A profession’s official documents reflect the philosophical and practice beliefs of its members. Such documents determine how members of the profession make decisions that influence the viability and evolution of the profession. Typically, documents that originate in the Commission on Practice are reviewed on a 5-year timetable and revised as necessary (American Occupational Therapy Association [AOTA], 2004a). The purpose of this article is to discuss the implications of the American Occupational Therapy Association’s adoption of the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2002b) and the potential effects it has had on the profession. This article discusses the Framework’s strengths and limitations and its implications for practice and education. It is hoped that an analysis of these issues will contribute to the discussion of the revision of the document and prompt an earlier review and modification.

Analysis began with an exploration of the component parts of the Framework. This was followed by an identification and systematic examination of the concepts, assumptions, and statements written in the document. The concepts, assumptions, and declarative statements in the document are foundational to the Framework’s use and influence how occupational therapists organize their thoughts and actions. Our goal was to evaluate the document to raise concerns regarding how the Framework’s use may affect practice and education. Analysis and recommendations for future revisions of the Framework were based on methods of logical reasoning. Sources for our analysis were Mosey (1996), Nickerson (1986), Rosen (2000), Sorensen (1993), and Stroll (2000).

Background

The Framework was developed as a document that could (1) describe the profession’s philosophical assumptions, (2) define the profession’s domain of concern, (3) offer direction for evaluation and intervention, and (4) help external audiences to better understand the profession’s unique contributions to health care. It also was intended to address several concerns regarding the rescinded Uniform Terminology for Occupational Therapy—Third Edition (Uniform Terminology; AOTA, 1994), including (1) too great an emphasis on performance components, (2) limited focus on the use of occupation, (3) difficulties in the categorization of certain terms, and (4) missing terminology from the taxonomy. There was further concern that the vocabulary in Uniform Terminology was unfamiliar to external audiences.

The Framework has swiftly become the singular representation of occupational therapy practice and has become infused into major professional documents by AOTA (2002a, 2004b, 2005). It is becoming more prevalent in occupational therapy education (Accreditation Council for Occupational Therapy Education, 2005) and is used by the National Board for Certification in Occupational Therapy (NBCOT, 2003). However, evidence of the infusion of this document into clinical practice has not been well documented.

Although the Framework was designed to address specific concerns relating to Uniform Terminology, similar concerns appear to be evident in the Framework. These concerns raise questions about the Framework’s role as the sole document directing practice and educational decisions.
Adoption of the Framework’s philosophical assumptions as the only principles guiding practice may limit the development of newly emerging practice areas, scholarship, and educational curricula that do not share the philosophical assumptions of the Framework.

The major strength of the Framework is the central focus it places on occupation. Occupation and a client-centered philosophy are described as fundamental to occupational therapy practice. The importance of occupation to the profession has been increasingly reaffirmed in past years and is acknowledged by the Framework. Further, all terms in the Framework are defined as they relate to occupational function, which is very positive because it brings the profession back to its roots of meaningful occupation. The document also places a strong emphasis on client-centered outcomes—outcomes that are meaningful to and desired by clients. Additionally, the Framework introduces important new terminology to the profession, such as the concept of activity demands.

The document’s categorization of Areas of Occupation, Performance Patterns, Contexts, and Activity Demands is valuable and has enhanced the understanding of the occupational therapy evaluation and intervention process for internal audiences. Structurally, the document attempts to balance all aspects of the profession’s domain so that therapists can better perceive each of the above areas as having equal importance (Boss, 2003). This encourages therapists to view the totality of the profession’s domain rather than focus primarily on one aspect.

Although the Framework has made significant contributions to the profession, certain areas of the document are somewhat underdeveloped. To address these areas it is recommended that the Framework’s evolution incorporate the following suggestions:

1. The document should address the importance of using theoretically based research to develop occupational therapy practice guidelines. It should be recognized that theories developed both within and outside the occupational therapy profession are needed to support the scope of practice within our own domain (Kielhofner, 2004).

2. The Framework advocates a top-down approach to evaluation and intervention in which the occupational profile is used first to evaluate the client’s role impairment. Greater appreciation for other evaluation and intervention approaches, however, should be made in the document. Such acknowledgment would reflect the reality of clinical care in which therapists must select evaluation and intervention methods based on medical necessity, the client’s goals for health, and the demands of the practice setting. There also should be recognition that the use of standardized evaluations would enhance evidence-based practice.

3. The Framework attempts to use terminology to describe occupational therapy processes that would be easily understood by external audiences. The decision to use ICF (International Classification of Functioning, Disability, and Health; World Health Organization [WHO], 2001) terminology to enhance the profession’s communication with other health care areas is very positive (Hemmingsson & Jonsson, 2005). The selection of the terms Performance Skills and Client Factors and their subterms, however, do not adequately reflect the profession’s domain and the array of clinical problems that occupational therapists must identify and treat. Whereas the decision to use terminology that is shared by other health professionals is highly beneficial, it is suggested that a more precise classification system be used to describe the specific skill components underlying occupational performance.

4. It is also suggested that the Framework acknowledge the need to incorporate clinical language used by fellow health care professionals, community care systems, and third-party payers. The use of such language is critical for therapists to continue to receive reimbursement for service from private insurers and from state and federal systems.

Use of Theory in Occupational Therapy Practice

Many occupational therapy scholars have emphasized the importance of using theory-based interventions (Christiansen, Baum, & Bass-Haugen, 2005; Kielhofner, 2004; Kramer, Hinojosa, & Royeen, 2003; Mosey, 1996). Theory-based interventions are grounded in clinical concepts that are supported by research. Theories that are accepted by the scientific community guide occupational therapists in the development of evaluation and intervention methods. The Framework suggests that only occupational therapy theories should be used to develop practice guidelines. This suggestion is most evident in the statement that “Problems and concerns that are addressed in evaluation and intervention… are based on occupational therapy theories…” (p. 613).

Although this suggestion is likely meant to acknowledge the validity of occupational therapy theories, it also should be recognized that the development of our practice guidelines (i.e., frames of reference, models, conceptual models of practice, conceptual systems of practice) is dependent on a wide array of theoretical information, including both theories regarding the meaning of occupation in human life and theories regarding the function of the human mind and body. Theoretical information allows therapists to both understand the biological underpinnings of health and disease and use occupation to enhance health and well-being. Occupational therapy theories help practitioners to make the link between theory and practice. The use of theories describing the meaning of occupation across the human lifespan has expanded the knowledge base of occupational therapy.

The sole reliance on such theories to guide intervention, however, tends to limit the scope of practice. Although theories describing the meaning of occupation provide a greater understanding of the relationship between activity participation and health, they cannot, by themselves, offer direction to treat many of the most prevalent conditions clinicians address in practice—such as the neurologic sequelae of stroke, head injury, and spinal cord injury. It should be noted that official documents representing the profession’s domain, process, and philosophical assumptions should encourage a balanced and harmonious integration of our medical expertise and our understanding of how occupation affects human health. The two are not at odds but rather complement each other.
Validity of Multiple Approaches for Evaluation and Intervention

Although a stated purpose of the Framework is to provide direction for occupational therapy evaluation and intervention, the document’s discussion of the evaluation process is limited to the occupational profile and an analysis of occupational performance (Kramer & Hinojosa, 2005). The Framework states that “The evaluation process is divided into two substeps, the first of which is the occupational profile. . . . The second substep of the evaluation process is an analysis of occupational performance” (p. 616). What appears to be missing, however, is recognition of the importance of standardized assessments and their ability to enable therapists to effectively measure intervention outcomes—a key element for evidence-based practice. Standardized assessments are based on established procedures and commonly have high levels of reliability and validity. When occupational therapists use standardized assessments in accordance with established procedures, therapists can be assured that the information they obtain is reliable and valid. Obtaining reliable and valid information about clients provides a high level of support that can justify the need for occupational therapy services. Standardized assessments also provide accurate baseline and outcome measurements that can be used to document client progress over the course of intervention. Client progress that is documented using a standardized assessment has greater reliability and validity than outcome measures obtained from nonstandardized instruments. The ability to document that occupational therapy services are needed and effective is essential if occupational therapy is to remain a valued and competitive health care service.

As stated earlier, the Framework advocates a top-down approach to evaluation in which therapists are directed to use the occupational profile as a first step in the evaluation process. Although the top-down approach is a valid method, it is only one of three primary approaches commonly recognized and practiced by occupational therapists. Historically, three primary evaluation approaches have been identified: top-down, bottom-up, and environment-first (Baum & Christiansen, 2005; Ideishi, 2003; Trombly, 1995). Many therapists practice within specialty areas requiring bottom-up approaches in which the impaired underlying skill components that prevent role acquisition are evaluated and addressed first. The bottom-up approach acknowledges that, although occupational role dysfunction can be identified first, treatment of impaired roles is dependent on identifying the underlying skill components that comprise the activities of that role. As therapists, we may identify role dysfunction during evaluation, but we directly treat the impaired underlying components that prevent the client from engaging in the activities of a specific role.

In certain practice areas a bottom-up approach is mandated by the medical necessity of acute illness. Areas of occupational therapy practice in which a bottom-up approach is necessitated by the client’s dysfunction, illness, or injury include burn therapy, hand therapy, and acute neurologic and orthopedic rehabilitation. In these practice areas, failure to first address the client’s medical condition can cause serious harm to the client.

Many therapists practice in clinical areas that first require an evaluation of the environment. For example, therapists who assess private homes or institutions (e.g., nursing homes) for safety do not use the occupational profile as the first step in evaluation, nor do therapists who assess classroom environments to modify sensory stimulation for children with attentional disorders and learning disabilities. Similarly, therapists who provide their expertise to ensure the safety of building designs for elderly residents, and therapists who use technology to enhance the environment for people with severe physical disabilities, cannot use the occupational profile as a first step in evaluation. Although the Framework acknowledges that “more occupational therapists and occupational therapy assistants are beginning to serve clients at the group and population level” (p. 615), it does not truly support the newly emerging practice areas of environmental assessment at the group and population levels by only advancing a top-down approach.

The pragmatic needs of treatment settings, including shortened lengths of stay, capped reimbursement, and a demand for service that exceeds the supply of occupational therapists, influence the selection of evaluation approaches. Because of the above expectations, therapists truly cannot perform top-down, bottom-up, or environmental approaches in isolation. Rather, the present clinical environment requires therapists to integrate all three approaches. Similar to Fleming’s (1991) concept of the therapist with a three-track mind, clinicians must concurrently juggle information about (1) the client’s acute medical problems and safety risks requiring immediate attention, (2) the specific underlying skill components that limit occupational performance, and (3) the functional roles that the client must assume upon discharge. Whether therapists use top-down, bottom-up, or environment-first approaches should be determined by the therapists’ judgment, the demands of specific practice areas, and the unique needs of clients. The Framework’s statement that the occupational profile be used as the first step in the evaluation process should be revised because it does not recognize that many occupational therapy practice areas require therapists to initially address performance skills or environmental conditions.

It should be remembered that all approaches—top-down, bottom-up, and environment-first—only suggest an emphasis with regard to the sequence of evaluation methods. At some point in all approaches, consideration of the client’s occupational roles must be addressed. However, whether occupational role dysfunction is addressed before or after an evaluation of the client’s acute medical needs should be determined by a practitioner’s clinical judgment and responsibility to prevent further harm. The argument that practitioners do not function as occupational therapists when they fail to use the occupational profile first in the evaluation process does not acknowledge (1) that above all else therapists are obligated to prevent further medical harm and (2) that once clients are medically stable, an evaluation of occupational role dysfunction can then be made more easily. When therapists use clinical reasoning to select an evaluation sequence other than a top-down approach, it does not follow that occupational role dysfunction will be neglected.
In future revisions of the Framework, it is recommended that the three primary evaluation approaches be acknowledged equally for the contributions each offers to the profession’s viability in an increasingly competitive health care environment. Consideration also should be given to the pragmatic needs of the varied practice settings in which therapists work. Recognition that practice areas require different evaluation and intervention methods—that best fit the needs of clients receiving services—is required for the profession to provide services that will be valued by society. Occupational therapy is based on an expansive set of philosophical assumptions. It is from these philosophical assumptions that scholars and master clinicians have been able to develop multiple, yet diverse, clinical approaches that encompass top-down, bottom-up, and environment-first approaches (Weinstock-Zlotnick & Hinojosa, 2004).

Recategorization of Terms to Adequately Reflect the Profession’s Domain

One of the Framework’s major contributions has been its emphasis on occupation-based terminology. This emphasis has helped the profession return to its roots as a health care service capable of restoring daily life function through participation in meaningful occupation. The Framework expanded on and clearly defined the Areas of Occupation that therapists address with clients. This contribution enhanced the definition of occupational therapy for external audiences and promoted the profession’s value.

One area lacking in the document, however, is the precise terminology describing the functional skill components necessary for occupational performance. In the Uniform Terminology documents (AOTA, 1979, 1989, 1994), these terms were referred to as performance components and were categorized by the five primary headings of sensory, perceptual, neuromusculoskeletal, cognitive, and psychosocial functions. These terms reflected the actual underlying components that therapists evaluate and treat in order to enhance function in specific occupations desired by clients. The classification of performance components into the above five primary headings is not a classification system unique to occupational therapy. Rather, the use of these five categories is recognized and used in client care by many health care professions, including medicine (particularly within the specialty of neurology), psychiatry, psychology, and nursing (American Psychiatric Association, 2000; Beers & Berkow, 1999; Venes, Thomas, & Taber, 2001; Weiner & Goetz, 2004).

The Framework divided performance components into two categories, Performance Skills and Client Factors, in an effort to use terminology that was more familiar to external audiences. The distinction between Performance Skills and Client Factors, as defined by the Framework, is somewhat ambiguous. The Framework defines Client Factors as “what one has” (p. 621) and “factors that reside within the client” (p. 624). The distinction between Performance Skills and Client Factors is based on work by Fisher and Kielhofner (1995) in which these scholars hold that skills are observable behaviors that emerge from a person’s interaction with the environment. In contrast, capacities are innate abilities that exist within the person but cannot be readily observed.

The Framework used the distinction between observable skills and innate capacities to define Performance Skills (i.e., observable skills) and Client Factors (i.e., innate capacities). One difficulty that emerges from the Framework’s distinction between Performance Skills and Client Factors, however, is its lack of congruency with the way that therapists practice. Occupational therapists observe a client’s performance to gain an understanding of the skills that clients currently possess and could possibly recover during rehabilitation. Therapists are trained to document observable behaviors in measurable terms. The Framework’s distinction between Performance Skills and Client Factors is theoretical rather than utilitarian. In clinical practice, all innate capacities must be operationalyzed on a function/dysfunction continuum so that they can be observed and measured. Innate capacities that are not operationalyzed into observable and measurable skills have little clinical utility, because they cannot be evaluated or used to document progress. As such, the distinction between innate capacities and observable skills should not serve as the primary characteristic around which to organize the taxonomy of clinical terminology. All physical, cognitive, and psychosocial functions are innate capacities until the client uses such functions to respond to environmental demands. Client Factors and Performance Skills should not be separated into two headings; rather, all functions should be categorized under one heading (e.g., Performance Components). The immediate subordinate category should identify the type of performance component—that is, sensory, perceptual, neuromusculoskeletal, cognitive, and psychosocial. The subterms within each of the above headings could then be (1) defined as innate capacities as well as (2) operationalized as observable and measurable skills. Reorganizing the Framework’s taxonomy in this way would provide greater clarity of terms and promote an understanding of how innate capacities can be transformed into observable and measurable skills.

Because the document is currently organized into Performance Skills and Client Factors, concern arises regarding the degree of specificity of terms within each category. The subterms within certain categories (of both Performance Skills and Client Factors) do not comprehensively represent the content area they intend to. In other instances, considerable overlap appears across Performance Skills and Client Factors. For example, in Table 2 of Performance Skills (p. 621), the subterm Motor Skills is represented by the terms posture (aligns), mobility, coordination, strength and effort, and energy. In Table 6 of Client Factors (p. 625), Neuromusculoskeletal and Movement-Related Functions are represented by mobility of joint and bone functions, passive range of motion, postural alignment, strength, muscle tone, endurance, reflexes, righting and supporting reactions, eye-hand-foot coordination, bilateral integration, motor perseveration, and gait. Mobility, alignment, strength, and coordination appear to be overlapping concepts, whereas terms such as motor planning are absent.

Both cognitive and psychosocial abilities are subcategorized under Mental Functions within the higher level category
of Client Factors (pp. 624–625). However, there is no distinction between abilities that are cognitive and those that are psychosocial. Instead, specific cognitive and psychosocial functions are defined and listed together without a clear categorization system. This lack of categorization is problematic, as occupational therapists must understand the distinction between each type of function to both evaluate and treat them. Therapists also must understand the distinction between these underlying skill components to communicate with other health care professionals who clearly differentiate these skills in their diagnostic classification systems. Moreover, the array of specific cognitive and psychosocial functions that therapists address in practice is not apparent in the Framework’s taxonomy. The absence of precise terminology addressing psychosocial skills becomes doubly important in light of the profession’s continued decline in the practice area of mental health (Brown, 2002; Mosey, 2004).

Terminology representing receptive communication is not present in either Performance Skills or Client Factors. Receptive communication functions—such as (a) the interpretation of another’s words, tonal inflections, facial expressions, and body language, and (b) the comprehension of written words and symbols—are essential functions to evaluate in clients with aphasia, cognitive impairment, auditory impairment, and clients with mental health concerns.

Client Factors are broken down into Body Functions and Body Structures—terms taken directly from the ICE. On pages 625–626, the Framework states that Body Functions include (1) mental functions; (2) sensory functions and pain; (3) neuromusculoskeletal and movement-related functions; (4) cardiovascular, hematological, immunological, and respiratory functions; (5) voice and speech functions; (6) digestive, metabolic, and endocrine functions; (7) genitourinary and reproductive functions; and (8) skin and related structure functions. Body Structures are described as structures of the above Body Functions. As therapists, we must have knowledge of Body Functions and Structures in relation to disease processes; however, we do not directly treat most of them in practice. It is not within our domain of concern to address hematological, immunological, respiratory, voice and speech, digestive, metabolic, endocrine, genitourinary, or reproductive functions. These functions are addressed by other health care professionals who hold expertise in the diagnosis and treatment of disorders of these body systems. As such, these terms do not belong in the classification system describing occupational therapy’s domain.

It is suggested that the terminology within the categories of Performance Skills and Client Factors be recombined within one heading (e.g., Performance Components) in future revisions of the Framework. The immediate subordinate categories should represent each type of performance component—sensory, perceptual, neuromusculoskeletal, cognitive, and psychosocial. All subterms within each category could be defined as both (a) an innate capacity and (b) operationalized as an observable and measurable skill. Each clinical term should have one mutually exclusive label—in other words, different concepts should not share the same label or be categorized within more than one heading.

The language that we use as therapists is critical for multiple reasons. Our language allows us to (a) communicate with each other and with other health care professionals regarding client care, (b) articulate the value of our services to clients, and (c) define our scope of practice for reimbursement purposes. At present, many therapists practice in areas that require the use of specific terms that describe occupational therapy services for reimbursement purposes, such as the Common Procedure Coding System of the Centers for Medicare & Medicaid Services (CMS) (including Current Procedural Terminology or CPT codes) (Gennnerman, 2005). The CMS terms reflect the underlying components that prevent function in daily activities and thus more closely match the performance components of Uniform Terminology. It is recommended that revision of the Framework include terminology required by third-party payers.

**Relationship to Education**

Because the Framework’s philosophical assumptions and terminology are being used in all AOTA official documents (AOTA, 2004b) and most current occupational therapy textbooks (Christiansen & Matuska, 2004; Katz, 2005; Watson & Wilson, 2003), distinct implications for occupational therapy education exist. Revision of the Framework should consider the impact that the document’s taxonomy has on education. Of specific concern is the Framework’s lack of clarity of clinical terms—specifically the array of terms that are needed to help students understand the underlying skill components of clinical dysfunction. Students who cannot readily comprehend the relationship between Performance Skills, Client Factors, and occupational role performance will have difficulty addressing the specific deficit areas needed to restore function in daily occupations. Whereas the Framework facilitates a clear understanding of how to identify occupational role dysfunction, it does not provide adequate direction for students to restore role performance by addressing the specific skills needed for those roles.

Occupational therapy curricula are influenced by association documents because they often play a role in determining the emphasis of material in educational programs. The Framework omits the critical concept of activity analysis and synthesis—an omission that poses great concern. Activities are the building blocks of occupational roles (Hinojosa, Kramer, Royeen, & Luebben, 2003). Without the ability to analyze clients’ performance in activities, therapists cannot assist clients in the development of meaningful occupational roles.

At the core of activity analysis is the breakdown of activity into its component parts (Buckley & Poole, 2004). During the process of activity analysis, therapists learn about client abilities and deficits as they perform a task. This knowledge helps therapists understand how the client’s underlying capacities and skill deficits affect specific activities. Although students may readily identify that a client cannot perform a particular functional activity, students need to develop the skill of activity analysis and synthesis to identify precisely why the client has difficulty performing that activity—in other words, students need to identify whether impairment occurs within the activity’s context, the client’s skills, or the...
activity’s demands (Kramer & Hinojosa, 2004). It is only through an understanding of these concepts that students can then perceive how to modify the activity or the environment to better enhance the client’s occupational performance. Including an activity analysis and synthesis section in the Framework would build on the important concept of activity demand that has been introduced in the document.

A second concern relates to the mission of educating students about all three primary methods of evaluation approaches—top-down, bottom-up, and environment-first. Although the Framework supports a top-down approach, our goal as educators is to produce therapists who can select evaluation methods that best meet the demands of both the client’s dysfunction and the treatment setting (Bass-Haugen, 2005). A professional document that describes the philosophy and processes of occupational therapy should emphasize that all approaches have merit and are beneficial in specific practice areas and that each makes a unique contribution to the profession’s continued viability. If we do not prepare the future generation of therapists to practice within the realities of the health care environment, we are ensuring the continued loss of our professional domain. Teaching the full array of clinical approaches better ensures that we produce clinicians who can generate new ideas and solve problems in accordance with the demands of the health care environment as it changes over time.

Future Directions

The language that we use as therapists is of great importance. Although the language of the Framework helps to clarify the mission of occupational therapy, it lacks usable and clinically relevant, everyday language for the occupational therapist. Without the practical usefulness that clinicians desire, the Framework will remain as a document used only in academia and scholarly work. If we do not have the words to communicate with each other, with other health care professionals, and with our clients, we cannot describe either the intended outcome of our services or the processes by which we deliver those services. If we do not have language that adequately describes our domain and enhances our ability to justify our services, we run the risk of losing occupational therapy practice areas to other health care professions (Mosey, 2004).

The evolution of the Uniform Terminology and Framework documents reflects the ability of the profession to grow when health care changes have demanded novel thinking, creative problem solving, and a vision of the future. One characteristic that has always benefited the profession has been our willingness to tolerate differing perspectives. Such willingness to accept the variety of contributions made by scholars with diverging views has strengthened the profession because it has enabled the profession to develop a unique body of knowledge and to flexibly meet the demands of a changing health care culture. The profession has grown from this willingness to accept diversity in scholarly thinking and clinical innovation. When such freedom in thinking is limited by the advancement of one perspective above all others, the type of creative and innovative problem solving that is needed to facilitate the profession’s continued evolution becomes restricted.

Thus, it is recommended that the Framework’s evolution incorporate the following suggestions:

1. The document should acknowledge the importance of using theory supported by research to develop occupational therapy practice guidelines. It should be recognized that theories developed both within and outside the occupational therapy profession are needed to support the scope of practice within our domain. It should be further acknowledged that the development of our practice guidelines are dependent on both (a) theories regarding the meaning of occupation in human life and (b) theories regarding the function of the human body and mind. Both sets of theories are essential to allow therapists to address the array of clinical conditions currently seen in practice. Further, the ability to prevent competing health care professions from misappropriating our domain depends on our use of treatment based on both medical theories and knowledge about the meaning of occupation.

2. The document should acknowledge the validity of multiple approaches to evaluation and treatment and recognize each approach’s unique ability to meet the requirements of the practice area in which it is primarily used. The three primary approaches—top-down, bottom-up, and environment-first—should be equally acknowledged in the Framework for the contributions each offers to the profession’s viability in an increasingly competitive health care environment. The Framework’s statement that the occupational profile be used as the first step in the evaluation process should be revised because it does not recognize that many occupational therapy practice areas must initially address performance components to prevent further harm to the client. The use of standardized assessments in the evaluation process should be emphasized to enhance evidence-based practice.

3. The Framework’s categorization of Areas of Occupation, Performance Patterns, Contexts, and Activity Demands is extremely sound and has significantly enhanced an understanding of occupational therapy processes for both internal and external audiences. The recategorization of performance components into Performance Skills and Client Factors, however, does not adequately reflect the profession’s domain and the array of clinical problems that therapists must identify and treat. It is suggested that the Framework use one superordinate heading (e.g., Performance Components) along with the subordinate headings of sensory, perceptual, neuromusculoskeletal, cognitive, and psychosocial functions because these are categories that are recognized by a majority of health care professions and comprehensively address the abilities needed for occupational performance. Each subterm within each heading should be defined as (1) an innate capacity and (2) operationalized so that it can be observed and measured along a function/dysfunction continuum. A more exhaustive list of psychosocial skills should be added to the document because such terms have never been adequately addressed by either the Uniform Terminology documents or the Framework.

4. It is also suggested that the Framework acknowledge the need to incorporate clinical language used by fellow health care professionals and third-party payers. Terminology, such as that accepted

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by CMS, should be added to the Framework’s Performance Skills so that both therapists and students can become familiar with the language that is critical to the profession’s survival in the current aggressively competitive health care culture.

In summary, the Framework’s strength has been its ability to refocus the profession’s attention on occupation and client-centered approaches. The Framework has also successfully addressed areas of clinical consideration that have historically been absent from the Uniform Terminology documents. For example, Performance Patterns and Contexts addresses essential concepts needed to understand how impairment affects one’s roles and habits in the context of multiple environments. Activity Demands aid therapists in their ability to assess the requirements of specific tasks in order to adapt those tasks to a client’s present functional level. All documents of a profession evolve in accordance with the changing needs and beliefs of its members. The present discussion of the Framework’s strengths and limitations is intended to contribute to the exchange of ideas leading to revisions of the document.

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