

Occupational Therapy

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Occupational therapy promotes health by enabling people to perform meaningful and purposeful activities. Occupational therapists work with individuals who suffer from a mentally, physically, developmentally, and/or emotionally disabling condition by utilizing treatments that develop, recover, or maintain clients' activities of daily living. The therapist helps clients not only to improve their basic motor functions and reasoning abilities, but also to compensate for permanent loss of function. The ultimate goal of occupational therapy is to help clients have independent, productive, and satisfying lives. Furthermore, occupational therapists are becoming increasingly involved in addressing the impact of social, political and environmental factors that contribute to exclusion and occupational deprivation.

The World Federation of Occupational Therapists provides the following definition of Occupational Therapy: "Occupational therapy is as a profession concerned with promoting health and well being through engagement in occupation." Occupational therapists use careful analysis of physical, environmental, psychosocial, mental, spiritual, political and cultural factors to identify barriers to occupation. Occupational therapy draws from the fields of medicine, psychology, sociology, anthropology, and many other disciplines in developing its knowledge base. A new discipline of occupational science has been developed to enhance the evidence base of the profession.

History of occupational therapy

The earliest evidence of using occupations as a method of therapy can be found in ancient times. In c. 100 BCE, Greek physician Asclepiades initiated humane treatment of patients with mental illness using therapeutic baths, massage, exercise, and music. Later, the Roman Celsus prescribed music, travel, conversation and exercise to his patients. However by medieval times the concept of humane treatment of people considered to be insane was rare, if not nonexistent.

In 18th century Europe, revolutionaries such as Philippe Pinel and Johann Christian Reil reformed the hospital system. Instead of the use of metal chains and restraint, their institutions utilized rigorous work and leisure activities in the late 18th century. Although it was thriving abroad, interest in the reform movement waxed and waned in the United States throughout the 19th century. At the turn of the 20th century, as physicians became increasingly interested in chronic disease, enthusiasm for the reform of the mental healthcare system was revived in the United States through work therapy.

The health profession of occupational therapy was conceived in the early 1910s. The focus was on promoting health in "invalids." Early professionals merged highly valued ideals, such as having a strong work ethic and the importance of crafting with one's own hands with scientific and medical principles. Early opponents of this view considered wood carving and crafting by ill patients trivial.

The emergence of occupational therapy challenged the views of mainstream scientific medicine. Instead of focusing on purely physical etiologies, they argued that a complex combination of social,

economic, and biological reasons cause dysfunction. Principles and techniques were borrowed from many disciplines--including but not limited to nursing, psychiatry, rehabilitation, self-help, orthopedics, and social work--to enrich the profession's scope. Between 1900 and 1930, the founders defined the realm of practice and developed theories of practice. In a short 20-year span, they successfully convinced the public and medical world of the value of occupational therapy and established standards for the profession.

A substantial lack of primary sources of information has left today's occupational therapists with many questions concerning the founders of the field. Information is collected from early training institutions and hospitals, professional writings of practitioners, World War I records from government agencies, newspaper articles, and personal testimonials.

World War I forced the new profession to clarify its role in the medical domain and to standardize training and practice. In addition to clarifying its public image, OT also established clinics, workshops, and training schools nationwide. Due to the overwhelming number of wartime injuries, "reconstruction aides" (an umbrella term for physical therapists and occupational therapists) were recruited by the Surgeon General. Between 1917 and 1920, nearly 148,000 wounded men were placed in hospitals upon their return to the states. This number does not account for those wounded abroad. The success of the reconstruction aides, largely made up of women trying to "do their bit" to help with the war effort, was a great accomplishment. Post-war, however, there was a struggle to keep people in the profession. Emphasis was shifted from the altruistic war-time mentality to the financial, professional, and personal satisfaction that comes with being a therapist. To make the profession more appealing, practice was standardized, as was the curriculum. Entry and exit criteria were established, and AOTA advocated for steady employment, decent wages, and fair working conditions. Via these methods, occupational therapy sought and obtained medical legitimacy in the 1920s.

Evolution of the philosophy of occupational therapy

The philosophy of occupational therapy has evolved over the history of the profession. The philosophy articulated by the founders have owed much to the ideals of romanticism, pragmatism and humanism which are collectively considered the fundamental ideologies of the past century.

One of the most widely cited early papers about the philosophy of occupational therapy was presented by Adolf Meyer, a psychiatrist who had emigrated to the United States from Switzerland in the late 19th Century and who was invited to present his views to a gathering of the new occupational therapy society in 1922. At the time, Dr. Meyer was one of the leading psychiatrists in the United States and head of the new psychiatry department and Phipps Clinic at Johns Hopkins University in Baltimore, Maryland.

William Rush Dunton, a supporter of the National Society for the Promotion of Occupational

Therapy, now the American Occupational Therapy Association, sought to promote the ideas that occupation is a basic human need, and that occupation was therapeutic. From his statements, came some of the basic assumptions of occupational therapy, which include:

Occupation has an effect on health and well-being.

Occupation creates structure and organizes time.

Occupation brings meaning to life, culturally and personally.

Occupations are individual. People value different occupations.

These have been elaborated over time in order to form the values which underpin the Codes of Ethics issued by each national association. However, the relevance of occupation to health and well-being remains the central theme. Influenced by criticism from medicine and the multitude of physical disabilities resulting from World War II, occupational therapy adopted a more reductionistic philosophy for a time. While this approach led to developments in technical knowledge about occupational performance, clinicians became increasingly disillusioned and re-considered these beliefs. As a result, client centeredness and occupation are re-emerging as dominant themes in the profession, perhaps indicating growing maturity and self confidence. Over the past century, the underlying philosophy of occupational therapy has evolved from being a diversion from illness, to treatment, to enablement through meaningful occupation. This became evident through the development and widespread adoption of the Canadian Model of Occupational Performance.

The two most commonly mentioned values are that occupation is essential for health and the concept of holism. However, there have been some dissenting voices. Mocellin in particular advocated abandoning the notion of health through occupation as obsolete in the modern world and questioned the appropriateness of advocating holism when practice rarely supports it. The values formulated by the American Occupational Therapy Association have also been critiqued as being therapist centred and not reflecting the modern reality of multicultural practice.

Central to the philosophy of occupational therapy is the concept of occupational performance. In considering occupational performance the therapist must consider the many factors which comprise overall performance. This concept is made more tangible using models such as the person-environment-occupation model proposed by Law et al. (1996). This approach highlights the importance of satisfactions in one's occupations, broadening the aim of occupational therapy beyond the mere completion of tasks to the holistic achievement of personal wellbeing.

In recent times occupational therapists have challenged themselves to think more broadly about the potential scope of the profession, and expanded it to include working with groups experiencing occupational deprivation which stems from sources other than disability. Examples of new and emerging practice areas would include therapists working with refugees, and with people experiencing homelessness

The expanded version of the Canadian model of occupational performance and engagement (CMOP-E) encourages occupational therapists to think beyond just occupational performance and address other modes of occupational interaction such as occupational deprivation, competence, and justice. The broader notion of occupational engagement encompasses all that we do to become occupied and is congruent with how occupational therapists address issues of occupational enablement today.

Enabling occupation

Best practice in occupational therapy seeks to offer effective, client-centred services that enable people to engage in occupations of life. The Canadian Model of Client Centered Enablement (CMCE) embraces occupational enablement as the core competency of occupational therapy and the Canadian Practice Process Framework (CPPF) as the core process of occupational enablement.

Occupational therapy process

An Occupational Therapist works systematically through a sequence of actions known as the occupational therapy process. There are several versions of this process as described by numerous writers. Creek has sought to provide a comprehensive version based on extensive research. This version has 11 stages, which for the experienced therapist may not be linear in nature. The stages are:

- Referral
- Information gathering
- Initial assessment
- Needs identification/problem formation
- Goal setting
- Action planning
- Action
- Ongoing assessment and revision of action
- Outcome and outcome measurement
- End of intervention or discharge
- Review

Another process framework for occupational therapists to use is the Canadian Practice Process Framework (CPPF), which portrays eight action points and three contextual elements for the process of occupation-based, client-centred enablement. The contextual elements are:

- societal context
- practice context

frame(s) of reference

The eight action points include:

enter/initiate

set the stage

assess/evaluate

agree on objectives and plan

implement plan

monitor/modify

evaluate outcome

conclude/exit

Fearing, Law, and Clark suggested a 7 stage process which includes:

identifying of occupational performance issues

choosing a theoretical frame of reference

assessing factors contributing the identified occupational performance issue(s)

considering the strengths and resources of both client and therapist

negotiating targeted outcomes and developing an action plan

implementing the plan through occupation

evaluating outcomes

A central element of this process model is the focus on identifying both client and therapists strengths and resources prior to beginning to develop the outcomes and action plan.

Areas of practice in occupational therapy

The role of Occupational Therapy allows OT's to work in many different settings, work with many different populations and acquire many different specialties. This broad spectrum of practice lends itself to difficulty categorizing the areas of practice that exist, especially considering the many countries and different healthcare systems. In this section, the categorization from the American Occupational Therapy Association is used. However, there are other ways to categorize areas of practice in OT, such as physical, mental, and community practice (AOTA, 2009). These divisions occur when the setting is defined by the population it serves. For example, acute physical or mental health settings (e.g.: hospitals), sub-acute settings (e.g.: aged care facilities), outpatient clinics and community settings.

In each area of practice below, an OT can work with different populations, diagnosis, specialities, and in different settings.

Physical health

Pediatrics - Schools, Community, inpatient hospital based child OT: Often, children need OT services for the same reasons an adult needs OT services. However, OTs approach intervention in a different way with children. OT delivers approaches treatment through occupation, and the occupations of a child are different from those of an adult, and include play, chores, self-care and schoolwork. Common conditions that are specific to or more common in the pediatric population creating a need for OT services include: developmental disorders, sensory regulation or sensory processing deficits, fine motor developmental delays or deficits, autism, emotional and behavioral disturbances (Lambert, 2005), among others. In addition, children are seen for every injury, illness or chronic condition that may cause a person of any age to have performance deficits in their daily life and thus benefit from OT services. Often, OT in pediatrics deals with the implications that certain medical conditions have for classroom learning and the remediation and strategies required. They need to be closely interwoven with existing teaching approaches to help the student achieve his or her educational potential.

Acute care hospitals: Acute care is an inpatient hospital setting for individuals with a serious medical condition(s) usually due to a traumatic event, such as a traumatic brain injury, spinal cord injury, etc. The primary goal of acute care is to stabilize the patient's medical status and address any threats to his or her life and loss of function. Occupational therapy plays an important role in facilitating early mobilization, restoring function, preventing further decline, and coordinating care, including transition and discharge planning. Furthermore, occupational therapy's role focuses on addressing deficits and barriers that limit the patient's ability to perform activities that they need or want to do related to independence in self-care, home management, work-related tasks, and participating in leisure and community pursuits.

Inpatient rehabilitation (e.g., Spinal Cord Injuries): People with disabilities have the right and the privilege to live meaningful purposeful lives. When a disability occurs it is sometimes possible to recover - when it is not it is important to learn the skills to adapt capacity and environmental supports to be able to participate. OTs use their knowledge to help both with recovery and adaptation.

Rehabilitation centers (e.g., Traumatic Brain Injury (TBI), Stroke (CVA), Spinal Cord Injuries, Head Injuries)

Skilled nursing facilities: An occupational therapists role in a skilled nursing facility is centered on each client's individual needs. Many of the skills an OT works on are known as activities of daily living or self-care such as feeding or dressing. OTs can provide equipment to assist with activities or offer expertise in modifying the environment to maximize independence and facilitate independence. Other OT roles include education in adaptive equipment (shower bench), energy conservation, or task simplification (Hofmann, 2008).

Home Health: Occupational therapists who work in this area of practice generally work with client's in the geriatric population who have one or more of the following diagnoses: Alzheimer's disease, arthritis, depression, CVA, generalized weakness, COPD, or Parkinson's disease. Occupational therapists working with these client's evaluate their level of independence, cognition, and safety.

Moreover, occupational therapists provide intervention to maximize independence and function through remedial and compensatory strategies, with the ultimate goal of the client's regaining the ability to live independently at home (Swanson Anderson & Malaski, 1999).

Outpatient clinics (e.g., Hand Therapy, orthopaedics) Hand therapy is a specialty practice area of occupational therapy that is mainly concerned with treating orthopedic-based upper extremity conditions to optimize the functional use of the hand and arm. Diagnoses seen by this practice area include: fractures of the hand or arm, lacerations and amputations, burns, and surgical repairs of tendons and nerves. Additionally, hand therapists treat acquired conditions such as tendonitis, rheumatoid arthritis and osteoarthritis, and carpal tunnel syndrome. Occupational therapists who work in this field address biomechanical issues underlying upper-extremity conditions. In addition, occupational therapists use an occupation-based and client-centered approach by identifying participation needs of the client, then tailoring intervention to improve performance in desired activities. (link for a picture of hand therapy)

Specialist assessment centres (e.g., Electronic assistive technology, Posture and Mobility services, functional capacity evaluation)

Hospices: An occupational therapists common role in hospice care is modifying and preventing. Modifying the demands of the activity to fit with the abilities of the client. The intervention may be directly with the client or with the client and the client's caregivers. OT can offer the caregivers support an education. Progress is defined as improved quality of life in hospice care. (Hasselkaus, 1998)

Assisted Living Facilities: In an assisted living facility OT services are provided by a home health agency, rehab agency, or a private practice. Medicare and some private insurance plans cover OT services in ALFs. Areas of treatment intervention often include: bathing, dressing, grooming, toileting, mobility, money management, laundry, and community participation. Can treat persons with occupational performance decline or at risk for a decline. Increase quality of life so less residents need the services of a long-term SNF. Special areas include mobility device assessment (scooter), continence training, psychosocial needs and low vision programs (Fagan, 2001).

Productive Aging: An OT practicing in this area would provide skills and services to older adults to maximize independence, participation, and quality of life. Typical issues addressed: Any impairment or condition that would limit their ability to carry out meaningful occupations and tasks that are necessary for daily life. Skills taught include: energy conservation, education in adaptive equipment (such as a shower bench), task simplification, adapting and modifying activities to progress with a client's changing abilities (Opp Hoffman, 2008), caregiver education and support (AOTA, 2004), safety, social interactions and communication, memory skills training, mobility device assessment and training (i.e. scooters, wheelchairs, walkers), low vision interventions, continence training, and facilitating performance in basic ADL and IADL (Fagan, 2001).

Work hardening is essentially a specialized program designed to enable people with physical, psychological, and psychosocial issues inhibiting a person's ability, to successfully return to work. The National Advisory Committee on Work Hardening best describes work hardening:

Work hardening is a highly structured, goal oriented, individualized treatment program designed to maximize the individual's ability to return to work. Work hardening programs, which are interdisciplinary in nature, use real or simulated work activities in conjunction with conditioning tasks that are graded to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic and psychosocial functions of the individual. Work hardening provides a transition between acute care and return to work while addressing the issues of productivity, safety, physical tolerances, and worker behaviors" (Ogden-Niemeyer & Jacobs, 1989, p. 1).

Work conditioning is similar to work hardening, except work conditioning purely involves improving physical capacities, whereas work hardening improves physical, psychological, and psychosocial factors.

Mental health

According to Medicare (2005) guidance, "Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function, and where appropriate, recommend to the physician a plan of treatment."

According to the American Occupational Therapy Association (AOTA), occupational therapists work with the Mental Health population throughout the life span and across many treatment settings where mental health services and psychiatric rehabilitation are provided (AOTA, 2009). Just as with other clients, the OT facilitates maximum independence in activities of daily living (dressing, grooming, etc.) and instrumental activities of daily living (medication management, grocery shopping, etc.). According to the American Occupational Therapy Association, OT improves functional capacity and quality of life for people with mental illness in the areas of employment, education, community living, and home and personal care through the use of real life activities in therapy treatments (AOTA, 2005).

Geriatric, Adult, Adolescents, and Children with any kind of mental illness or mental health issues. These conditions include but are not limited to: Schizophrenia, substance abuse, addiction, dementia, Alzheimer's, mood disorders, personality disorders, psychoses, eating disorders, anxiety disorders (including post-traumatic stress disorder, separation anxiety disorder) (Cara & MacRae, 2005), and reactive attachment disorder (children only) (Lambert, 2005).

Typical issues that are addressed are as follows: Helping people acquire the skills to care for themselves or others including; keeping a schedule, medication management, employment, education, increasing community participation, community access (grocery store, library, bank, etc.), money management skills, engaging in productive activities to fill the day, coping skills, routine building, building social skills, and childcare (Cara & MacRae, 2005).

In the UK, the College of Occupational Therapists (COT) have published Recovering Ordinary Lives, which details the strategy for OTs in mental health up to 2017, and makes explicit the goals that have been set for the profession, in line with government directives (COT 2006).

Areas that Mental Health OT's could work in are as follows:

Mental health inpatient units

Adolescent, adult and older people's acute mental health wards

Adult and older people's rehabilitation wards

Prisons/secure units (Forensic psychiatry)

Psychiatric intensive care unit

Specialist units for Eating Disorders, Learning disabilities

Community based mental health teams

Child and adolescent mental health teams

Adult and older people's community mental health teams

Personalized Recovery Oriented Services (PROS) programs

Rehabilitation and recovery and Assertive Outreach community teams

Primary care services in GP practices

Home treatment teams

early intervention in psychosis teams

Specialist learning disability, eating disorder community services

Day services

Vocational Services

Dementia & Alzheimer Care: OTs focus on adapting activities as the client progresses through the illness (Hofmann, 2008) OT also works with caregivers to teach them how to grade activities to the client's ability. Interventions are based on using the client's strengths to increase their quality of life and their relationships with caregivers. Use of social interactions, communication, memory, safety and self maintenance.

Community

Community based practice involves working with people in their own environment rather than in a hospital setting. It often combines the knowledge and skills related to physical and mental health. It can also involve working with atypical populations such as the homeless or at-risk populations. Examples of community-based practice settings:

Health promotion and lifestyle change: Remaining healthy is the goal of all people in a society, including people with chronic disabling or health conditions. Achieving health requires skills to self-

manage conditions that might limit their ability to function in daily life. The occupational therapist helps people acquire these skills (Wilcock, 2005).

Private Practice

Aging in place: Occupational therapists implement environmental modifications in senior housing, assisted living, long-term-care facilities, and homes (Yamkovenko, 2008) Environmental modifications can include rearranging furniture, building ramps, widening doorways, grab bars, special toilet seats, and other safety equipment to use performance capabilities to their fullest (Moyers & Christiansen, 2004).

Low Vision: Occupational therapists help clients use their remaining vision to complete their daily routines with compensation, remediation, disability prevention and health promotion. Compensations or that modifications to the environment may include proper lighting, color contrast, reducing clutter and education on adaptive equipment (Golembiewski, 2004).

Intermediate care services

Driving Centers: Driving is an instrumental activity of daily living and an occupational therapist may evaluate and treat skills needed to drive such as vision, executive function or memory. If a client needs more skilled assessment and training they would refer them to an OT Driver Rehabilitation Specialist which could do on the road assessment, training in adaptive equipment and make more specific recommendations.

Day centres

Schools

Child development centres

People's own homes, carrying out therapy and providing equipment and adaptations

Work and Industry: To be a healthy successful worker there must be a person environment fit between the task, the equipment, and the person's skills. Occupational therapists work to achieve that fit (Ellexson, 2000; Clinger, Dodson, Maltchev, & Page, 2007). **Populations, conditions, and diagnoses:** People of working age and ability who have been born with or developed a condition, injury, or illness that compromises their ability to work (Ellexson, 2000; Clinger, Dodson, Maltchev, & Page, 2007). **Settings:** Return to work programs, large organizations, consultants to large organizations, work hardening programs, work conditioning programs, transitional return to work programs (Ellexson, 2000; Clinger, Dodson, Maltchev, & Page, 2007). **Typical issues addressed:** assessment of ability to work, interventions to enhancing work performance by means of work hardening, work conditioning, and improvement of ergonomics in the workplace, identification of accommodations necessary to return-to-work following illness or injury, prevention of work related injury, illness, or disability (Ellexson, 2000; Clinger, Dodson, Maltchev, & Page, 2007).

Homeless Shelters
Educational Settings
Refugee Camps

Children & Youth:

Psychosocial Needs of Children & Youth
Self-management for Physical & Occupational Therapy Students
Life Skills Trainings for children & Youth with Special Needs (Khemthong, 2006)

Health & Wellness:

Health & Wellness Consulting
Design & Accessibility Consulting & Home Modification
Ergonomic Consulting
Private Practice Community Health Services

Productive Aging:

Driver Rehabilitation & Training
Low Vision Services
Fatigue & Leisure Management (Khemthong, 2006)
Musical trainings for elderly (Khemthong, 2006)

Rehabilitation, Disability, & Participation:

Technology & Assistive Device Development & Consulting
Meditation trainings for Diabetes Mellitus (Khemthong, 2006)
Leisure management for Chronic Obstructive Pulmonary Disease (Khemthong, 2006)
Health Systematization of Occupational Therapy for Stroke
Mental Practice & Recovery Programs (Khemthong, 2006)
Leisure Management for Mental Health (Khemthong, 2006)
Fatigue & Psychospirituality of Multi-Sensory Leisure for Cancer, Depression, Rheumatoid Arthritis(Khemthong, 2006)

Work & Industry:

Ticket to Work Services
Welfare to Work Services
Leadership Maturity Fitness to Work Services (Khemthong, 2006)
Fatigue & Leisure Management to Work Services (Khemthong, 2006)

Occupational therapy approaches

Services typically include:

Teaching new ways of approaching tasks

How to break down activities into achievable components e.g. sequencing a complex task like cooking a complex meal

Comprehensive home and job site evaluations with adaptation recommendations.

Performance skills assessments and treatment.

Adaptive equipment recommendations and usage training.

Environmental adaptation including provision of equipment or designing adaptations to remove obstacles or make them manageable

Guidance to family members and caregivers.

The use of creative media as therapeutic activity

Activity analysis

Activity analysis has been defined as a process of dissecting an activity into its component parts and task sequence in order to identify its inherent properties and the skills required for its performance, thus allowing the therapist to evaluate its therapeutic potential

Theoretical Frameworks

Occupational Therapists use a number of theoretical frameworks to frame their practice. Note that terminology has differed between scholars. Theoretical bases for framing a human and their occupation being include the following:

Frames of Reference/Generic models

Frames of reference or generic models are the overarching title given to a collation of compatible knowledge, research and theories that form conceptual practice. More generally they can be defined as "those aspects which influence our perceptions, decisions and practice".

Occupational Therapy Frame of References/Models:

Person Environment Occupation Performance Model (PEOP) (Charles Christiansen & Carolyn Baum)

Occupational Therapy Intervention Process Model (OTIPM) (Anne Fisher and others)

Occupational Performance Model (OPM)

Model of Human Occupation (MOHO) (Gary Kielhofner and others)

MOHO was first published in 1980. It explains how people select, organise and undertake occupations within their environment. The model is supported with evidence generated over thirty years and has been successfully applied throughout the world.

Canadian Model of Occupational Performance and Engagement (CMOP-E)

Kawa (River) Model (Michael Iwama)

Functional Information-Processing Model

Biomechanical Frame of Reference

The Biomechanical Frame of Reference is primarily concerned with motion during occupation. It is used with individuals who experience limitations in movement, inadequate muscle strength or loss of endurance in occupations. The Frame of Reference was not originally compiled by Occupational Therapists, and Therapists should translate it to the Occupational Therapy perspective, to avoid the risk of movement or exercise becoming the main focus.

Rehabilitative (compensatory)

Neurofunctional (Gordon Muir Giles and Clark-Wilson)

Cognitive Disabilities

Sensory Integration

Lifestyle Performance Model (Fidler)

Client-Centered Frame of Reference

This Frame of Reference is developed from the work of Carl Rogers. It views the client as the center of all therapeutic activity, and the client's needs and goals direct the delivery of the Occupational Therapy Process.

Cognitive-Behavioural Frame of Reference

Psychodynamic Frame of Reference

Ecological of Human Development Model

Recovery Models & Self-Management Models

Curtin pARTicipation Model

Knowledge Translation of Self-Management Models

Life-Skills Tree Model

Occupational Therapy - Mahidol Clinical System (OT-MCS) Model

Challenges for occupational therapy

A key challenge for occupational therapy is to develop and maintain a definition of its nature and scope assert that while this presents a challenge, it also results in a unique flexibility which allows the discipline to move with the flow of social, cultural and environmental change. This difficulty in definition may be a cause of chronic strain for practitioners and may also contribute to a lack of role definition and subsequent blurring

Recent literature has also called for occupational therapy to address the political nature of who occupational therapists are and what they do (Kronenberg & Pollard, 2005). Profession specific models of occupational therapy have also been critiqued for being biased towards a western, ableist and generally unrepresentative of the most occupationally deprived groups

Occupational therapy and ICF

The International Classification of Functioning, Disability and Health (ICF) is a framework to measure health and ability by illustrating how these components impact one's function. This relates very closely to the Occupational Therapy Practice Framework as it is stated, "The profession's core beliefs are in the positive relationship between occupation and health and its view of people as occupational beings". The ICF is also built into the 2nd edition of the practice framework. Activities and participation examples from the ICF overlap Areas of Occupation, Performance Skills, and Performance Patterns in the framework. The ICF also includes contextual factors (environmental and personal factors) that relate to the context in the framework. In addition, body functions and structures classified within the ICF help describe the client factors as described in the OT framework

Further exploration of the relationship between occupational therapy and the components of the ICIDH-2 (revision of the original International Classification of Impairments, Disabilities, and Handicaps (ICIDH); later becoming the ICF) was conducted by McLaughlin Gray. First, the ICF is an international framework and provides an opportunity for the occupational therapy field to become better known across the globe. Second, the ICF provides occupational therapists with a global language to describe their expertise to the larger international health care community. The ICF uses a positive, holistic language emphasizing skills, capacities, and strengths of an individual rather than focusing on one's deficits and disabilities. This is similar to the outlook of occupational therapists. Third, the ICF includes environmental and personal contextual factors which are incorporated into the theory behind occupational therapy. It is important to take into consideration an individual's personal, environmental, and occupational factors to develop an effective intervention. The last notable application of the ICF to occupational therapy is the recognition of cultural patterns in occupation. Culture has significance on an individual's activities and participation and it is important to keep this in mind when treating an individual.

Although the ICF can be very useful for occupational therapists, it is noted in the literature that occupational therapists should use specific occupational therapy vocabulary along with the ICF in order to ensure correct communication about specific concepts. The ICF might lack certain categories to describe what occupational therapists need to communicate to clients and colleagues. It also may not be possible to exactly match the connotations of the ICF categories to occupational therapy terms. The ICF is not an assessment and specialized occupational therapy vocabulary should not be replaced with ICF terminology. The ICF is an overarching framework for

current therapy practices.

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