves on the board of a local park district to encourage inclusion of children with disabilities in mainstream district sports programs when possible</li> <li>• Collaborates with adults who have serious mental illness to raise public awareness of the impact of stigma</li> <li>• Collaborates with and educates staff at federal funding sources for persons with disabling conditions</li> </ul>
<b>Self-advocacy</b>	Advocacy efforts undertaken by the client, which the practitioner can promote and support.	<ul style="list-style-type: none"> <li>• A student with a learning disability requests and receives reasonable accommodations such as textbooks on tape.</li> <li>• A grassroots employee committee requests and procures ergonomically designed keyboards for their work computers.</li> <li>• People with disabilities advocate for the use of universal design principles with all new public construction.</li> <li>• Young adults contact their Internet service provider to request support for cyberbullying prevention.</li> </ul>

*(Continued)*

**TABLE 6. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS***(Continued)*

Category	Description	Examples
<b>GROUP INTERVENTIONS</b> —Use of distinct knowledge and leadership techniques to facilitate learning and skill acquisition across the lifespan through the dynamics of group and social interaction. Groups may also be used as a method of service delivery.		
<b>Groups</b>	Functional groups, activity groups, task groups, social groups, and other groups used on inpatient units, within the community, or in schools that allow clients to explore and develop skills for participation, including basic social interaction skills, tools for self-regulation, goal setting, and positive choice making.	<ul style="list-style-type: none"> <li>• A group for older adults focuses on maintaining participation despite increasing disability, such as exploring alternative transportation if driving is no longer an option and participating in volunteer and social opportunities after retirement.</li> <li>• A community group addresses issues of self-efficacy and self-esteem as the basis for creating resiliency in preadolescent children at risk for being bullied.</li> <li>• A group in a mental health program addresses establishment of social connections in the community.</li> </ul>

**TABLE 7. ACTIVITY AND OCCUPATIONAL DEMANDS**

Activity and occupational demands are the components of activities and occupations that occupational therapy practitioners consider during the clinical reasoning process. Depending on the context and needs of the client, these demands can be deemed barriers to or supports for participation. Specific knowledge about the demands of activities and occupations assists practitioners in selecting activities for therapeutic purposes. Demands of the activity or occupation include the relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures.

Type of Demand	Description	Examples
<b>Relevance and importance to client</b>	Alignment with the client's goals, values, beliefs, and needs and perceived utility	<ul style="list-style-type: none"> <li>• Driving a car equates with independence.</li> <li>• Preparing a holiday meal connects with family tradition.</li> <li>• Voting is a rite of passage to adulthood.</li> </ul>
<b>Objects used and their properties</b>	Tools, supplies, and equipment required in the process of carrying out the activity	<ul style="list-style-type: none"> <li>• Tools (e.g., scissors, dishes, shoes, volleyball)</li> <li>• Supplies (e.g., paints, milk, lipstick)</li> <li>• Equipment (e.g., workbench, stove, basketball hoop)</li> <li>• Inherent properties (e.g., heavy, rough, sharp, colorful, loud, bitter tasting)</li> </ul>
<b>Space demands</b> (related to the physical environment)	Physical environmental requirements of the activity (e.g., size, arrangement, surface, lighting, temperature, noise, humidity, ventilation)	<ul style="list-style-type: none"> <li>• Large, open space outdoors for a baseball game</li> <li>• Bathroom door and stall width to accommodate wheelchair</li> <li>• Noise, lighting, and temperature controls for a library</li> </ul>
<b>Social demands</b> (related to the social environment and virtual and cultural contexts)	Elements of the social environment and virtual and cultural contexts that may be required by the activity	<ul style="list-style-type: none"> <li>• Rules of the game</li> <li>• Expectations of other participants in the activity (e.g., sharing supplies, using language appropriate for the meeting, appropriate virtual decorum)</li> </ul>
<b>Sequencing and timing</b>	Process required to carry out the activity (e.g., specific steps, sequence of steps, timing requirements)	<ul style="list-style-type: none"> <li>• <i>Steps to make tea:</i> Gather cup and tea bag, heat water, pour water into cup, let steep, add sugar.</li> <li>• <i>Sequence:</i> Heat water before placing tea bag in water.</li> <li>• <i>Timing:</i> Leave tea bag to steep for 2 minutes.</li> <li>• <i>Steps to conduct a meeting:</i> Establish goals for meeting, arrange time and location, prepare agenda, call meeting to order.</li> <li>• <i>Sequence:</i> Have people introduce themselves before beginning discussion of topic.</li> <li>• <i>Timing:</i> Allot sufficient time for discussion of topic and determination of action items.</li> </ul>
<b>Required actions and performance skills</b>	Actions (performance skills—motor, process, and social interaction) required by the client that are an inherent part of the activity	<ul style="list-style-type: none"> <li>• Feeling the heat of the stove</li> <li>• Gripping a handlebar</li> <li>• Choosing ceremonial clothes</li> <li>• Determining how to move limbs to control the car</li> <li>• Adjusting the tone of voice</li> <li>• Answering a question</li> </ul>
<b>Required body functions</b>	"Physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10) required to support the actions used to perform the activity	<ul style="list-style-type: none"> <li>• Mobility of joints</li> <li>• Level of consciousness</li> <li>• Cognitive level</li> </ul>
<b>Required body structures</b>	"Anatomical parts of the body such as organs, limbs, and their components" that support body functions (WHO, 2001, p. 10) and are required to perform the activity	<ul style="list-style-type: none"> <li>• Number of hands or feet</li> <li>• Olfactory or taste organs</li> </ul>

**TABLE 8. APPROACHES TO INTERVENTION**

Approaches to intervention are specific strategies selected to direct the process of evaluation and intervention planning, selection, and implementation on the basis of the client's desired outcomes, evaluation data, and evidence. Approaches inform the selection of practice models, frames of references, or treatment theories.

Approach	Description	Examples
<b>Create, promote (health promotion)</b>	An intervention approach that does not assume a disability is present or that any aspect would interfere with performance. This approach is designed to provide enriched contextual and activity experiences that will enhance performance for all people in the natural contexts of life (adapted from Dunn, McClain, Brown, & Youngstrom, 1998, p. 534).	<ul style="list-style-type: none"> <li>• Create a parenting class to help first-time parents engage their children in developmentally appropriate play</li> <li>• Provide a falls prevention class to a group of older adults at the local senior center to encourage safe mobility throughout the home</li> </ul>
<b>Establish, restore (remediation, restoration)</b>	An intervention approach designed to change client variables to establish a skill or ability that has not yet developed or to restore a skill or ability that has been impaired (adapted from Dunn et al., 1998, p. 533).	<ul style="list-style-type: none"> <li>• Restore a client's upper-extremity movement to enable transfer of dishes from the dishwasher into the upper kitchen cabinets</li> <li>• Develop a structured schedule, chunking tasks to decrease the risk of being overwhelmed when faced with the many responsibilities of daily life roles</li> <li>• Collaborate with a client to help establish morning routines needed to arrive at school or work on time</li> </ul>
<b>Maintain</b>	An intervention approach designed to provide the supports that will allow clients to preserve the performance capabilities they have regained, that continue to meet their occupational needs, or both. The assumption is that without continued maintenance intervention, performance would decrease, occupational needs would not be met, or both, thereby affecting health, well-being, and quality of life.	<ul style="list-style-type: none"> <li>• Provide ongoing intervention for a client with amyotrophic lateral sclerosis to address participation in desired occupations through provision of assistive technology</li> <li>• Maintain independent gardening for people with arthritis by recommending tools with modified grips, long-handled tools, seating alternatives, and raised gardens</li> <li>• Maintain safe and independent access for people with low vision by increasing hallway lighting in the home</li> </ul>
<b>Modify (compensation, adaptation)</b>	An intervention approach directed at "finding ways to revise the current context or activity demands to support performance in the natural setting, [including] compensatory techniques . . . [such as] enhancing some features to provide cues or reducing other features to reduce distractibility" (Dunn et al., 1998, p. 533).	<ul style="list-style-type: none"> <li>• Simplify task sequence to help a person with cognitive impairments complete a morning self-care routine</li> <li>• Consult with builders to design homes that will allow families to provide living space for aging parents (e.g., bedroom and full bath on the main floor of a multilevel dwelling)</li> <li>• Modify the clutter in a room to decrease a client's distractibility</li> </ul>
<b>Prevent (disability prevention)</b>	An intervention approach designed to address the needs of clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables (adapted from Dunn et al., 1998, p. 534).	<ul style="list-style-type: none"> <li>• Aid in the prevention of illicit chemical substance use by introducing self-initiated routine strategies that support drug-free behavior</li> <li>• Prevent social isolation of employees by promoting participation in after-work group activities</li> <li>• Consult with a hotel chain to provide an ergonomics educational program designed to prevent back injuries in housekeepers</li> </ul>

**TABLE 9. OUTCOMES**

Outcomes are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention. The outcomes of occupational therapy can be described in two ways. Some outcomes are measurable and are used for intervention planning, monitoring, and discharge planning. These outcomes reflect the attainment of treatment goals that relate to engagement in occupation. Other outcomes are experienced by clients when they have realized the effects of engagement in occupation and are able to return to desired habits, routines, roles, and rituals. The examples listed specify how the broad outcome of health and participation in life may be operationalized and are not intended to be all inclusive.

Category	Description	Examples
<b>Occupational performance</b>	Act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fisher, 2009; Fisher & Griswold, 2014; Kielhofner, 2008) and results from the dynamic transaction among the client, the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).	See “Improvement” and “Enhancement,” below.
Improvement	Outcomes targeted when a performance limitation is present. These outcomes reflect increased occupational performance for the person, group, or population.	<ul style="list-style-type: none"> <li>• A child with autism playing interactively with a peer (person)</li> <li>• An older adult returning to a desired living situation in the home from a skilled nursing facility (person)</li> <li>• Decreased incidence of back strain in nursing personnel as a result of an in-service education program in body mechanics for carrying out job duties that require bending, lifting, and so forth (group)</li> <li>• Construction of accessible playground facilities for all children in local city parks (population)</li> </ul>
Enhancement	Outcomes targeted when a performance limitation is not currently present. These outcomes reflect the development of performance skills and performance patterns that augment existing performance in life occupations.	<ul style="list-style-type: none"> <li>• Increased confidence and competence of teenage mothers in parenting their children as a result of structured social groups and child development classes (person)</li> <li>• Increased membership in the local senior citizen center as a result of expanding social wellness and exercise programs (group)</li> <li>• Increased ability of school staff to address and manage school-age youth violence as a result of conflict resolution training to address bullying (group)</li> <li>• Increased opportunities for older adults to participate in community activities through ride-share programs (population)</li> </ul>
<b>Prevention</b>	Education or health promotion efforts designed to identify, reduce, or prevent the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries (AOTA, 2013b). Occupational therapy promotes a healthy lifestyle at the individual, group, community (societal), and governmental or policy level (adapted from AOTA, 2001).	<ul style="list-style-type: none"> <li>• Appropriate seating and play area for a child with orthopedic impairments (person)</li> <li>• Implementation of a program of leisure and educational activities for a drop-in center for adults with severe mental illness (group)</li> <li>• Access to occupational therapy services in underserved areas regardless of cultural or ethnic background (population)</li> </ul>
<b>Health and wellness</b>	Resources for everyday life, not the objective of living. For individuals, <i>health</i> is a state of physical, mental, and social well-being, as well as a positive concept emphasizing social and personal resources and physical capacities (WHO, 1986). Health for groups and populations includes these individual aspects but also includes social responsibility of members to the group or population as a whole. <i>Wellness</i> is “an active process through which individuals [or groups or populations] become aware of and make choices toward a more successful existence” (Hettler, 1984, p. 1117). Wellness is more than a lack of disease symptoms; it is a state of mental and physical balance and fitness (adapted from <i>Taber’s Cyclopedic Medical Dictionary</i> , 1997, p. 2110).	<ul style="list-style-type: none"> <li>• Participation by a person with a psychiatric disability in an empowerment and advocacy group to improve services in the community (person)</li> <li>• Implementation of a company-wide program for employees to identify problems and solutions regarding the balance among work, leisure, and family life (group)</li> <li>• Decreased incidence of childhood obesity (population)</li> </ul>

(Continued)

**TABLE 9. OUTCOMES***(Continued)*

Category	Description	Examples
<b>Quality of life</b>	Dynamic appraisal of the client's life satisfaction (perceptions of progress toward goals), hope (real or perceived belief that one can move toward a goal through selected pathways), self-concept (the composite of beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995).	<ul style="list-style-type: none"> <li>• Full and active participation of a deaf child from a hearing family during a recreational activity (person)</li> <li>• Residents being able to prepare for outings and travel independently as a result of independent living skills training for care providers (group)</li> <li>• Formation of a lobby to support opportunities for social networking, advocacy activities, and sharing of scientific information for stroke survivors and their families (population)</li> </ul>
<b>Participation</b>	Engagement in desired occupations in ways that are personally satisfying and congruent with expectations within the culture.	<ul style="list-style-type: none"> <li>• A person recovering the ability to perform the essential duties of his or her job after a flexor tendon laceration (person)</li> <li>• A family enjoying a vacation while traveling cross-country in their adapted van (group)</li> <li>• All children within a state having access to school sports programs (population)</li> </ul>
<b>Role competence</b>	Ability to effectively meet the demands of roles in which the client engages.	<ul style="list-style-type: none"> <li>• An individual with cerebral palsy being able to take notes or type papers to meet the demands of the student role (person)</li> <li>• Implementation of job rotation at a factory that allows sharing of higher demand tasks to meet the demands of the worker role (group)</li> <li>• Improved accessibility of polling places to all people with disabilities to meet the demands of the citizen role (population)</li> </ul>
<b>Well-being</b>	Contentment with one's health, self-esteem, sense of belonging, security, and opportunities for self-determination, meaning, roles, and helping others (Hammell, 2009). <i>Well-being</i> is "a general term encompassing the total universe of human life domains, including physical, mental, and social aspects" (WHO, 2006, p. 211).	<ul style="list-style-type: none"> <li>• A person with amyotrophic lateral sclerosis being content with his ability to find meaning in fulfilling the role of father through compensatory strategies and environmental modifications (person)</li> <li>• Members of an outpatient depression and anxiety support group feeling secure in their sense of group belonging and ability to help other members (group)</li> <li>• Residents of a town celebrating the groundbreaking of a school during reconstruction after a natural disaster (population)</li> </ul>
<b>Occupational justice</b>	Access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004).	<ul style="list-style-type: none"> <li>• An individual with an intellectual disability serving on an advisory board to establish programs offered by a community recreation center (person)</li> <li>• Workers having enough break time to have lunch with their young children in their day care center (group)</li> <li>• Increased sense of empowerment and self-advocacy skills for people with persistent mental illness, enabling them to develop an antistigma campaign promoting engagement in the civic arena (group) and alternative adapted housing options for older adults to age in place (population)</li> </ul>

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## Appendix A. Glossary

### A

#### Activities

Actions designed and selected to support the development of performance skills and performance patterns to enhance occupational engagement.

#### Activities of daily living (ADLs)

Activities oriented toward taking care of one's own body (adapted from Rogers & Holm, 1994). ADLs also are referred to as *basic activities of daily living (BADLs)* and *personal activities of daily living (PADLs)*. These activities are “fundamental to living in a social world; they enable basic survival and well-being” (Christiansen & Hammecker, 2001, p. 156; see Table 1).

#### Activity analysis

Analysis of “the typical demands of an activity, the range of skills involved in its performance, and the various cultural meanings that might be ascribed to it” (Crepeau, 2003, p. 192).

#### Activity demands

Aspects of an activity or occupation needed to carry it out, including relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures (see Table 7).

#### Adaptation

Occupational therapy practitioners enable participation by modifying a task, the method of accomplishing the task, and the environment to promote engagement in occupation (James, 2008).

#### Advocacy

Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their daily life occupations. Efforts undertaken by the practitioner are considered advocacy, and those undertaken by the client are considered self-advocacy and can be promoted and supported by the practitioner (see Table 6).

#### Analysis of occupational performance

The step in the evaluation process in which the client's assets and problems or potential problems are more specifically identified through assessment tools designed to observe, measure, and inquire about factors that support or hinder occupational performance and in which targeted outcomes are identified (see Exhibit 2).

### Assessments

“Specific tools or instruments that are used during the evaluation process” (American Occupational Therapy Association [AOTA], 2010, p. S107).

### B

#### Body functions

“Physiological functions of body systems (including psychological functions)” (World Health Organization [WHO], 2001, p. 10; see Table 2).

#### Body structures

“Anatomical parts of the body, such as organs, limbs, and their components” that support body functions (WHO, 2001, p. 10; see Table 2).

### C

#### Client

Person or persons (including those involved in the care of a client), group (collective of individuals, e.g., families, workers, students, or community members), or population (collective of groups or individuals living in a similar locale—e.g., city, state, or country—or sharing the same or like concerns).

#### Client-centered care (client-centered practice)

Approach to service that incorporates respect for and partnership with clients as active participants in the therapy process. This approach emphasizes clients' knowledge and experience, strengths, capacity for choice, and overall autonomy (Boyt Schell et al., 2014a, p. 1230).

#### Client factors

Specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations. Client factors include values, beliefs, and spirituality; body functions; and body structures (see Table 2).

#### Clinical reasoning

“Process used by practitioners to plan, direct, perform, and reflect on client care” (Boyt Schell et al., 2014a, p. 1231). The term *professional reasoning* is sometimes used and is considered to be a broader term.

#### Collaborative approach

Orientation in which the occupational therapy practitioner and client work in the spirit of egalitarianism and mutual participation. Collaboration involves encouraging clients to describe their therapeutic concerns, identify their own goals, and contribute to decisions regarding therapeutic interventions (Boyt Schell et al., 2014a).

## **Context**

Variety of interrelated conditions within and surrounding the client that influence performance, including cultural, personal, temporal, and virtual contexts (see Table 5).

## **Co-occupation**

Occupation that implicitly involves two or more people (Boyt Schell et al., 2014a, p. 1232).

## **Cultural context**

Customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society of which a client is a member. The cultural context influences the client's identity and activity choices (see Table 5).

## **D**

### **Domain**

Profession's purview and areas in which its members have an established body of knowledge and expertise.

## **E**

### **Education**

- *As an occupation:* Activities involved in learning and participating in the educational environment (see Table 1).
- *As an intervention:* Activities that impart knowledge and information about occupation, health, well-being, and participation, resulting in acquisition by the client of helpful behaviors, habits, and routines that may or may not require application at the time of the intervention session (see Table 6).

### **Engagement in occupation**

Performance of occupations as the result of choice, motivation, and meaning within a supportive context and environment.

### **Environment**

External physical and social conditions that surround the client and in which the client's daily life occupations occur (see Table 5).

### **Evaluation**

"Process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results" (AOTA, 2010, p. S107).

## **G**

### **Goal**

Measurable and meaningful, occupation-based, long-term or short-term aim directly related to the client's

ability and need to engage in desired occupations (AOTA, 2013a, p. S35).

### **Group**

Collective of individuals (e.g., family members, workers, students, community members).

### **Group intervention**

Skilled knowledge and use of leadership techniques in various settings to facilitate learning and acquisition by clients across the lifespan of skills for participation, including basic social interaction skills, tools for self-regulation, goal setting, and positive choice making, through the dynamics of group and social interaction. Groups may be used as a method of service delivery (see Table 6).

## **H**

### **Habilitation**

Health care services designed to assist people in acquiring, improving, minimizing the deterioration of, compensating for an impairment of, or maintaining (partially or fully) skills, function, or performance for participation in occupation and daily life activities (AOTA policy staff, personal communication, December 17, 2013).

### **Habits**

"Acquired tendencies to respond and perform in certain consistent ways in familiar environments or situations; specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation" (Boyt Schell et al., 2014a, p. 1234). Habits can be useful, dominating, or impoverished and can either support or interfere with performance in areas of occupation (Dunn, 2000; see Table 4).

### **Health**

"State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO, 2006, p. 1).

### **Health promotion**

"Process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment" (WHO, 1986).

### **Hope**

"Perceived ability to produce pathways to achieve desired goals and to motivate oneself to use those pathways" (Rand & Cheavens, 2009, p. 323).

## I

### **Independence**

“Self-directed state of being characterized by an individual’s ability to participate in necessary and preferred occupations in a satisfying manner irrespective of the amount or kind of external assistance desired or required” (AOTA, 2002a, p. 660).

### **Instrumental activities of daily living (IADLs)**

Activities that support daily life within the home and community and that often require more complex interactions than those used in ADLs (see Table 1).

### **Interdependence**

“Reliance that people have on one another as a natural consequence of group living” (Christiansen & Townsend, 2010, p. 419). “Interdependence engenders a spirit of social inclusion, mutual aid, and a moral commitment and responsibility to recognize and support difference” (Christiansen & Townsend, 2010, p. 187).

### **Interests**

“What one finds enjoyable or satisfying to do” (Kielhofner, 2008, p. 42).

### **Intervention**

“Process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review” (AOTA, 2010, p. S107; see Table 6).

### **Intervention approaches**

Specific strategies selected to direct the process of interventions on the basis of the client’s desired outcomes, evaluation data, and evidence (see Table 8).

## L

### **Leisure**

“Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep” (Parham & Fazio, 1997, p. 250; see Table 1).

## M

### **Motor skills**

“Occupational performance skills observed as the person interacts with and moves task objects and self around the task environment” (e.g., activity of daily liv-

ing [ADL] motor skills, school motor skills; Boyt Schell et al., 2014a, p. 1237; see Table 3).

## O

### **Occupation**

Daily life activities in which people engage. Occupations occur in context and are influenced by the interplay among client factors, performance skills, and performance patterns. Occupations occur over time; have purpose, meaning, and perceived utility to the client; and can be observed by others (e.g., preparing a meal) or be known only to the person involved (e.g., learning through reading a textbook). Occupations can involve the execution of multiple activities for completion and can result in various outcomes. The *Framework* identifies a broad range of occupations categorized as activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation (see Table 1).

### **Occupational analysis**

See *activity analysis*.

### **Occupational demands**

See *activity demands*.

### **Occupational identity**

“Composite sense of who one is and wishes to become as an occupational being generated from one’s history of occupational participation” (Boyt Schell et al., 2014a, p. 1238).

### **Occupational justice**

“A justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences” (Nilsson & Townsend, 2010, p. 58). Access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004).

### **Occupational performance**

Act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fisher, 2009; Fisher & Griswold, 2014; Kielhofner, 2008) that results from the dynamic transaction among the client, the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).

## **Occupational profile**

Summary of the client's occupational history and experiences, patterns of daily living, interests, values, and needs (see Exhibit 2).

## **Occupational therapy**

Therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, routines, and rituals in home, school, workplace, community, and other settings. Occupational therapy practitioners use their knowledge of the transactional relationship among the person, his or her engagement in valued occupations, and the context to design occupation-based intervention plans that facilitate change or growth in client factors (values, beliefs, and spirituality; body functions, body structures) and performance skills (motor, process, and social interaction) needed for successful participation. Occupational therapy practitioners are concerned with the end result of participation and thus enable engagement through adaptations and modifications to the environment or objects within the environment when needed. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs. These services include acquisition and preservation of occupational identity for those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction (adapted from AOTA, 2011).

## **Organization**

Entity composed of individuals with a common purpose or enterprise, such as a business, industry, or agency.

## **Outcome**

End result of the occupational therapy process; what clients can achieve through occupational therapy intervention (see Table 9).

## **P**

### **Participation**

“Involvement in a life situation” (WHO, 2001, p. 10).

### **Performance patterns**

Habits, routines, roles, and rituals used in the process of engaging in occupations or activities; these patterns can support or hinder occupational performance (see Table 4).

### **Performance skills**

Goal-directed actions that are observable as small units of engagement in daily life occupations. They are learned and

developed over time and are situated in specific contexts and environments (Fisher & Griswold, 2014; see Table 3).

## **Person**

Individual, including family member, caregiver, teacher, employee, or relevant other.

## **Personal context**

“Features of the individual that are not part of a health condition or health status” (WHO, 2001, p. 17). The personal context includes age, gender, socioeconomic and educational status and may also include membership in a group (i.e., volunteers, employees) or population (i.e., members of a society; see Table 5).

## **Physical environment**

Natural and built nonhuman surroundings and the objects in them. The natural environment includes geographic terrain, plants, and animals, as well as the sensory qualities of the natural surroundings. The built environment includes buildings, furniture, tools, and devices (see Table 5).

## **Play**

“Any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion” (Parham & Fazio, 1997, p. 252; see Table 1).

## **Population**

Collective of groups of individuals living in a similar locale (e.g., city, state, country) or sharing the same or like characteristics or concerns.

## **Preparatory methods and tasks**

Methods and tasks that prepare the client for occupational performance, used either as part of a treatment session in preparation for or concurrently with occupations and activities or as a home-based engagement to support daily occupational performance. Often preparatory methods are interventions that are done to clients without their active participation and involve modalities, devices, or techniques.

## **Prevention**

Education or health promotion efforts designed to identify, reduce, or prevent the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries (AOTA, 2013b).

## **Process**

Way in which occupational therapy practitioners operationalize their expertise to provide services to clients. The occupational therapy process includes evaluation, intervention, and targeted outcomes; occurs within the

purview of the occupational therapy domain; and involves collaboration among the occupational therapist, occupational therapy assistant, and client.

### **Process skills**

“Occupational performance skills [e.g., ADL process skills, school process skills] observed as a person (1) selects, interacts with, and uses task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered” (Boyt Schell et al., 2014a, p. 1239; see Table 3).

## **Q**

### **Quality of life**

Dynamic appraisal of life satisfaction (perception of progress toward identified goals), self-concept (beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995).

## **R**

### **Reevaluation**

Reappraisal of the client’s performance and goals to determine the type and amount of change that has taken place.

### **Rehabilitation**

Rehabilitation services are provided to persons experiencing deficits in key areas of physical and other types of function or limitations in participation in daily life activities. Interventions are designed to enable the achievement and maintenance of optimal physical, sensory, intellectual, psychological, and social functional levels. Rehabilitation services provide tools and techniques needed to attain desired levels of independence and self-determination.

### **Rituals**

Sets of symbolic actions with spiritual, cultural, or social meaning contributing to the client’s identity and reinforcing values and beliefs. Rituals have a strong affective component (Fiese, 2007; Fiese et al., 2002; Segal, 2004; see Table 4).

### **Roles**

Sets of behaviors expected by society and shaped by culture and context that may be further conceptualized and defined by the client (see Table 4).

### **Routines**

Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying and promoting or damaging. Routines

require momentary time commitment and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004; see Table 4).

## **S**

### **Self-Advocacy**

Advocating for oneself, including making one’s own decisions about life, learning how to obtain information to gain an understanding about issues of personal interest or importance, developing a network of support, knowing one’s rights and responsibilities, reaching out to others when in need of assistance, and learning about self-determination.

### **Service delivery model**

Set of methods for providing services to or on behalf of clients.

### **Social environment**

Presence of, relationships with, and expectations of persons, groups, and populations with whom clients have contact (e.g., availability and expectations of significant individuals, such as spouse, friends, and caregivers; see Table 5).

### **Social interaction skills**

“Occupational performance skills observed during the ongoing stream of a social exchange” (Boyt Schell et al., 2014a, p. 1241; see Table 3).

### **Social participation**

“Interweaving of occupations to support desired engagement in community and family activities as well as those involving peers and friends” (Gillen & Boyt Schell, 2014, p. 607) or involvement in a subset of activities that involve social situations with others (Bedell, 2012) and that support social interdependence (Magasi & Hammel, 2004). Social participation can occur in person or through remote technologies such as telephone calls, computer interaction, and video conferencing (see Table 1).

### **Spirituality**

“Aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (Puchalski et al., 2009, p. 887; see Table 2).

## **T**

### **Task**

What individuals do or have done (e.g., drive, bake a cake, dress, make a bed; A. Fisher, personal communication, December 16, 2013).

### **Temporal context**

Experience of time as shaped by engagement in occupations. The temporal aspects of occupations that “contribute to the patterns of daily occupations” include “rhythm . . . tempo . . . synchronization . . . duration . . . and sequence” (Larson & Zemke, 2003, p. 82; Zemke, 2004, p. 610). The temporal context includes stage of life, time of day, duration and rhythm of activity, and history (see Table 5).

### **Transaction**

Process that involves two or more individuals or elements that reciprocally and continually influence and affect one another through the ongoing relationship (Dickie, Cutchin, & Humphry, 2006).

## **V**

### **Values**

Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008); principles, standards, or qualities considered worthwhile or desirable by the client who holds them (Moyers & Dale, 2007).

### **Virtual context**

Environment in which communication occurs by means of airwaves or computers in the absence of physical con-

tact. The virtual context includes simulated, real-time, or near-time environments such as chat rooms, email, video conferencing, and radio transmissions; remote monitoring via wireless sensors; and computer-based data collection (see Table 5).

## **W**

### **Well-being**

“General term encompassing the total universe of human life domains, including physical, mental, and social aspects” (WHO, 2006, p. 211).

### **Wellness**

“Perception of and responsibility for psychological and physical well-being as these contribute to overall satisfaction with one’s life situation” (Boyt Schell et al., 2014a, p. 1243).

### **Work**

“Labor or exertion; to make, construct, manufacture, form, fashion, or shape objects; to organize, plan, or evaluate services or processes of living or governing; committed occupations that are performed with or without financial reward” (Christiansen & Townsend, 2010, p. 423).

## Appendix B. Preparation and Qualifications of Occupational Therapists and Occupational Therapy Assistants

### *Who Are Occupational Therapists?*

To practice as an occupational therapist, the individual trained in the United States

- Has graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®) or predecessor organizations;
- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapists; and
- Fulfills state requirements for licensure, certification, or registration.

### *Educational Programs for the Occupational Therapist*

These include the following:

- Biological, physical, social, and behavioral sciences
- Basic tenets of occupational therapy
- Occupational therapy theoretical perspectives
- Screening, evaluation, and referral
- Formulation and implementation of an intervention plan
- Context of service delivery
- Management of occupational therapy services (master's level)
- Leadership and management (doctoral level)
- Scholarship
- Professional ethics, values, and responsibilities.

The fieldwork component of the program is designed to develop competent, entry-level, generalist occupational therapists by providing experience with a variety of clients across the lifespan and in a variety of settings. Fieldwork is integral to the program's curriculum design and includes an in-depth experience in delivering occupational therapy services to clients, focusing on the application of purposeful and meaningful occupation and/or research, administration, and manage-

ment of occupational therapy services. The fieldwork experience is designed to promote clinical reasoning and reflective practice, to transmit the values and beliefs that enable ethical practice, and to develop professionalism and competence in career responsibilities. Doctoral-level students also must complete a doctoral experiential component designed to develop advanced skills beyond a generalist level.

### *Who Are Occupational Therapy Assistants?*

To practice as an occupational therapy assistant, the individual trained in the United States

- Has graduated from an occupational therapy assistant program accredited by ACOTE or predecessor organizations;
- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapy assistants; and
- Fulfills state requirements for licensure, certification, or registration.

### *Educational Programs for the Occupational Therapy Assistant*

These include the following:

- Biological, physical, social, and behavioral sciences
- Basic tenets of occupational therapy
- Screening and assessment
- Intervention and implementation
- Context of service delivery
- Assistance in management of occupational therapy services
- Scholarship
- Professional ethics, values, and responsibilities.

The fieldwork component of the program is designed to develop competent, entry-level, generalist occupational therapy assistants by providing experience with a variety of clients across the lifespan and in a variety of settings. Fieldwork is integral to the program's curriculum design and includes an in-depth experience in

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*Note.* The majority of this information is taken from ACOTE (2012).

delivering occupational therapy services to clients, focusing on the application of purposeful and meaningful occupation. The fieldwork experience is designed to promote clinical reasoning appropriate to the occupational therapy assistant role, to transmit the values and beliefs that enable ethical practice, and to develop professionalism and competence in career responsibilities.

### *Regulation of Occupational Therapy Practice*

All occupational therapists and occupational therapy assistants must practice under federal and state law. Currently, 50 states, the District of Columbia, Puerto Rico, and Guam have enacted laws regulating the practice of occupational therapy.