CHAPTER 3

Domain of Concern of Occupational Therapy: Relevance to Pediatric Practice

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A profession exists within the context of society. It has to address the needs and concerns of society. The profession's domain of concern is its areas of expertise, the knowledge and services used to address societal needs. The domain of concern defines the scope of practice, the breadth of a profession, and the expertise of practitioners. Within occupational therapy, the *Occupational Therapy Practice Framework*: *Domain and Process* (American Occupational Therapy Association, 2014) defines its domain of concern. It is beyond the scope of this book to review that entire document or to identify the whole domain of concern for the profession of occupational therapy. This chapter focuses, therefore, on the domain of pediatric occupational therapy practice.

Society rarely remains the same. A profession needs to be dynamic and continually respond to changes in society. If the profession remains static, it runs the risk of becoming irrelevant. To remain viable and healthy, a profession needs to continue to develop and adapt to meet the current needs, and even anticipate future concerns of society. As a profession responds to the changing needs of society, the profession's domain of concern evolves.

Occupational therapy is a complex, vibrant profession. It is impossible to define it simply, in one sentence. This is frustrating to students and new therapists, who often would like an "elevator speech" to easily explain their profession. When a profession starts out, it is relatively easy to develop a simple definition. However, when a profession like occupational therapy evolves over a period of 100 years, it is virtually impossible to use discrete terms to describe its domain of concern. At this time, the complexity of occupational therapy does not allow for a simple definition or a quick description of its domain of concern.

A profession must also adapt to changes in social priorities and methods of service delivery. At various times, society has shown concern for a specific age-group or particular category of disability. This leads to an increased professional focus on those particular groups and may lead to specialized practice. This has

been the case in occupational therapy in the United States. For example, pediatric occupational therapy practice has been influenced dramatically by societal changes. In the early 1970s, federal laws emphasized and supported the educational needs of special children and required occupational therapy as a related service. This idea was expanded during the 1980s when family-centered early intervention services for infants and toddlers became an area of concern, and occupational therapy became a primary service. During the 1990s, there was an increasing trend toward more community-based services and natural settings for intervention such as the home and school, and assistive technology became a more important aspect of service provision.

Federal legislation in the early 2000s has expanded the potential for school-based occupational therapists who have the education, training, and skills to provide leadership in the response-to-intervention movement, which includes early intervention services that offer research-based intervention to individual children who do not qualify for special education but are in need of short-term assistance. In the 2010s, with the integration of technology in everyday life, occupational therapists were increasingly using mobile applications as a therapeutic tool and telehealth to provide services to clients, which continues today and has even expanded. Although insurance coverage and legislation has not yet provided good coverage for telehealth, the benefits of telehealth have increased services to rural areas and areas without many therapists available. Additionally, increased identification and awareness of autism has increased the demand for occupational therapists. Understanding what occupational therapy can offer is crucial, and knowing the potential locations of service delivery is also important. Currently, pediatric occupational therapists work in a wide variety of settings, including well-baby clinics, neonatal intensive care units, early intervention centers, preschools, home-based care, Head Start programs, and school systems.

Classification Systems

A profession needs a common language. This common language provides the ability for smooth communication among professionals within the profession. It also helps to define the scope of practice for the profession as well as to the external world. The scope of practice is what occupational therapists can practice. Unlike the domain, the scope of practice limits practice based on federal and state legislation and institutional policy. A common language is also used to document services for reimbursement purposes and can be used to show evidence that an intervention is effective. Over the years, the occupational

therapy profession in the United States has adopted various classification systems that provide a common language.

Also, over time, health care systems have often used a classification system of uniform terminology. Occupational therapists working within the medical model have used what is now called the *International Classification of Diseases* for years. The first edition of this system, the *International List of Causes of Death* (based on classification systems developed decades earlier) was adopted in 1893 by the International Statistical Institute. The World Health Organization, which assumed responsibility for the international classification, officially expanded the listing to include diseases, conditions, and injuries in 1948. *International Classification of Diseases, 10th revision* was adopted by the World Health Organization in 1994, and it has taken a long time for many countries to adopt its use because of technology constraints. The most current edition is *International Classification of Diseases, 10th revision* (World Health Organization, 2016a). Despite all countries not yet using *International Classification of Diseases, 10th revision*, *International Classification of Diseases, 11th revision* has been developed. This revision was reviewed in early 2015 (Roberts, Greenberg, & Richardsson, 2015) and it was determined that more work was still needed to complete the project. *International Classification of Diseases, 11th revision* is currently in a beta test version (https://icd.who.int/dev11/l-m/en), but the *International Classification of Diseases, 10th revision* is the edition that is used predominantly (WHO, 2016a). Because the *International Classification of Diseases, 11th revision* is the international standard diagnostic system used to classify diseases and other health conditions, the standard naming and measuring system allows coding, collection, storage, and analysis of morbidity and mortality statistics. The statistics can be compared at the individual, institutional, societal, and international levels (WHO, 2007).

The *International Classification of Disease* allows for systematic naming and measuring across an etiological framework. It is a part of the World Health Organization family of classification systems. The system does not provide much information in terms of outcomes other than changes in mortality or morbidity rate by diagnosis. In 1980, the World Health Organization developed, for trial purposes, another classification system that was revised and subsequently published as the *International Classification of Functioning, Disability and Health*. The *International Classification of Functioning, Disability and Health* (World Health Organization, 2001) is a blending of medical and social models, a biopsychosocial framework of naming and measuring, designed to collect information about functioning, health, and well-being, and other health-

related domains. The *International Classification of Functioning, Disability and Health* is a framework for measuring health and disability at both individual and population levels. This classification was operationalized through the World Health Organization Disability Assessment Schedule, which was developed through a collaborative international approach. The intent was to develop a single instrument that would be effective across different settings and cultures for assessing health status and disability (World Health Organization, 2016b).

Although initially designed for rehabilitation, this systematic standard framework for classification by functioning is designed to stand alone or work in conjunction with the *International Classification of Disease* to provide international statistics about health outcomes. It should be noted that the World Health Organization is working on updating the International *Classification of Functioning, Disability and Health* manual to a 2017 version; however, this project is not yet completed (World Health Organization, 2017).

A profession-developed classification system of uniform terminology based on functioning is not a new idea in occupational therapy. In the United States, the occupational therapy profession has been using a biopsychosocial framework to provide a uniform language, naming aspects of the profession's domain of concern, which predated the international classification system. In 1979, a document that came to be known as *Uniform Terminology* was approved by the American Occupational Therapy Association's Representative Assembly to promote uniformity of definition for practice within the profession (American Occupational Therapy Association, 1979). As the profession changed and evolved, the American Occupational Therapy Association developed second (American Occupational Therapy Association, 1989) and third (American Occupational Therapy Association, 1994a) editions. The third edition (American Occupational Therapy Association, 1994b) of *Uniform Terminology-III* refined common language and provided a needed expansion that included context and environments that influence performance. As this document was more expansive and complex than previous Uniform Terminology documents, the American Occupational Therapy Association published a companion document to help occupational therapists apply the revised classification system to practice (American Occupational Therapy Association, 1994a).

After the World Health Organization published the *International Classification of Functioning, Disability and Health*, occupational therapy scholars noted that it contains language very familiar to many occupational therapists, with its focus on activity and participation. Rather than adopt the *International Classification of Functioning, Disability and Health*, designed "to provide a unified and standard

language and framework for the description of health and health-related states" (World Health Organization, 2001, p. 3), the American Occupational Therapy Association replaced the Uniform Terminology document with the *Occupational Therapy Practice Framework: Domain and Process*, commonly called the *Practice Framework*. This document is currently in its third edition (American Occupational Therapy Association, 2014).

The *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.) (American Occupational Therapy Association, 2014) expands context to context and environment, with environments being physical and social. It expands client factors to include values, beliefs, and spirituality. However, it does not include the types of occupational therapy interventions, approaches to interventions, or expected outcomes (American Occupational Therapy Association, 2014). The Practice Framework has increased the complexity of the domain of occupational therapy to a level some critics believe makes the classification system difficult to apply in practice. More recently, in a report on the *Study of the Future of Education*, it was found that the Practice Framework was very widely used in the education of occupational therapists, although this document was intended for practice. The authors of the study hypothesized that this was because the Practice Framework is occupation focused and client centered. However, they noted that it does not have a community-based focus, which is becoming more common in practice (Fisher, 2013). There were no data available on the current usage of the Practice Framework in actual practice.

Because of the complexity of the *Occupational Therapy Practice Framework: Domain and Process (3rd ed.)*, the American Occupational Therapy Association developed documentation templates called PERFORM (American Occupational Therapy Association, 2017), to reflect how it can be documented in practice. It explains all aspects of the Practice Framework. The one section of the Practice Framework that is frequently mentioned in discussions of the evaluation process is the Occupational Profile (Laverdure, 2018; Nichols, Wasemann, Coatie, Moon, & Weller, 2018; Whitney & Caretta, 2018).

Table 3.1 provides a comparison of the Practice Framework and the *International Classification of Functioning*. It is arranged with the two classifications as the two main columns. The three main rows attempt to group similar aspects of the classifications. Although the two documents seem roughly similar, a simple one-to-one comparison is not possible. In the main bottom row, both classification systems include contextual factors, division categories with context in the name. The main top row of each classification contains occupation-based life areas (also called "activities and participation" in the

International Classification of Functioning). To include client factors (based on *International Classification of Function* body functions and structure), the Practice Framework adds other classification system categories (performance skills, performance patterns, and activity demands). See the bottom row of Table 3.1 for specifics.

Table 3-1

Comparison of the Practice Framework (AOTA, 2014) and the International Classification of Function, Disability, and Health (World Health Organization, 2001)

Practice Framework								
Occupations								
Activities of daily living	Instrumental activities of daily living	Rest and sleep	Education	Work	Play	Leisure	Social participation	Learn and applyi know
Body Functions and Structures								
Client factors		Performance skills			Performance patterns			Menta
Context and Environment						**Contextual Factors**		
Environment		**Context**				**Environmental Factors**		
Physical	Social	Personal	Cultural	Temporal	Virtual	Products and technology	Natural environment and the human-made changes to the environment	Suppo relatic

American Occupational Therapy Association. (2014). *Occupational therapy practice framework: Domain and process* (3rd ed.). *American Journal of Occupational Therapy, 68*(Suppl. 1), S1–S48. doi:10.5014.ajot682006; World Health Organization (WHO). (2001). *ICF: International classification of functioning, disability and health*. Geneva, Switzerland: World Health Organization.

Note: Table originally created by Aimee J. Luebben, Ed.D., OTR, FAOTA. Printed with permission. Adapted by Sara E. Benham, used with permission.

International Classification of Functioning

This chapter uses the *International Classification of Functioning*, as it is a worldwide taxonomy that provides a uniform language while offering assessment capabilities. The uniform language aspect is designed in stem-branch-leaf fashion: categories are mutually exclusive and lower-level order categories are subsumed under higher-order levels. The classification system and definitions allow occupational therapists to provide consistent communication with other disciplines and reimbursement sources, using terminology such as activity, function, performance, functioning, and

participation—words that have been part of the occupational therapy lexicon for decades. While the Practice Framework is specific to occupational therapy, there is a distinct benefit to having occupational therapists use a language that is accepted internationally. Indeed, the viability of the profession may rest on the ability of occupational therapy to adapt the profession's language to the international standard naming and measuring system that allows coding, collection, storage, and analysis of statistics. For occupational therapists, using the *International Classification of Functioning* has an added benefit: This uniform language classification has an integrated coding system that allows measurement of baseline information for comparison with subsequent evaluation data. This universal classification and assessment tool provide a systematic method of building evidence to demonstrate the effectiveness of occupational therapy.

Although the *International Classification of Functioning* was divided into three rows in Table 3.1 to show similarities with the Practice Framework, the international classification system has two parts—Part 1: Health Condition and Part 2: Contextual Factors. Each part has two subdivisions. Part 1: Health Condition comprises the subdivisions: (1) activities and participation and (2) body functions and structures. Part 2: Contextual Factors comprise the subdivisions: (1) environmental factors and (2) personal factors.

Occupation-Based Life Areas (Activities and Participation)

In the *International Classification of Functioning*, the activities and participation subdivision (of Part 1. Functioning and Disability) has nine daily life area domains: learning and applying knowledge, general tasks and demands, communication, mobility, self-care, domestic life, interpersonal interactions and relationships, major life areas, and community and social and civic life. (Note: the term "domain," used as a subcomponent name in the *International Classification of Functioning*, is not equivalent to domain of concern.)

To an occupational therapist, items within the nine *International Classification of Function* daily life domains are considered occupations, a core concept of the profession of occupational therapy. "Occupation, a collection of activities that people use to fill their time and give life meaning, is organized around roles or in terms of activities of daily living, work and productive activities or play/leisure" (Hinojosa & Kramer, 1997, p. 865). Occupations serve a multitude of purposes; people become involved in them for survival, necessity, pleasure, and personal meaning. Each individual's occupations comprise a unique combination of activities that are meaningful to that person. "Occupations are

the ordinary and familiar things that people do every day" (Christiansen, Clark, Kielhofner, Rogers, & Nelson, 1995, p. 1015). People engage in occupations throughout their everyday lives to fulfill their time and give their lives meaning. An individual's unique occupations define that person. Depending on life situation and circumstances, the occupations that are important to the individual may change over time (Hinojosa & Kramer, 1997). Although the occupational therapy profession uses the term "occupation," the *International Classification of Functioning* uses the term "activities and participation" in nine daily life areas, also called "domains." This chapter works to integrate and unite occupational therapy terminology with *International Classification of Functioning* language. Therefore, the term "occupation-based life areas" is used in this chapter interchangeably with International Classification of Function activities and participation, *International Classification of Function* life areas, or *International Classification of Function* domains.

The flexibility of the *International Classification of Functioning* allows items within the activities and participation domains to be reclassified as an activity, defined as "the execution of task or action by an individual," or as participation, "involvement in a life situation" (World Health Organization, 2001, p. 10). A simplified way of looking at activity versus participation is from a role standpoint. If a person does something in his or her "self" role, then that action is likely to be categorized as an activity. Keep in mind that the root word of activity is active, so the person has to be engaged in doing something. A person involved in a role beyond the self (e.g., functioning as a son, brother, student, or pet owner) is operating in participation mode, is the person part of something. In other words, from an occupational therapy standpoint, occupations (tasks or actions) a person completes in the self-role would be classified as *International Classification of Functioning* activities and occupations (tasks and actions) an individual completes in other role are termed participation.

In addition to determining whether a part of a daily life domain is categorized as an activity or participation, qualifiers can be added to each. When qualifiers are used during the assessment process, the list of nine daily life area domains becomes a classification that allows quantitative measurement of baseline information to be compared with subsequent reevaluation data. For activities and participation, the two qualifiers are *performance* and *capacity*. In the *International Classification of Functioning*, performance is used in the same way occupational therapists have used the term for years. Performance is what an individual can do in his or her current context (e.g., home, school) within society. For an individual, assessment of performance includes all equipment typically

used in that environment. For example, if a person used eyeglasses (considered a "technical aid" under the *International Classification of Functioning* category of environmental factors) to correct visual disabilities, the person would be assessed using his or her glasses. Capacity, as identified by the *International Classification of Functioning*, determines the person's ability within the standard environment, alone and without aids.

To assess capacity, the individual would be evaluated in a standard environment (e.g., a rehabilitation unit bathroom that is part of a simulated apartment). The person is evaluated without any equipment (not even eyeglasses) in such an evaluation. Capacity assesses a person's true ability in a standard environment.

There are positive and negative aspects of the nine daily life domains in activities and participation. Functioning, the positive aspect of activities and participation, is a term familiar to occupational therapists. The occupational therapy domain of practice includes various aspects of all nine daily life area domains of the *International Classification of Functioning.* For evaluation and intervention, therapists apply information from the learning and applying knowledge domain when they work on specific school functioning of students, such as focusing attention, solving problems, and making decisions. Therapists use aspects of the general tasks and demands domain when working with a child on carrying out a daily routine, handling stress and other responsibilities, and operating alone or in a group. Although speech and language pathologists are responsible for many of the items in the communication domain, occupational therapists work with children on various communication domain aspects such as comprehending body gestures or using a tablet computer to access alternative communication apps. Mobility is a major domain for occupational therapists working with children. The mobility domain includes changing and maintaining body positions, transferring from one surface to another, lifting and carrying objects, walking and moving, driving (e.g., bikes, four-wheelers, boats, cars, horse-drawn cart), and riding animals. The self-care domain is also a primary area for pediatric occupational therapy. Aspects of this domain are expanded later in this chapter.

The domestic life domain includes acquiring goods and services, preparing meals, doing housework, and taking care of domestic animals. Pediatric therapists address this domain when they work with children on tasks involving making a bed, doing household chores, shopping, or taking responsibility for a pet. The interpersonal interactions and relationships domain is another area within the occupational therapy scope of practice. The focus is on this domain

when therapists work with children on completing actions needed for basic and complex interactions with others (e.g., tolerance in relationships, interacting according to rules, and family relationships).

Another primary area for pediatric occupational therapists is the *International Classification of Functioning* domain, major life areas, which includes education (informal, daycare, preschool, school), vocational training, and higher education. Many pediatric therapists practice in natural settings such as school systems that include aspects of major life areas. Therapists may also address work and employment activities when they are working with older children or youth who are involved in transitioning to employment or have remunerative employment, such as paper routes, mowing lawns, or shoveling snow. Within all domains, therapists will evaluate for supports for participation, which may include human supports such as parents or teachers and environmental support such as the integration of assistive technology.

In the *International Classification of Functioning*, the community, social, and civic life domain includes community life, recreation and leisure, religion and spirituality, human rights, and political life and citizenship. This domain has an aspect that is a primary focus of pediatric occupational therapy—recreation and leisure—which includes play, sports, arts and culture, crafts, hobbies, and socializing. The emphasis of the remaining occupation-based life areas section of this chapter is on self-care as a whole domain and on the recreation and leisure section of the community, social, and civic life domain.

Self-Care

The self-care domain includes washing oneself, caring for body parts, toileting, dressing, eating, drinking, and looking after one's health (Figure 3.1). Depending on the individual situation of the children, the therapist may intervene with the child, the care provider, or both to address aspects of the self-care domain. The ability to perform self-care activities independently is crucial to an individual's dignity and the preparation for transitions in roles and routines. Therefore, this is a primary area of concern for the pediatric occupational therapist and should not be overlooked in intervention.

FIGURE 3.1 Child learning to self-feed.

(Courtesy of Meggie Boyd McKeever.)

Although it may be difficult for therapists to work with some self-care domain activities, it is critical that they do so because this may enable the child to become as independent as possible and to develop a positive sense of self. Although some frames of reference in this text do not address the self-care domain directly, such as sensory integration (Chapter 6) and

neurodevelopmental treatment (Chapter 8), it is understood that they are laying the foundation that allows the child to become independent in self-care. Other frames of reference, such as motor skill acquisition (Chapter 12) and the Four Quadrant model (Chapter 11), lend themselves to address self-care more directly.

Play, Recreation, and Leisure

The community, social, and civic life domain includes sections dealing with community life, recreation and leisure, religion and spirituality, human rights, and political life and citizenship. The recreation and leisure section encompasses play (ranging from spontaneous, informal play as seen with younger children to rule-based games such as cards or video games, more frequently seen in older children), sports (e.g., soccer or bowling), arts and culture (e.g., reading for enjoyment, playing musical instruments, or going to the movie theater, art museum, art gallery), crafts (e.g., painting, sewing, scrapbooking), hobbies (e.g., collecting action figures, bugs, shells), and socializing (e.g., informal or casual gatherings, structured play dates, accessing social networking Web sites).

Play, recreation, and leisure include those inherently gratifying activities in which children choose to engage. When used in therapy, play activities are selected for a child's amusement, enjoyment, or self-expression (Figure 3.2). Intrinsically, play, recreational, and leisure activities should be pleasurable, promoting children's enjoyment or relaxation. Involvement in play, recreation, and leisure activities hopefully should encourage skill development through involvement with objects and interaction with others.