Occupational Adaptation: Toward a Holistic Approach for Contemporary Practice, Part 2

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This paper introduces a practice model based on the occupational adaptation frame of reference (Schkade & Schultz, 1992). The occupational adaptation practice model emphasizes the creation of a therapeutic climate, the use of occupational activity, and the importance of relative mastery. Practice based on occupational adaptation differs from treatment that focuses on acquisition of functional skills because the practice model directs occupational therapy interventions toward the patient's internal processes and how such processes are facilitated to improve occupational functioning. The occupational adaptation practice model is holistic. The patient's occupational environment (as influenced by physical, social, and cultural properties) are as important as the patient's sensorimotor, cognitive, and psychosocial functioning and the patient's experience of personal limitations and potential is validated. The integration of these concepts drives the treatment process. Through a description of treatment with a variety of patients, this paper presents the model's diversity and illustrates the relationship between the concepts. The occupational adaptation practice model reflects the uniqueness of occupational therapy and integrates the profession's historical practice with contemporary interventions and methods.

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functional skills illustrates this trend. We believe, however, that a focus on the patient’s functional skills may actually limit the contribution of occupational therapy and may deny patients the opportunity to make vital changes in their occupational adaptation process until they are discharged from the treatment setting. At home, former patients often discard techniques and assistive devices that they have received and design more efficient or effective methods for meeting their needs and going about their activities with greater satisfaction. The patient’s resulting occupational adaptation may bear little resemblance to the occupational therapy that was received.

The Occupational Adaptation Practice Model does not disregard the necessity of functional skills. However, in this model, the occupational adaptation process has a more direct link to future occupational functioning than does the acquisition of specific functional skills. Therefore, the model focuses primarily on the patient’s internal process of occupational adaptation. Because the present paper incorporates the assumptions and terminology introduced in Part 1 (Schkade & Schultz, 1992), a review of that paper will be necessary for complete understanding of the perspectives presented in the present paper. Additionally, four concepts that are required to apply the concepts introduced in Part 1 must be defined: occupational activities, occupational readiness, occupations of daily living, and therapeutic climate.

**Occupational activities** are discrete activities that are occupational (i.e., active, meaningful, and process-oriented with a tangible or intangible product) and are incorporated into treatment because they can promote the occupational adaptation process. **Occupational readiness** includes skill-based activities and other such interventions that focus on change in the person systems in preparation for occupational activities (e.g., the use of preparatory techniques, instruction, or assistive devices necessary for the patient to engage in occupational activity). **Occupations of daily living** are the unique patterns of occupations in which the person regularly engages as a result of the interaction between his or her occupational environments and related occupational roles. **Therapeutic climate** is the product of an interdependent exchange wherein the therapist, as the primary facilitator, functions as the agent of the patient’s occupational environment and the patient functions as the agent of his or her unique person systems. The climate defines the role of each party, the goal of therapy, and the expected outcome; both parties are empowered to make their optimal contribution.

### Occupational Adaptation: A Practice Model

The Occupational Adaptation Practice Model is based on the same essential beliefs stated by the founders and leaders of the occupational therapy profession: (a) human beings have an occupational nature and can influence their health through occupation; (b) human development is a continuous process of adaptation; (c) biological, sociological, and psychological factors may interrupt and impair the adaptation process at any point in the life cycle; and (d) appropriate occupation can facilitate the adaptive process (American Occupational Therapy Association [AOTA], 1979; Meyer, 1922; West, 1989). Occupational adaptation practice focuses on identifying and treating impairment or interference in the patient’s occupational adaptation process. The following discussion identifies the conditions and parameters of practice that is based on the occupational adaptation frame of reference discussed in Part 1 (Schkade & Schultz, 1992).

#### Facilitating the Therapeutic Climate

Through exchange of knowledge, experience, ability, analysis of motivation, and shared vision, the therapeutic climate is created. Practice based on this frame of reference (Schkade & Schultz, 1992) requires the therapist to establish a close therapeutic relationship with the patient (Fidler & Fidler, 1965; Peloquin, 1990). The treatment process is an ongoing collaboration with mutual identification of goals between therapist and patient. It depends on an exchange of “needs, visions, and expectations” (Pel­oquin, 1990, p. 13). Such an exchange is made possible through the roles of agency that are assumed by the patient and the occupational therapist. The role of the patient is to function as his or her own agent. The role of the therapist is to function as the agent of the patient’s occupational environment. This approach directs the therapist to base treatment on the patient’s occupational environments and the associated expectations of occupational performance. Treatment guided by mutual agency may free each party to act in a way that empowers both to make optimal contributions to the treatment process.

Aspects of the therapeutic climate will change over time. In the initial stages of therapy, the therapist’s role is greater than the patient’s, but as therapy progresses, the patient’s role becomes greater. Although the therapist is the primary catalyst in this evolutionary process, the concept of agency empowers each party to assume a unique and vital role. As the therapist fulfills the identified role and function, therapeutic use of self may become the most important element in both the process and outcome of therapy.

The overarching goal of therapy is improvement in the patient’s internal occupational adaptation process (Schkade & Schulz, 1992). To meet this goal, the therapy program must be directly related to the patient’s occupations of daily living.

**Assumption.** For maximal effect on occupational adaptation, the activities, tasks, methods, and techniques of intervention must be centered on occupation-
al activity that promotes satisfaction for the patient and society.

Perspective on Motivation

The therapist incorporates all sources of motivation, such as the patient’s desires, potential, limitations, and societal expectations, to facilitate the therapeutic climate. The experience of mastery is accepted as a major component of motivation. In this practice model, mastery is conceptualized as a relative phenomenon rather than an absolute condition; therefore, the term relative mastery is used. Relative mastery is incorporated in occupational adaptation practice as a patient-centered concept because it measures performance from the patient’s orientation. This perspective is based on the belief that each person is endowed with a desire for mastery, that the occupational environment also has a demand for mastery, and that together these internal and external motivational forces provide an interactive press for mastery (Schkade & Schultz, 1992).

Assumptions: (a) Change in the occupational adaptation process occurs as a result of both internal and external sources of motivation that interact to prompt a striving for mastery. (b) Mastery is more than the ability to perform a discrete task; it is a reflection of the patient’s experience as an occupational being. (c) Relative mastery has three major properties: efficiency, effectiveness, and satisfaction to self and others. These properties are operative explanations of the interactive influence of internal and external motivation.

The occupational adaptation practice model is organized around a set of concepts and assumptions that add a unique perspective to the current body of knowledge on the efficacy of occupational therapy. The following statements summarize this perspective. First, the patient’s level of relative mastery is directly related to the degree that the internal occupational adaptation process is activated and affected by therapy. Second, a change in the patient’s occupational adaptation process is more predictive of future occupational functioning than is the patient’s ability to perform discrete functional tasks. Third, the patient’s internal occupational adaptation process is the optimal pathway for occupational therapy to affect occupational functioning. The assumptions of the Occupational Adaptation Practice Model are considered to be universal regardless of age, race, culture, gender, condition, or other classifications.

Occupational Adaptation Practice Guide

The systematic guide for applying the occupational adaptation concepts and assumptions to a variety of settings and populations (see the Appendix) is based on the normative construct of occupational adaptation presented in Part 1 (Schkade & Schultz, 1992). The flow of the practice guide matches our understanding of the occupational adaptation process and how that process may be affected by therapeutic intervention. The format of the guide provides the therapist with a sequence of questions to be asked, rather than an identification of specific treatment methods or techniques. The intent of this format is to free the therapist to address the uniqueness of each patient and each treatment setting. Specific interventions will vary greatly. It is hoped that therapists will find the practice guide useful in the development of population-specific practice models. The occupational adaptation practice guide has three main parts: data gathering and assessment, programming, and evaluation. The following discussion provides further explanation of the practice guide and an example of each part of the guide.

Occupational Adaptation Data Gathering and Assessment

An occupational adaptation assessment is conducted in the following sequence. First, information is collected about the patient’s occupational environments and the respective occupational role expectations (past, present, and future). Next, the effect of the presenting problem (e.g., illness, condition, behavior) on the patient’s person systems (i.e., sensorimotor, cognitive, and psychosocial functioning) is evaluated. Traditional occupational therapy tests and instruments are used as indicated. On the basis of the accumulated information, the patient and the therapist determine the relative match between the patient’s current occupational functioning and the role expectations of the occupational environments. Last, the therapist estimates the patient’s present potential for occupational adaptation and how this potential can be facilitated over the course of occupational therapy intervention. Identifying the sources of dysfunction in the components of the occupational adaptation process and their effect on relative mastery is an underlying theme of occupational adaptation practice. Such identification enables the therapist to clarify the points in the patient’s occupational adaptation process where intervention will be most effective. During the initial phase of therapy, the therapist’s essential task is to transform the patient’s assessment into an occupational adaptation treatment program that reflects the patient as an occupational being. The following example demonstrates responses for patients with similar person systems but different occupational roles.

Two patients complain of pain, edema, and limited range of motion due to traumatic tendon and nerve damage in their dominant hands. For Patient A, the mother of four young children, the greatest concern might be performing the occupations of preparing meals, doing laundry, and bathing her children. Assessment of the person systems reveals sensorimotor deficits in range of motion, strength, sensation, and dexterity; no cognitive impairment; and psychosocial anxiety about ability to carry out her occupational role. The primary treatment focus would become her work...
Occupational Adaptation Programming

The occupational adaptation assessment is used to design an intervention program focused on helping the patient achieve the highest level of internal occupational adaptation. The program is designed to improve the occupational adaptation process to help the patient narrow the gap between present occupational functioning and the role performance required by both the patient and the occupational environments. As the gap narrows, it is expected that the patient's experience of relative mastery will improve. All therapy activities and methods should be consonant with these two effects. On the basis of a thorough review of the occupational adaptation assessment and patient and family collaboration, a primary occupational environment is selected and the expected role performance within that occupational environment is identified as the primary treatment focus.

The resulting treatment program for Patients A and B would vary because the primary treatment focus is different for each. The activities and associated tasks planned by the patient and therapist would give the patient the maximum opportunity to improve her internal occupational adaptation process relative to the primary treatment focus.

Improvement in the patient's occupational adaptation process is accomplished through a therapy program that includes both occupational readiness and occupational activity. It is expected that both aspects of treatment would be indicated for most patients. Examples of occupational readiness are progressive resistive exercise, assertiveness training, social skill development, and passive or active range of motion. Occupational activities allow the patient and the therapist to put into meaningful action the benefit derived from occupational readiness. Both the occupational readiness and the occupational activities used in treatment must be directly related to the primary treatment focus.

For Patient A, the occupational readiness should focus on addressing edema, range of motion, dexterity, and sensory loss relevant to meal preparation or other appropriate role expectations. The therapist may use a variety of occupational readiness techniques such as assistive devices, alternative methods, and a home exercise program. Occupational activities would be progressive. For example, therapy may be initiated with the patient preparing a simple lunch with the therapist and then may progress to a real-life situation in which the children are present and the demand for occupational adaptation is increased. In this more challenging occupational environment, the opportunity for experiencing relative mastery is enhanced, and motivation is therefore increased.

For Patient B, occupational readiness would also focus on addressing edema, range of motion, dexterity, and sensory loss. However, the specific form would be relevant to the type of secretarial work performed by the patient. Occupational activities for this patient may range from putting a floppy disk into a computer to completing segments of real work brought from the office. As with Patient A, occupational activity enhances the opportunity for experiencing relative mastery and increasing motivation.

Throughout the course of therapy, the therapist must continually critique the therapy program to ensure that its design offers the patient the optimal opportunity to improve the occupational adaptation process. Changes in relative mastery indicate that the therapy program is appropriately designed.

Assumption: Although the patient may be improving in functional skills, change in occupational adaptation may not be occurring. An increase in relative mastery is the best indicator that change in the occupational adaptation process is taking place.

Evaluation of the Occupational Adaptation Process

In the Occupational Adaptation Practice Model, treatment effectiveness depends on a view of the patient as a whole person with a unique occupational nature. For example, even though the chief complaint may be physical, other aspects of the patient's occupational environments and relative roles may affect treatment outcome more than physiological deficits. Consequently, the therapist should consider the patient as a whole occupational system when documenting progress. In addition to reporting traditional measures of patient improvement, such as level of functional independence, the therapist should note the patient's change in occupational adaptation by documenting the patient's energy level, adaptive response mode, adaptive response behavior, and resulting relative mastery (Schkade & Schulz, 1992). Holistic evaluation and documentation are essential for an understanding of the effect of programming on the patient's occupational adaptation process and potential for occupational performance.

Occupational adaptation is an internal phenomenon and therefore seems to be less measurable than observable behaviors that can be counted or functional skills that can be objectively measured. However, a systematic approach based on both observable and phenomenological criteria could be generated to measure change in occupational adaptation. We believe that change in the occupational adaptation process is manifested by three predictable outcomes: improvement in self-initiation,
generalization, and relative mastery. Many practitioners have observed these outcomes and have noted their positive effect on the patient’s empowerment.

Assumption: As the internal occupational adaptation process changes, the following outcomes result: (a) the patient begins to initiate changes in the way occupational activities are approached; (b) the patient begins to spontaneously generalize knowledge and competencies acquired in therapy to other occupational activities; and (c) the patient begins to experience greater relative mastery.

Periodic measurement of these outcomes may show the changes that are occurring in the patient’s occupational adaptation process. Self-initiation and generalization may be readily measured by frequency counts. However, the measurement of relative mastery requires a different approach, such as a framework that practitioners may use to measure relative mastery as an outcome of change in occupational adaptation (see Figure 1). Although it is a phenomenological experience, relative mastery can be translated into quantitative information, as is described below.

The three properties of relative mastery, as discussed in Part 1 (Schkade & Schultz, 1992), are efficiency, effectiveness, and satisfaction to self and others. A procedure to measure change in relative mastery involves three steps. First, the patient and the therapist select one or more occupational activities for outcome measurement. The activity selected is drawn from those identified as part of the primary treatment focus during the initial occupational adaptation assessment. The occupational activity selected to measure change in relative mastery must not be one in which the patient has had direct training or experience in occupational therapy. A degree of novelty in the occupational activity is necessary for the therapist to determine whether the associated outcomes of self-initiation and generalization are occurring. Second, the patient and the therapist determine the criteria that describe the levels of expected occupational performance for each property of relative mastery (i.e., what will con-

Figure 1. Measurement of relative mastery.
The following examples are excerpts from the course of priorities.

Provided based on the occupational adaptation frame of reference (see Figure 1).

Outcome effect may provide the patient, the therapist, and the patient and the therapist collaborate to plot the results. The relative weight of each property is determined by the patient.

Assumption: The patient will weight the three elements of relative mastery according to personal priorities.

For example, a patient with many competing responsibilities may weight efficiency as the most important property, whereas a patient with few demands on time may place more importance on satisfaction. The patient determines the relative weight of each property given the selected occupational environment and relative role expectations. One can calculate the composite measure of the patient’s relative mastery by adding the ordinal data points from each property and computing a composite percentage for relative mastery. For example, if on the first occurrence of outcome measurement the patient rated efficiency as 1, effectiveness as 2, and satisfaction as 4, the sum would be 7. One would compute a composite percentage of relative mastery by dividing the calculated value into the highest possible total value (7 ÷ 15 = 47%). The percentage is then plotted (see Figure 1).

A comparison of the composite percentage on admission with the percentage at different points during therapy provides a measure of change in relative mastery over time. Such comparison may be useful in determining whether the patient is ready for discharge, requires continued inpatient treatment, or requires referral to outpatient rehabilitation services. An analysis of performance within each of the three properties of relative mastery may clarify where therapy should be concentrated for greater effect on relative mastery and the overall occupational adaptation process. A graphic representation of outcome effect may provide the patient, the therapist, family members, and concerned professionals with a visual record of therapeutic effect (see Figure 1).

Two caveats should be kept in mind about this method of measuring relative mastery. First, the measurement assumptions have not been fully tested. Second, a 5-point scale was used within each property of relative mastery to suggest one approach to measurement. Different treatment settings or patient conditions may call for either a smaller or greater number of levels. This decision is left to the discretion of the therapist. Examples of program evaluation can be found in the illustrations that follow.

Illustrations of Occupational Adaptation Practice

The following examples are excerpts from the course of therapy with four hypothetical patients. They are provided to illustrate various aspects of practice applications based on the occupational adaptation frame of reference. Familiarity with Part 1 (Schkade & Schultz, 1992) is required for a complete understanding.

The treatment presented in these examples is based on three factors: the normative construct of occupational adaptation discussed in Part 1, the conditions and parameters of occupational adaptation practice discussed in the present paper, and the questions posed in the occupational adaptation practice guide (see the Appendix).

Example 1: Outpatient Rehabilitation for Carpal Tunnel Syndrome

For the patient in this example, occupational therapy was initiated after surgery. As the patient began to experience increased occupational functioning, the therapist transferred more and more of the responsibility for planning and managing the therapeutic outcome to the patient. With the therapist’s facilitation, the patient designed a home program that would incorporate essential movement patterns and precautions into her occupations of daily living. This process increased the magnitude of the patient’s agency and empowered the patient to make changes in her occupational adaptation process. The primary focus throughout treatment was on helping the patient experience greater relative mastery in her occupational environment of work and role of mother. The patient placed the most importance on the property of satisfaction. As the patient began to change her approach to occupational challenges, such as doing the laundry, her overall relative mastery increased. She found that the splints recommended by the therapist helped her to maintain proper wrist position and enabled her to make necessary hand motions with less pain. However, although her efficiency and effectiveness were increasing, her satisfaction was not. In response, the therapist encouraged the patient to reassess her occupational role expectations. The patient revealed that before surgery, she had always taken great pride in methodically folding and putting away the laundry. She now realized that the task took so much of her energy and ability that it gave her little satisfaction. She began to see folding laundry as an unnecessary task and a performance expectation that, if eliminated, would allow her to focus on occupational activities with greater potential for satisfaction. Her assessment had a similar effect on the occupational role expectations relative to her occupational environment. Family members began to verbalize their desire to do tasks that would help prevent exacerbation of the patient’s carpal tunnel syndrome. The children changed their expectations of their mother and began to help with the laundry, although they had never done so before. Other tasks that were related to performance expectations were also modified by the patient. The patient’s change in occupational role expectations relative to her occupational environment had a positive influence on the patient’s satisfaction and her overall experience of relative mastery.
Example 2: Inpatient Rehabilitation for Traumatic Brain Injury

The patient in this example had deficits in upper extremity movement and sensation in his dominant arm. The initial therapy program emphasized activities designed to promote sensorimotor functioning and independence in self-care. The primary occupational environment was self-maintenance, and the relative role was that of independent adult. Although he was making satisfactory progress in self-care, discussion with the patient revealed that the treatment program was not meaningful. The patient was experiencing little relative mastery. The therapist suggested a change in the occupational environment and role. The patient and the therapist selected the patient’s work and the role of architect to guide treatment. Occupational activities were incorporated to provide a better fit with what the patient found meaningful. Occupational challenges were included that engaged his occupational adaptation process. For example, the patient’s drafting tools were brought in and the patient and therapist observed the patient’s adaptiveness, identified the sources of interference with relative mastery, and designed a plan to help the patient become more adaptive and increase relative mastery.

Example 3: Inpatient Rehabilitation for Post-Cerebral Vascular Accident

After 1 month of rehabilitation, this patient’s occupational skills were little improved. Aphasia and depression continued to interfere with therapy. It seemed to the therapist and the patient’s wife that the patient was not meeting his potential. To the extent possible, the therapist reviewed the treatment program with the patient. The patient showed little response to any of the activities being used and was not experiencing any relative mastery. The therapist determined that, although the patient needed much more occupational readiness, it was essential to begin occupational activity to increase motivation. Further discussion with family members resulted in a new treatment plan that emphasized occupational activity. Gardening became the primary modality for occupational therapy because it had been the patient’s main leisure occupation. Occupational readiness training that emphasized strength and sensorimotor skills related to gardening was begun by a certified occupational therapy assistant. The occupational therapist emphasized to the patient the connection between the exercises and the new program. Occupational activity was incorporated when possible (e.g., following oral and written directions in the care of seedlings, managing the plants in the clinic, using more complex gardening tools, tending plants in the outdoor garden). Sensorimotor, cognitive, and psychosocial systems improved through occupational readiness and occupational activity. Relative mastery also began to improve; efficiency was the biggest obstacle for the patient. The therapist encouraged the use of the gardening modality by other members of the treatment team. Speech therapy began to focus on words associated with gardening. Physical therapy engaged the patient by relating necessary exercises to his hobby. A plan was designed with the patient and the family to extend the gardening occupation into his occupational environments and related roles upon discharge.

Example 4: Public School Special Education for Behavior Disorder, Attention Deficit, and Fine Motor Problems

The 15-year-old student was referred to the occupational therapist for handwriting and attention problems. She had a severe behavior disorder, an attention deficit disorder, and fine motor problems. She came from a dysfunctional family and was failing in school. Her intelligence was within average range. She was described as explosive, physically aggressive, and at risk for dropping out of school. She had no vocational interests or goals. The therapist’s occupational adaptation assessment revealed that the student was occupationally dysadaptive in all of her occupational environments and roles and experienced no relative mastery. When faced with an occupational challenge, the student used primary energy most of the time. Her fine motor deficits interfered with performance tasks. Her adaptive response behaviors were largely hyperstabilized, which usually resulted in her being fixated with no action occurring. She would finally respond, “I can’t do it.” At other times, she was hypermobile and approached tasks randomly with no apparent plan of action. She perseverated in the use of existing but ineffective adaptive response modes. Her ability to generate, evaluate, and integrate adaptive responses was dysadaptive. She was markedly inefficient and ineffective and experienced little satisfaction.

The therapist collaborated with the special education teacher to develop a holistic program to treat the student’s occupational dysadaptation. Occupational readiness was instituted with a variety of media designed to improve the student’s fine motor skills, develop interests, and increase self-control. As the therapeutic climate evolved, the student began to express how, as a child, she had always loved to style her doll’s hair. As her interest in hairstyling became more apparent, the therapist expanded the occupational readiness program by giving her information about the role expectations of a hairstylist and the knowledge required to be licensed and by giving her home therapy assignments to visit and discuss work with practicing hairstylists. As a result of the occupational readiness, the student decided she wanted to become a hairstylist. Occupational readiness was further tailored to be consistent with her goal: A home program that emphasized fine motor tasks and other coordination activities
specific to her work goal, and relevant behavioral goals such as timeliness, dependability, and impulse control were instilled in the classroom.

In addition, the therapist guided the student into extracurricular activities to widen her exposure to occupational challenges (e.g., decorating for the school dance, collecting and sorting food for a community food pantry). She began to display more mature adaptive response behaviors and to modify her existing adaptive response modes. For example, as the student became more aware of her dysadaptation, she began to anticipate the ways in which her adaptive response modes were obstacles to relative mastery and to generate alternative modes and modified responses. These changes in her occupational adaptation process resulted in greater relative mastery. The most dramatic improvements occurred in satisfaction to self and others.

As therapy continued, the student integrated these changes and began to generalize her new occupational adaptation process. She was able to see the relevance of school and the need to develop her fine motor skills, self-control, and social skills as part of her future life goals. The fine motor exercises were improving her handwriting and she noted her improved efficiency in the use of hair-styling tools and equipment.

Additional occupational activity was begun in which the student began to style the hair of other students. She achieved positive recognition and acceptance from her peers for her competency in this activity. Her relative mastery increased substantially. As therapy progressed, the teacher noted to the therapist that the student was modifying her way of doing things by attempting to plan her approach to tasks, displaying more organization, and showing more neatness and pride in her handwriting. Behavioral problems in the classroom declined. The student had begun to initiate changes in how she responded to other occupational challenges (e.g., occupational performance at home and at her part-time job).

The occupational therapist discontinued direct service but periodically monitored the student’s progress. She made suggestions to the teacher on ways to provide the student opportunities to increase relative mastery in the occupational environment of school. To the student she suggested ways to increase her awareness of her adaptive response behaviors, to develop new adaptive response modes, and to evaluate and affect her relative mastery when faced with new occupational challenges.

Conclusion

The Occupational Adaptation Practice Model integrates the beliefs, principles, and techniques that have been addressed by many theorists and are reflected tacitly in the practice of many clinicians. The uniqueness of the Occupational Adaptation Practice Model lies in the adherence to a theoretical framework that concentrates treatment on the patient’s internal occupational adaptation process. The construct of occupational adaptation discussed in Part 1 (Schkade & Schultz, 1992) provides an overall explanation of this process and how the patient generates, evaluates, and integrates adaptive responses. We believe that interventions that affect relative mastery are instrumental in helping the patient become more adaptive, thus enhancing the potential for a productive and satisfying life.

In treatment based on the occupational adaptation frame of reference, the occupational environment is as important as the patient’s physical or mental condition and is conceptualized as a blend of the physical, social, and cultural influences that affect the patient. The style of patient-therapist interaction is process oriented rather than performance driven. The therapist’s primary gauge of effectiveness is change in the patient’s internal occupational adaptation as opposed to improvement in self-care or other function-oriented criteria. The concept of relative mastery is introduced as an outcome of change in occupational adaptation. The occupational adaptation practice model views mastery as a relative phenomenon that can, however, be understood in terms of three predictable outcomes. Such outcomes are identified and methods for measurement are proposed. The effect of relative mastery on treatment is described in practical illustrations that provide an overview of occupational adaptation concepts and assumptions and their effect on the nature of practice. These illustrations clarify the construct of occupational adaptation, the conditions and parameters of occupational adaptation practice, and use of the occupational adaptation practice guide.

We believe that the occupational adaptation frame of reference (Schkade & Schultz, 1992) and model for practice have potential benefits for the occupational therapist. First, they may formally articulate the current practice of therapists who use a similar approach but have lacked a formal structure, thus validating what has been perceived as intuitive by many therapists. Second, they may provide a fresh perspective for therapists who have practiced within the medical model but are searching for a practice model that is more holistic. Third, the model offers a generic perspective: it is not specific to any particular dysfunction or condition. Consequently, the model is applicable to many settings, such as schools, hospitals, and home health care. It is an appropriate practice model for patients with a variety of conditions such as behavioral problems, physical dysfunction, developmental disability, or psychosocial dysfunction.

The concepts and assumptions presented in this paper and in Part 1 (Schkade & Schultz, 1992) remain to be formally tested. We hope that these writings will lead to increased scholarly debate and research on the integrative nature of occupation and adaptation with regard to the discipline and the practice of occupational therapy.
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Appendix

Occupational Adaptation Guide to Practice

Occupational Adaptation Data Gathering/Assessment

What are the patient’s occupational environments and roles?
What occupational performance is expected in the primary occupational environment and role?
What is the physical, social, cultural features of the primary occupational environment and role?
What is the patient’s sensorimotor, cognitive, and psychosocial status?

Occupational Adaptation Programming

What combination of occupational readiness and occupational activity is needed to promote the patient’s occupational adaptation process?
What help will the patient need to assess occupational responses and use the results to affect the occupational adaptation process?
What is the best method to engage the patient in the occupational adaptation program?

Evaluation of the Occupational Adaptation Process

How is the program affecting the patient’s occupational adaptation process?
• Which energy level is used most often (primary or secondary)?
• What adaptive response mode is used most often (preexisting, modified, or novel)?
• What is the most common adaptive response behavior (primitive, transitional, or mature)?
What outcomes does the patient show that reflect change in the occupational adaptation process?
• Self-initiated adaptations?
• Enhanced relative mastery?
• Generalization to novel activities?
What program changes are needed to provide maximum opportunity for occupational adaptation to occur?

Note. The italicized terms are constructs in the Occupational Adaptation Frame of Reference (Schkade & Schultz, 1992).

References


