Therapeutic Occupation: A Definition

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This article builds on prior work and defines terms basic to the profession of occupational therapy. The prior work defined occupation as the relationship between occupational form and occupational performance and defined related terms, such as meaning, purpose, developmental structure, impact, and adaptation. This article shows how these terms relate to therapeutic occupation, a special type of occupation. Therapeutic occupation through occupational synthesis is the core of occupational therapy. Occupational synthesis is the design of the occupational form by the occupational therapist in collaboration with the recipient of services to advance therapeutic evaluation or achieve a therapeutic goal. Therapeutic occupation, then, is meaningful, purposeful occupational performance leading to assessment, adaptation, and compensation, all in the context of occupational synthesis. Finally, the idea of therapeutic occupation through occupational synthesis is related to frames of reference and models of practice in occupational therapy today.

In 1917, the profession of occupational therapy was founded for the following purposes: “the advancement of occupation as a therapeutic measure,” “the study of the effect of occupation on the human being,” and “the scientific dissemination of this knowledge” (National Society for the Promotion of Occupational Therapy, 1917, p. 1). The purpose of this article is to define occupation as a therapeutic measure, or therapeutic occupation.

Useful definitions are essential to knowledge development in a profession. Therefore, as Christiansen (1990) pointed out, it is surprising that there have been so few attempts to define some of the most common and basic terms used in the occupational therapy profession. What precisely is occupation, and what are its components? What precisely is therapeutic occupation (occupation used as therapy), and what are its components?

Several years ago, I defined occupation as the relationship between occupational form and occupational performance (Nelson, 1988). While discussing the relationship between occupational form and occupational performance, I also defined the following terms: meaning, purpose, developmental structure, impact, and adaptation. Since that time, scholars of occupational therapy have cited these definitions as worthy of discussion in the development of the profession’s core knowledge (e.g., Christiansen, 1994; Clark et al., 1991; Kielhofner, 1992, chap. 16). Researchers have also found these definitions useful in conceptualizing empirical issues (e.g., Wu, Trombly, & Lin, 1994; Yoder, Nelson, & Smith, 1989).

Currently, there is a need to relate this basic terminology of occupation to essential components of therapeutic occupation, including the assessment process, the change process experienced by occupational therapy recipients, and the various frames of reference and models of practice used in occupational therapy (Nelson, 1994).

Therapeutic occupation is a special type of occupation. Figure 1 depicts terms used in Nelson (1988). To explain this figure, I will provide definitions of basic terms and will analyze a specific occupation as an example of how these terms relate to each other. Next, I will use the same example to highlight the special features of therapeutic occupation.

The person’s developmental structure: The present nature of the person as a holistic being with sensorimotor, cognitive, and psychosocial characteristics. This definition stresses both the unity and the complexity of the person. At any point in time, the person is the result of a lifelong developmental process that involves physical maturation as well as experience (what is termed occupational adapta-
**Figure 1.** Occupation as meaningful, purposeful occupational performance of a person in the context of an occupational form.

**OCCUPATION**

<table>
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For a hypothetical example, consider the developmental structure of a 21-year-old woman who sustained a closed head injury in a motor vehicle accident 5 years ago. She has just returned to occupational therapy on an outpatient basis after a prolonged period of not receiving services. A full description of her developmental structure from a clinical point of view would take several pages of text. Therefore, for the sake of this example, some of the relevant features of this patient's developmental structure are as follows: (a) age-related expected sensorimotor abilities except for minor impairments in coordination of the left arm and depth perception and moderate impairment in topographical orientation; (b) good verbal intelligence and memory but moderate impairments in spatial intelligence, processing strategies, and metacognition (she was aware of her residual sensorimotor deficits but denied her impulsivity in complex situations); and (c) psychosocial features, including high values for autonomy and equality with others, a sustained interest in driving again, and a tendency to be anxious about possible failure. In sum, these are personal characteristics she brings to the occupational form.

**Occupational form:** The composition of objective physical and sociocultural circumstances external to the person that influences his or her occupational performance. Physical circumstances include shape, size, distance, mass, texture, lighting, timing, color, odor, sound, and all the other occupationally relevant features that are material in nature. The sociocultural dimension includes symbols, norms, roles, typical uses, labels, language rules, and other social conventions.

In the example, selected relevant features of the patient's occupational form include a mid-sized, automatic transmission sedan owned by the rehabilitation facility, a street map, city streets with moderate midday traffic, intense sunshine with considerable glare on the windshield, the physical presence of the therapist in the front passenger seat, and the therapist's words. At the start of the session, the therapist suggested a focus on self-awareness in problem situations and ways to get around town safely. Over the course of the session, the therapist provided reflecting and information-giving (nonprobing and nonevaluating) feedback to the patient. Sociocultural aspects of the occupational form include the state's driving laws, the culture's fascination with and dependence on the automobile, and society's definitions of roles for patient and therapist.

In addition to the ongoing analysis of the entire driving occupation, this article will focus on a specific suboccupation to further clarify the definitions as they are given. The suboccupation involves a right-hand turn in a stressful situation.

**Focus on a suboccupation.** Fifteen minutes into the occupation, the patient's car is stationary for 40 seconds at a stop sign marking a major road. The route called for a right turn, but steady traffic moved by at approximately 50 miles per hour. The driver in the car behind her throws up his hands in apparent frustration.

**Meaning:** The person's entire interpretive process when encountering an occupational form, including perceptual, symbolic, and affective experience. As depicted in Figure 1, meaning depends on both the occupational form and the person's developmental structure. Meaning is the sense that the person makes of a situation. Meaning is an active construction, not a passive response to stimuli, as in a reflex. In the example, the patient generally perceived and interpreted the occupational form, as would be expected by a healthy, enculturated adult. She heard the therapist's words, and she interpreted them according to the rules of the English language. With few exceptions, her visual and somatosensory perceptions were also accurate. The car had a different feel from the family car, and she was aware of the extra tension in the steering wheel and the spongy quality of the brakes. Her affective meanings were characterized by calmer feelings than in recent driving occupations, and she felt comfortable with the therapist. Generally, she enjoyed herself except for the incident in the focused suboccupation.

**Focus on a suboccupation.** The traffic on the major road confused the...
patient. She misperceived the speed of oncoming cars, and the glare of the sun on the windshield compounded the problem. The apparent frustration of the man in the car behind her made her feel anxious. When it finally appeared that there was a break in the traffic flow, she overestimated the force necessary to depress the accelerator and underestimated the interval between accelerating and turning.

**Purpose:** The experience of wanting an outcome from an anticipated occupational performance. After a person finds meaning in a situation, he or she experiences purpose, or the desire to do something about the situation. In the example, the patient experienced long-term as well as short-term purposes. She wanted to relearn how to drive, she wanted to commute to college, and she wanted to show her family that she was ready for more independence. Other purposes included a desire to show driving competence to the therapist, to learn new ways around town, to express herself in conversation, and to show the therapist that she had developed enhanced self-awareness and problem-solving ability. Lower level purposes included all the momentary intentions guiding her movements. For example, she had the purpose of wanting to move the steering wheel every time she did so.

*Focus on a suboccupation.* Initially at the intersection, the patient simply wanted to make a right turn and be on her way. However, the longer she waited at the stop sign, the more she felt torn between wanting to be safe and wanting to escape the discomfort. When she almost lost control of the car, she had a powerful desire to right its course. Then she consciously wanted to learn from her mistake.

**Occupational performance:** The person's voluntary doing in the context of the occupational form. From its Latin derivation, performance literally means to go through a form. There is a close, reciprocal relationship between occupational form and occupational performance. However, they are logically distinct. For example, a car accelerator (part of the occupational form) requires a certain degree of force for a certain velocity, and the person's occupational performance provides that kinetic force. In the example, the patient's occupational performance included perusal of the map before entering traffic, posture in the seat, bilateral manipulations of the steering wheel, movement of the right foot back and forth between the brake and the accelerator, finely graded pressure of the feet on these instruments, and speech. She talked about her boyfriend and continuously evaluated her driving performance.

*Focus on a suboccupation.* At the busy intersection, the patient's occupational performance was marked by 40 seconds of repeated trunk and neck rotation with alternating glances at the rear-view mirror. Suddenly, she made an uncommonly quick move of the right foot from the brake to the accelerator and then plantar flexed her foot with power. Next, she forcefully rotated the steering wheel to the right. Immediately after, she frowned and declared forcefully, "I've got to take my time and concentrate on the right thing." A few moments later in a calmer voice, she stated, "That guy behind us has his own problems... I had enough to concentrate on." She said further, "You know, I used to avoid situations like this and go only where there are stop lights. That's been the story of my life—avoiding things."

**Impact:** The effect of occupational performance on the subsequent occupational form. Impact can be divided into two categories: end impact and step-by-step impact occurring within the occupation. In the example, the end impact of the patient's occupational performance was the return of the car and its occupants in good order to the rehabilitation center parking lot, with a minor expenditure of gasoline. No one was hurt, and there was no damage to property.

Step-by-step impact included all the displacements of the accelerator, the brake, and the steering wheel; the resulting effects within the machinery of the car; and the movement of the car moment by moment through the streets. Each event changed the occupational form, providing new opportunities for occupational performance.

*Focus on a suboccupation.* The patient's foot push (an occupational performance) affected the mechanics of the car in such a way that the car lurched onto the far lane of traffic (an impact on the occupational form) before she could turn (another occupational performance) the steering wheel to align the car properly on the road (another impact).

### Therapeutic Occupation

Thus far, this article has used terms defined in Nelson (1988). Now we can see how these previously defined terms relate to therapeutic occupation, a special type of occupation (see Figure 2).

**Occupational synthesis:** The design of the occupational form by the occupational therapist in collaboration with the recipient of services to advance therapeutic assessment or achieve a therapeutic goal. Occupational synthesis is an essential act of the occupational therapist. The term synthesis is used because many factors must be considered when designing an occupational form. The goal is to provide a just-right challenge to the person's developmental structure.

2 In the literature, the term goal sometimes refers to the identified therapeutic outcome, but sometimes it refers to the subjective motive of the person (what is called purpose in this article). For example, Crunchfield and Barnes (1993) used the term goal in both ways on successive pages (i.e., pp. 469 & 470). Sometimes there is a good match between the therapeutic goal and the person's purpose, but sometimes there is not (e.g., persons capable only of limited perspectives, persons with conflicting purposes). The position taken here is that it is best to have separate labels for different phenomena. Hence, purpose refers only to the subjective desire of the person, and goal refers only to therapeutic outcome.
Occupational synthesis depends on the therapist’s knowledge of occupational forms and understanding of the person’s developmental structure. In addition, the person’s own occupational performance has a collaborative impact on the synthesis (see Figure 2). The person’s statement of wishes in a prior occupation is an occupational performance that contributes to the occupational synthesis. The therapist’s perception of the person’s nonverbal occupational performance also contributes to the occupational synthesis. In the example, the therapist and patient decided together that the patient was ready to resume driving. The therapist arranged for the car and urged the patient to bring a map. An important part of the occupational synthesis was that the therapist consciously decided to state the goal of the session at the beginning. From then on, the therapist’s plan was to take on a reflective and responsive role. The occupational synthesis also took advantage of what the culture had to offer (i.e., city streets, the rules of the road, impatient fellow drivers).

Occupational assessment: The therapist’s drawing of inferences about the person’s developmental structure and occupational configuration through observation of the person’s occupational performances and impacts in the context of synthesized occupational forms. In other words, the therapist learns about the person by observing the person in selected situations (see Figure 3). A hallmark of occupational therapy is that people reveal themselves through their actions. Observation can be direct (the therapist’s own perceptions) or indirect (reports by the person or by others). Standardized assessments provide controlled occupational forms and norms to guide the therapist’s interpretations of the person’s occupational performances and impacts. In the example, the therapist knew before the driving session that the patient’s left-hand dexterity was mildly impaired because of observed performance on the nine-hole peg test. The therapist also gained information about the patient in nonstandardized ways. Indeed, assessment is an ongoing process that continues until discharge. For example, the therapist learned from the patient’s self-report that she feels pressured by her boyfriend to discontinue therapy.

Focus on a suboccupation: The patient’s occupational performance of making an overly wide turn confirmed the therapist’s inference that the patient tended to be impulsive in complex situations. However, she was not so impulsive as to pull out in front of traffic. The therapist also observed that the patient was able to process her mistake verbally and refocus quickly on the problems of driving.

Occupational adaptation as a therapeutic goal: In the context of a synthesized occupational form, the positive effect of a person’s purpose and occupational performance on his or her developmental structure. In other words, the therapist helps the person set up a situation in which performance will lead to self-change. Adaptation can be the restoration of a previously lost ability or the development of a totally new ability (adaptation) and related terms adapt, adapted, and adaptive are used in a variety of ways in the occupational therapy literature. For example, Neistadt (1988) used the term adaptive as a synonym for what this article calls compensatory and used the term remedial for what this article terms adaptive. On the other hand, Gilfoyle, Grady, and Moore (1990) and Christiansen (1990) have used the term adaptation in the same way as it is used in this article. Other important figures who have used the term adaptation to describe change in the person through doing are Piaget and Inhelder (1969), who described cognitive development, and Meyer (1922), who called for a profession based on the idea of adaptation through occupation. Mosey (1986, p. 23) prescribed a third option: The term adaptation may refer either to a change in the person (as in this article) or to a change in the environment (what this article terms impact). Schkade and Schultz (1992) theorized that occupational adaptation can be a process (similar in meaning to the definition here) or a state of competency (part of the developmental structure in the language of this article). This article’s recommendation is to avoid ambiguity and its resulting confusion by having a single label for a single phenomenon. It is proposed that the term adaptation and related terms refer only to self-change by the person’s active doing. Therefore, the terms assistive device and modified environment are preferred over the terms adaptive device and adapted environment.
In occupational assessment, the occupational therapist collaboratively synthesizes an occupational form and observes the occupational performance and impact. The occupational therapist then makes inferences about the person's developmental structure and occupational configuration. If positive adaptation is to occur, the occupational synthesis must provide just the right challenge to the person's developmental structure (see Figure 4).

In the example, the patient took an important step toward achieving a therapeutic goal and experienced a therapeutic adaptation. She learned about herself by talking openly about her driving mistake instead of denying it, as she frequently did before therapy. She recognized that she had a special need in complex situations to concentrate on relevant factors and to ignore irrelevant factors. This kind of self-awareness is a prerequisite to the ability to monitor one's performance. A person can develop new processing strategies only when aware of a need for such strategies. Hence, metacognition was the focus of the therapist's occupational synthesis in this particular example.

Occupational compensation as a therapeutic goal: The achievement of a successful impact through a substitute occupational performance in the context of a synthesized occupational form. Therapeutic compensation through occupation involves finding a way around an intractable problem. Usually, the occupational therapist synthesizes an occupational form that is not used by most persons in society (it is atypical) but that has meaning and purpose to them. The person engages in an occupational performance that substitutes for the typical way of doing things. The result is a comparable impact, a level of success similar to the success one would have by doing things in the socioculturally typical way (see Figure 5).

The reacher is a somewhat atypical occupational form in that most persons in our society do not use one. However, it has meaning to this person, and she has a sense of purpose in using it. Her occupational performance of manipulating the reacher is a substitute for bending at the hips, but the impact is comparable: The item has been picked up successfully.

Compensation is different from adaptation, but frequently, an adaptation is necessary before a compensation can take place. For example, the elderly woman must first learn how to use the reacher. This learning, like all learning, is an adaptation. After she has made this adaptation, she is able to compensate successfully in everyday life. Likewise, a person must first learn how to use a wheelchair (an adaptation) before being able to use the wheelchair in getting from one place to another (a compensation).

Health promotion and disease prevention as therapeutic goals: In the context of a synthesized occupational form, the

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**Figure 3.** In occupational assessment, the occupational therapist collaboratively synthesizes an occupational form and observes the occupational performance and impact. The occupational therapist then makes inferences about the person's developmental structure and occupational configuration.

**Figure 4.** To promote therapeutic adaptation, the occupational therapist collaboratively synthesizes an occupational form and makes a prediction about the person's meaning, purpose, occupational performance, and adaptation.

**Figure 5.** To promote therapeutic compensation, the occupational therapist collaboratively synthesizes an occupational form (often somewhat socioculturally atypical) and makes a prediction about the person's meaning and purpose. The resulting occupational performance substitutes for the typical way of doing things but leads to a comparable impact.
advancement of wellness and the deterrence of impairment, disability, and handicap through occupational assessment, occupational adaptation, and occupational compensation. Occupational synthesis is a powerful tool in health promotion and disease prevention. Health promotion and disease prevention can involve occupational assessment, occupational adaptation, and occupational compensation. Through occupational assessment (see Figure 3), a therapist can determine that a person is at risk and can make an appropriate referral. For example, a child engaged in play might exhibit temporary losses of attention and memory accompanied by muscle twitches, suggesting focal seizures that can be treated by a pediatric neurologist. The occupational therapist’s hands-on perspective and knowledge base lead to an appropriate referral. Next, consider an example of occupational adaptation (see Figure 4) in the promotion of health. The synthesis of an occupationally embedded exercise program for sedentary workers can lead to multiple adaptations in the participants’ sensorimotor and psychosocial domains. Here, instead of remedial adaptation, we speak of adaptation that is health promoting and disease preventing. Occupational compensation (see Figure 5) is a third mode of health promotion and disease prevention. For example, a person with osteoarthritis is shown an energy conservation technique in which instead of lifting heavy dishes, he or she pushes them across the counter. In summary, occupational synthesis in health promotion and disease prevention can be conceptualized within the same conceptual framework as other interventions.

Therapeutic occupation: Meaningful, purposeful occupational performance leading to accurate assessment, positive adaptation, and successful compensation, all in the context of a synthesized occupational form. Therapeutic occupation can be visualized as the combination of occupational assessment (Figure 3), occupational adaptation (Figure 4), and occupational compensation (Figure 5). These three basic processes underlie the service of occupational therapy. All depend on occupational synthesis, the essential act of the occupational therapist and the core of the profession. Therapeutic occupation through occupational synthesis is what the profession has to offer to society.

Frames of Reference and Models of Practice
In synthesizing occupational forms, the occupational therapist should be guided by a frame of reference (Mossey, 1970) or model of practice (Kielhofner, 1992). A frame of reference or model of practice provides guidelines for practice, or, in the terminology of this article, a frame of reference or model of practice provides guidelines for occupational synthesis. Many frames of reference and models of practice in occupational therapy currently exist. Some of them are relatively well developed and provide specific, theory-based guidelines that are consistent with research findings; others are in the early stages of formation. All are interpretable with the terminology presented in this article. Indeed, the idea of occupational synthesis can be thought of as the common factor shared by the various frames of reference and models of practice within occupational therapy.

In the example of the young patient with brain injury, the therapist used the multicontext treatment approach to cognitive-perceptual impairment (Toglia, 1991). This approach advocates the use of multiple, naturally occurring occupational forms to promote enhanced processing strategies and metacognition. In the language of this article, the emphasis is on adaptation. As Toglia stated, “Instead of attempting to teach the patient compensatory strategies, it is suggested that treatment directly address the problem of awareness” (p. 510). The emphasis is also on generalization, not just situation-specific learning. In the example, the therapist was interested in the patient’s self-monitoring abilities, particularly with regard to impulsiveness in complex, demanding situations. Driving involves a naturalistic occupational form, as opposed to a contrived or atypical situation. The therapist viewed the driving situation as one of many occupational forms in which the patient had the opportunity to develop enhanced, generalized metacognition.

What if the therapist had used a different frame of reference or model of practice, for example, one that emphasizes compensatory approaches? Such an approach would conceptualize the patient’s lack of processing strategies and metacognition as intractable problems. The goal of therapy would have been for the patient to engage in the highest level of occupational performance she was capable of, but occupational adaptation would not have been expected. Occupational syntheses would have in-

5The concept of frame of reference (Mossey, 1970, 1981, chap. 13, 1986, chap. 20) has been an important link between theory and practice and a useful method for organizing different approaches to occupational therapy. A frame of reference includes statements that describe a theoretical base, function-dysfunction continuums, behaviors indicative of function or dysfunction, and postulates regarding intervention. In contrast, a model of practice according to Kielhofner (1992, chap. 5) includes an interdisciplinary base; theoretical arguments about order, disorder, and therapeutic intervention; technology for application; and research. From the point of view presented in this article, both systems are useful but share the same problem: They are not specific to occupational therapy. Indeed, both organizing systems could be applied to any health profession. There is a need for a system that provides guidelines for practice that are specifically occupational in nature.
volved simplifications of the patient's occupational forms. In other words, we can say that the occupational form would be graded down. For example, the therapist might have urged the patient to drive only on selected routes, seek the assistance of others in safe ways, or use alternative means of transportation. The comparable impact in these compensations would have been success in getting from one place to the other.

The point is not to argue the relative benefits of adaptation strategies as opposed to compensation strategies. The point is to show that all the different frames of reference and models of practice in occupational therapy involve occupational synthesis and therapeutic occupation as defined in this article. Indeed, the terms presented in this article provide a systematic way for contrasting models of practice.

Conclusion

The use of occupational synthesis to encourage therapeutic occupation is the process that best distinguishes the occupational therapy profession from other professions. Whether the occupational therapist is setting up a scooter board ramp for a child with sensorimotor impairment, modifying a mobile arm support for an adult with quadriplegia, using a standarized instrument to evaluate the cognitive level of a person with dementia, designing a home program for a person with stroke, leading a group for persons with depression, or redesigning a workstation to prevent cumulative trauma disorder; occupational synthesis is necessary. Occupational synthesis is the common core of the use of occupation as therapy.6 Theories of the developmental structure will come and go from culture to culture and from time to time as different civilizations change their views on human nature. With these changes will come new models of practice and frames of reference. But there will continue to be a need for a profession that bases itself on the design of occupational forms that encourage meaningful, purposeful occupational performance leading to assessment, adaptation, and compensation. It is hoped that this article advances our understanding of therapeutic occupation through occupational synthesis by providing its definition.

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References


