Published reference: Dancza, K., & Rodger, S. (Eds.). (2018). Implementing Occupation-centred Practice: A Practical Guide for Occupational Therapy Practice Learning (1st ed.). Routledge. https://doi.org/10.4324/9781315297415

Chapter 2: Occupation-centred practice and reasoning

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Intended chapter outcomes

By the end of this chapter, readers will have an overview of:

- The unique occupation-centred perspective of occupational therapy
- The difference between occupation-focused and occupation-based practice as a way of reflecting on occupational therapy services
- How close or far away is occupation to practice and the implications of this for professional identity
- Reasoning including top-down, bottom-up and top-to-bottom-up

Introduction

In this chapter, we provide an overview of what it is to be an occupational therapist. We begin by offering some ideas about how to reinforce our professional identity (how *occupation* impacts health and well-being) and how to market the value of occupational therapy to the public as well as those who fund our services.

We consider types of reasoning that occupational therapists' use such as top-down and bottom-up reasoning, the former being more occupation-centred (Fisher, 2009). We then explore occupation-centred practice as an overarching term, and how occupation-focused and occupation-based practice fits within this (Fisher, 2013). Next, we address practice from the perspective of how close or distant occupation is to the therapist's thinking. Finally, we discuss how occupation-centred practice relates to participation.

Defining occupational therapy

It is not uncommon when meeting a new person, that they ask you what it is that you do. As occupational therapists, we understand how influential a work role is to our own identity. Why is it then, that when asked to explain what it is that an occupational therapist does, it fills many of us with dread?

We may stumble about an explanation which can turn into a lengthy monologue describing many of the tasks that we carry out within our work (such as helping an elderly person to get home from hospital following a fall, working with a child to ride his/her bike or adjusting the environment so that a person can return to work following a brain injury). We may state or imply that occupational therapy is different in different settings, as it is such a diverse profession. We may also avoid the use of the word *occupation* as it can cause confusion with people thinking our work has something to do with either employment services or occupational health and safety. Issues may be magnified when we abbreviate our name to ***OT***: at best, ***we distance ourselves from occupation***; at worst, we are confused with other acronyms like *over-time*, *operating theatre* or even *information technology* (as OT can be misheard as IT!).

Having an ambiguous explanation of our role creates significant challenges for us as a profession. An overly long and complicated explanation encourages our audience to tune-out to the principal elements of our role. Suggesting we are different in different settings emphasises a lack of cohesion and common thread between us, adding to role blurring and a devaluing of our core philosophy. By not using the word *occupation*, we are also missing an important opportunity to market ourselves and link what we do with our professional title.

Coming up with a short, simple, yet comprehensive definition of occupational therapy is challenging, yet essential for the continuing prosperity of the profession. Our offer has been adapted from World Federation of Occupational Therapists, (2012) and the Royal College of Occupational Therapists, (2015a):

"Occupational therapists are concerned with how people 'occupy' their time."

Figure 2.1 illustrates this explanation. We might expand by saying:

"What people do to <u>occupy</u> their time (their occupations) is fundamental to their health and wellbeing. Daily life is made up of many <u>occupations</u>, such as getting ready to go out, cooking a meal or working. An occupational therapist will help people who may need support or advice if they are not able to do their occupations due to illness, disability, circumstances or because of changes in their lives as they get older."

Figure 2.1 Explaining occupational therapy

Finding an explanation of occupational therapy that works for you is important. It is critical, however, that we as a profession agree on common elements to our explanations. If all occupational therapists ***link the importance of occupation with health and well-being*** as the primary focus of the profession, it will provide a common identity for us, regardless of where and with whom we work.

Using the word *occupation* with a simple explanation of what we mean, can also promote the link between our name and what we do. Our language is constantly evolving which is evidenced by the everyday use and understanding of several 'made up' words (e.g. Google – meaning an internet search engine; Twitter – a social media site). Branding ourselves clearly

using *occupation* is more likely to support the community's understanding of our profession. Similarly, using the full title of occupational therapist rather than shortening it to 'OT' may further support the promotion of our profession.

Activity

- How do you explain your role to others?
- How does *occupation* feature in this explanation?
- When you write down your definition of occupational therapy, how long is it?

The importance of occupation

The Royal College of Occupational Therapists (the professional body in the United Kingdom), released a position statement (2015a) which emphasised the importance of occupation to health and well-being and the role of the occupational therapist in promoting occupation. In this document, it was stated that:

> *"Occupation should be considered a basic need and human right, like eating, drinking and breathing (Dunton 1919). There is a renewed understanding of how engagement in occupation is therapy and fundamental to health and wellbeing (Wilcock 2006)…The focus of the practitioner in any setting, with any service user group is to maximise occupational performance and participation."*

Importantly humans are occupational beings and are experts on their own occupations. Additionally, Townsend and Polatajko (2007) outlined several other core beliefs about occupation:

- it organises human behaviour
- it develops and changes over a lifetime
- it shapes and is shaped by the environment
- it has therapeutic potential

Occupations give meaning to life (Townsend & Polatajko, 2007). Occupation should not be considered part of a person's life only if it is easy to do, or if services have time to focus on it. The Royal College of Occupational Therapist's position statement reinforces that occupational therapists' primary focus is occupation. If the duties of an occupational therapist also include generic health and human care tasks, then they should not be undertaken at the expense of assisting clients to engage in occupations. Occupational therapists are educated in the fundamentals of occupation, drawing from occupational science, and these skills and expertise should be front and centre of our practice and must not be side-lined when resources are stretched.

Occupation-centred practice means that occupation is at the core of everything that we do. We believe that it is through occupation that health and well-being (Wilcock, 2006) and justice (Townsend & Polatajko, 2007) are influenced.

This is a unique perspective from that of many other professionals, as it is often the body functions and structures (e.g. memory, cognition, motor, perceptual or sensory abilities and skills – see the International Classification of Functioning in Chapter 3) which are the close focus of their interventions. It is anticipated that improvements in body functions and structures will lead to improvements in occupation and participation. However, evidence is limited which suggests that interventions focused at one level (e.g. body functions and structures) translates to improvements at another level (e.g. occupation and participation) (Novak et al., 2013). Therefore, if you want to see improvements, your interventions need to focus on occupation and participation. It may also be that through engaging in one's occupations, body functions and structures change. However, these changes are a bonus rather than our primary focus.

There is growing evidence regarding the benefits of using an occupation-centred approach with children and adults who experience a range of occupational performance challenges. Practicing from an occupation-centred perspective has also shown improvements in job satisfaction for occupational therapists as it aligns with our profession's unique perspective (Estes & Pierce 2012).

Unpacking reasoning: Top-down, bottom-up, top-to-bottom-up

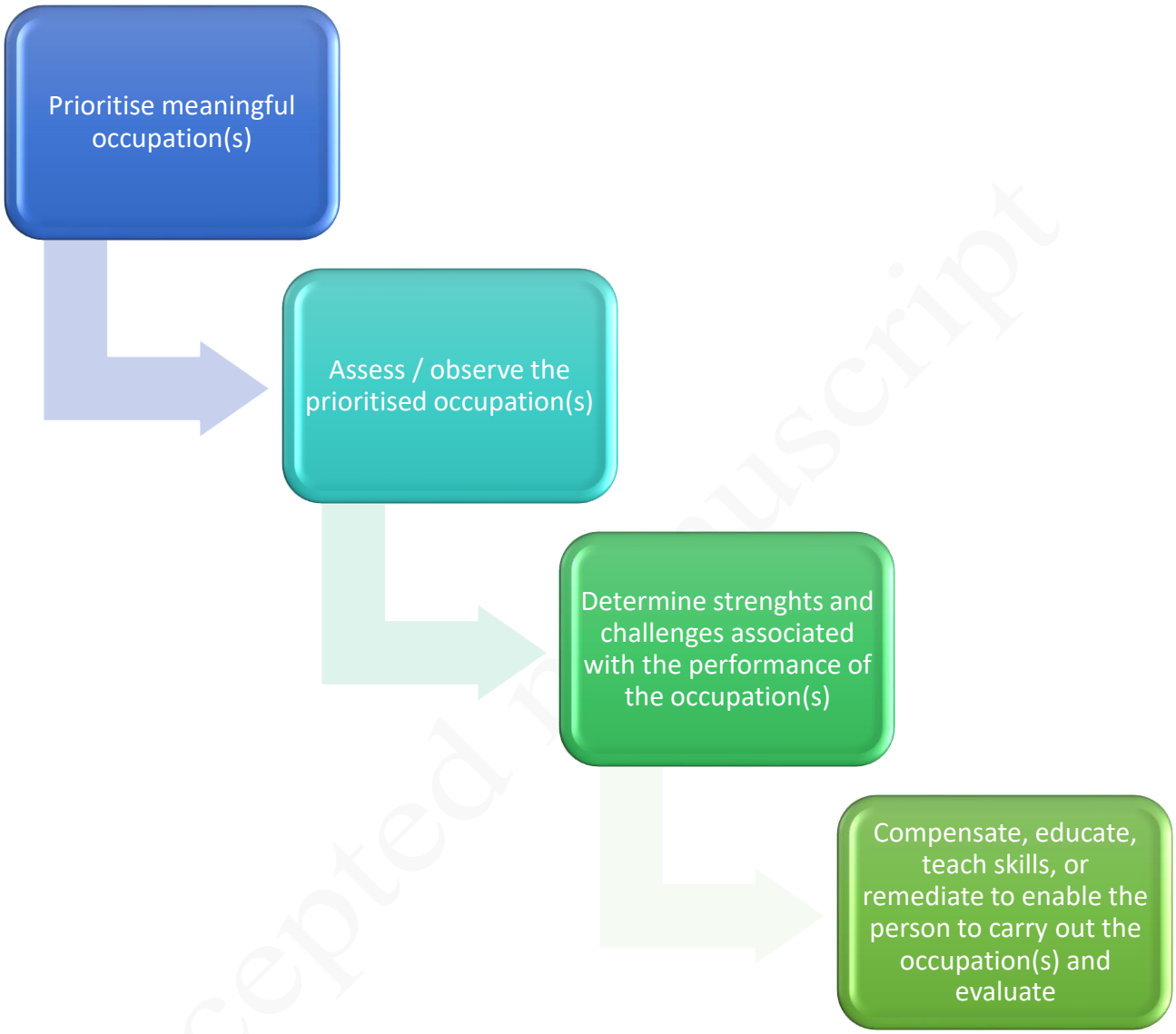
Reasoning is a "context dependent way of thinking and decision making in professional practice to guide practice actions" (Higgs & Jones, 2008, p. 4). Reasoning is used throughout the occupational therapy process from the preliminary stages of information gathering (what information should be sought and from whom?), goal setting and prioritising, making decisions about assessment, intervention and what and how to re-evaluate a client's performance. There are many classifications of reasoning that have been proposed by various authors (e.g., Mattingly & Fleming, 1994; Schell & Cervero, 1993, Taylor, 2008) at various times (see Chapter 11).

The more experienced the occupational therapist in an area of practice, the more automatic or sub-conscious his/her reasoning becomes. Being occupation-centred means that occupation remains core at all stages of the occupational therapy process. This can sound obvious, but there are common patterns of reasoning which can be thought of as occupation-centred, but in reality, their focus is elsewhere. Fisher (2009) described three categories of reasoning within practice, namely top-down, bottom-up and top-to-bottom-up reasoning that will be expanded upon here.

Top-down reasoning

Top-down reasoning (Fisher, 2009) can be considered as the reasoning used when engaged in occupation-centred practice. Within the occupational therapy process, it has key stages which are identified in Figure 2.2.

Figure 2.2 Top-down reasoning



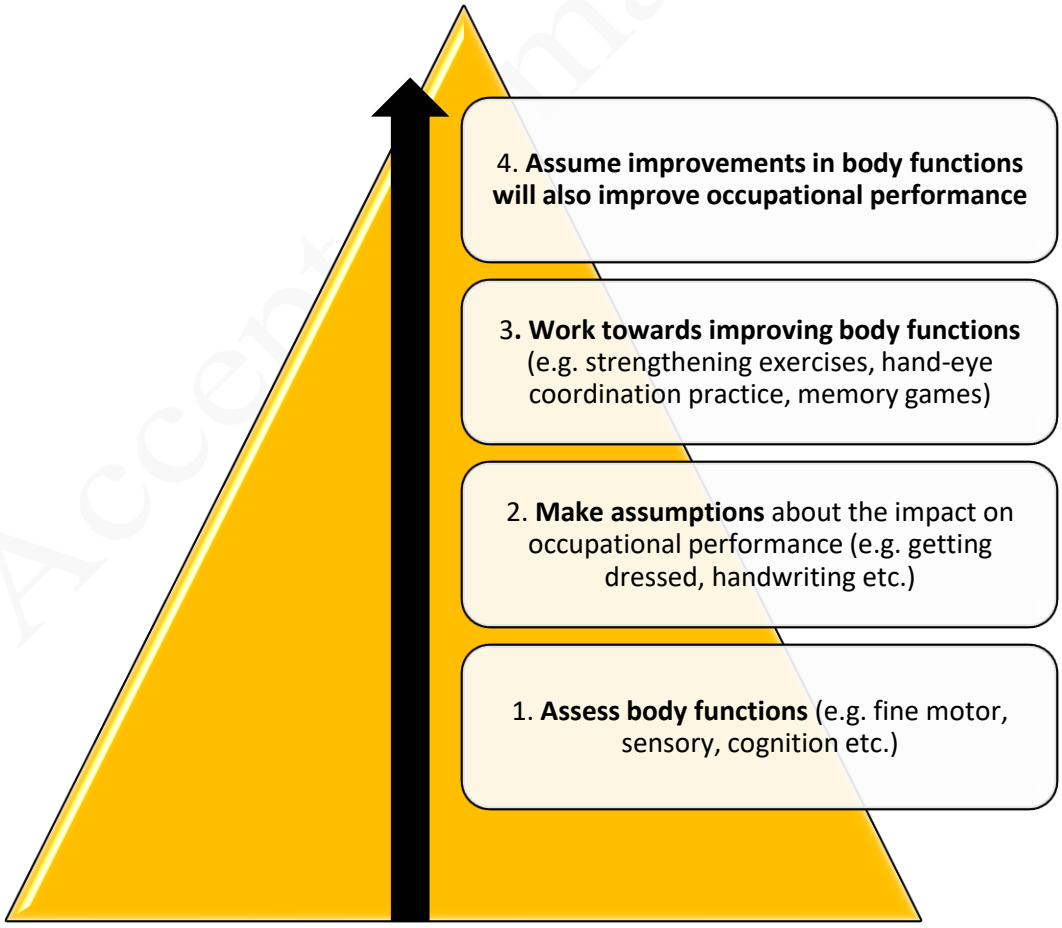
Adapted from Fisher (2009)

These stages involve an identification of the client's occupational needs, assessment of these needs (i.e., occupation-focused and occupation-based analysis), intervention which is designed to enable performance of that occupation, and evaluation of success through improvement in performance of this occupation. A more detailed explanation of top-down reasoning is given in the Occupational Therapy Intervention Process Model (Fisher, 2009) in Chapter 3, which is the basis for the process described in Section two of this book.

Bottom-up reasoning

Bottom-up reasoning (Fisher, 2009) is commonly associated with a medical perspective of the person. Bottom-up reasoning begins with an assessment of the underlying body functions and structures (e.g., gross and fine motor skills, strength, sensory, posture, joint range of motion, visual perception, memory, anxiety, depression, cognition etc.). When strengths and impairments are identified, assumptions are made about how this might impact on various occupations (e.g., cooking, shopping, going to work etc.). Intervention often involves a focus on restoring, repairing or developing the body functions and structures which are felt to be impeding occupational performance (e.g. strengthening exercises, memory games, self-esteem groups, relaxation techniques). Evaluation focuses on any improvement in the underlying body functions and structures using specific assessments of these functions, rather than the impact on occupations. This is illustrated in Figure 2.3.

Figure 2.3: Bottom-up reasoning Adapted from Fisher (2009)

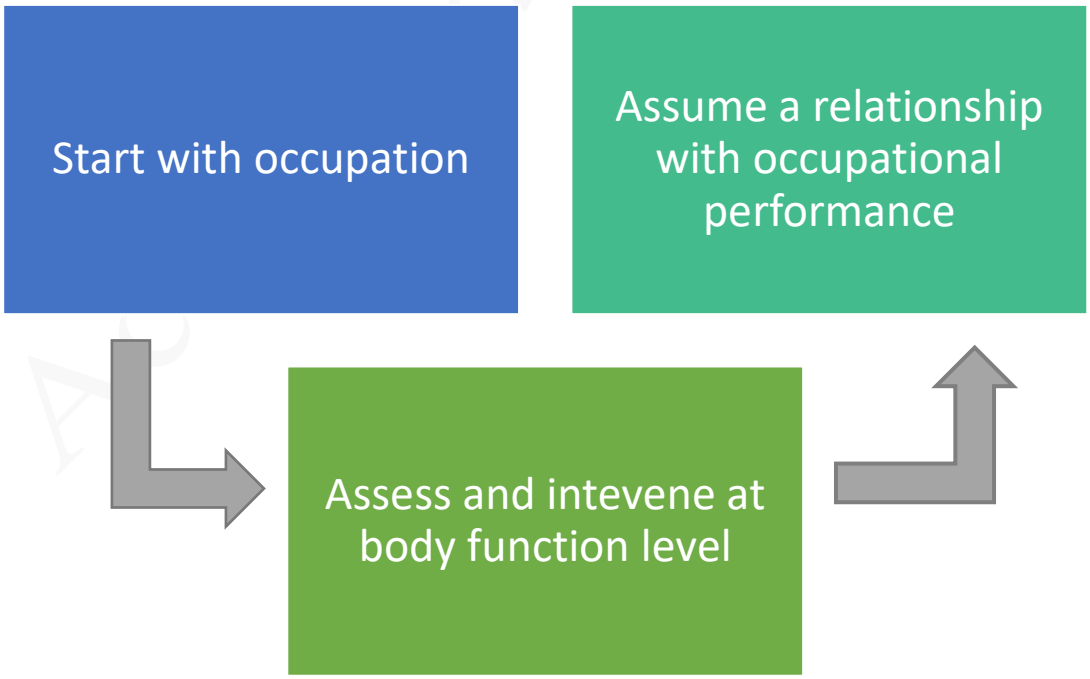


Top-to-bottom-up reasoning

Top-to-bottom-up (Fisher, 2009) reasoning is a variation on bottom-up reasoning, but can be quite confusing as it attempts to also focus on occupation. As with bottom-up reasoning, this cannot be considered a form of occupation-centred reasoning. The occupational therapist is still placing body functions and structures as central.

Top-to-bottom-up reasoning begins with a focus on the occupations which are important or needed for the person (e.g. an occupation-focused interview). This then jumps to an investigation of the underlying body functions and structures which make up these valued occupations (like motor skills, perception, cognition etc.). Assumptions are made as to how the client's strengths and impairments relate to his/her important occupations, and interventions are chosen that focus on remediating these impairments. Evaluation may consider changes in the underlying impairment and/or occupational performance. This is represented in Figure 2.4.

Figure 2.4: Top-to-bottom-up reasoning



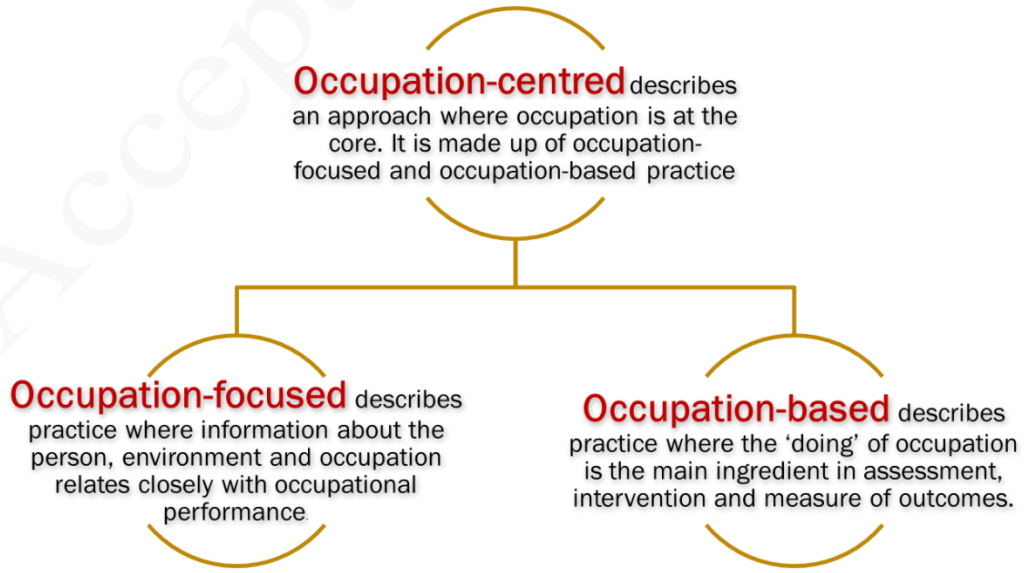
Adapted from Fisher (2009)

In this book we focus on top-down or occupation-centred reasoning. It is useful, however, to identify when other forms of reasoning are guiding practice areas. Labelling our reasoning correctly will support us to understand the effective elements of our practice and use research evidence appropriately.

Reflecting on practice: Occupation-centred, occupation-focused, occupation-based

Top-down reasoning in this book is considered occupation-centred. The Royal College of Occupational Therapists produced further explanation of occupation-centred practice in their briefing of the same name (2015b). In this document, they emphasised the need for occupational therapists to have a common language of what is meant by the terms occupation-centred, occupation-focused and occupation-based (based on the work of Anne Fisher, 2013). Reflecting on practice with these terms in mind, can offer us as occupational therapists a way of critiquing what we are doing and offer some clarity to our professional reasoning processes. Fisher (2013) explains, occupation-centred practice is the overarching term which incorporates occupation-focused and occupation-based elements. This is illustrated in Figure 2.5.

Figure 2.5: Occupation-centred, occupation-focused and occupation-based.



Adapted from Fisher (2013).

Occupation-focused practice

In the occupational therapy process, when you talk about occupations with your client/family/community, this is considered ***occupation-focused*** (Fisher, 2013). For example, an interview is occupation-focused when you ask about the occupations which are important and make up a person's daily routine. Questions you might ask include '*tell me about your typical day/week?*', '*what can you manage and what are you finding challenging to do?*' These discussions enable us to understand the occupational profile (American Association of Occupational Therapists, 2014; see Chapter 4) of the person/family/community and helps frame the remainder of occupational therapy involvement.

For discussions to be called *occupation-focused*, ***occupation remains close to the discussion***; that is how illness, life events and the environment impact on occupation. For example, how a mother's depression might be impacting on her ability to get her children ready for school in the morning. In contrast, if you ask about the person's condition (e.g., depression) or body functions (e.g. mood / anxiety / memory), your conversation has become condition- or body-function focused. Likewise, asking solely about the environment (e.g., does the person have stairs in their home, or a bath or shower) becomes environment-focused. While these different foci may be important at various times, do not confuse them with an occupation-focus.

Activity

- Think about a person (client) you (or a supervisor) have worked with. Consider the conversations you have had (or witnessed). What elements and percentage of this conversation were:
  - Occupation-focused?
  - Body function/condition focused?
  - Environment-focused?
  - Another focus?

It is important for occupational therapists to gather information about a range of areas (such as the person, occupations and environment). Considering the amount of time spent talking about occupation or other areas, could offer a point of reflection. Similarly, considering when we introduce the term occupation to our clients may help us to frame our interactions with them and help to explain our role to them. For example, is occupation the first thing you discuss with a client? Or do you talk about occupation during or towards the end of your conversation? Introducing occupation first may help those we work with better understand our focus and role, as well as what to expect from their engagement with occupational therapists.

It is not only our conversations which need to be occupation-focused; our documentation such as reports, progress notes, and marketing materials (e.g. website, leaflet or handouts) also promote what it is that we do. Using the language of occupation and relevant examples to provide explanations can influence what others learn about our unique role.

Activity

- Have a browse of your service's website or a local occupational therapy service's website. Consider:
  - Is there a clear message that occupational therapists are concerned with occupation?
  - Does it use the language of occupation (e.g. getting dressed, back to work, engaging in school etc.)?
  - Are there any areas which might be considered confusing for the public about the core focus of occupational therapy?

Occupation-based practice

Occupation-based practice refers to where the *doing* of occupation is at the core of practice (Fisher, 2013). For example, an occupation-based assessment consists of the person doing an occupation (such as a person making a cup of tea in his/her home). Similarly, an occupation-based intervention may adapt/change the way the person is doing specific tasks to improve performance or independence (such as providing a piece of equipment or memory prompts as part of the task sequence). Finally, evaluation measures how the person is now doing his/her occupation (for example, can they make a cup of tea independently when they want to?) (Royal College of Occupational Therapists, 2015b).

Occupational therapists have many strategies to enable a person to do his/her occupations. For example, we can break down the activity through activity analysis (see Chapter 4) and grade and/or adapt elements of the activity to support the person to improve his/her performance. Techniques such as the Cognitive Orientation to daily Occupational Performance (CO-OP; Rodger & Polatajko, 2017) and Occupational Performance Coaching (Graham, Rodger & Kennedy-Behr, 2017) are examples of occupation-based intervention approaches. These consider the person doing an occupation and uses enabling strategies to enhance that performance.

Occupation-based practice should not be confused with the use of assessment techniques where the purpose is to evaluate body-functions. For example, a person may be cooking a meal (an occupation). If the occupational therapist is concerned with how a client is cooking a meal so that they can enhance the way they are cooking safely and independently, then this could be considered occupation-based. If, however, the purpose of the cooking observation is for the occupational therapist to assess the person's memory, balance, sequencing, muscle strength etc., then the assessment activity is less occupation-based and more body function focussed.

While it may be that the person's body functions are impacting on what they are doing (such as a person may forget where the cups are kept when making tea), you cannot 'see' these body functions. You are making assumptions that it is the poor memory, but what you *see* is the person looking in different places for the cups and a slowness to complete the task.

Making assumptions whilst observing can mean that other reasons for the challenges are missed (such as the cups may have been moved recently or the person is unfamiliar with the hospital kitchen). You may also make assumptions that the person's memory might be poor during other activities (such as getting dressed or going shopping), but this does not take into consideration that the activity and environment have changed, so the person's performance is also going to change (thinking about the Person-Environment-Occupation Model, Law et al., 1996, see Chapter 3).

Being occupation-based means that you analyse the person's performance during an observation of them doing an occupation, such as cooking a meal. This may reveal a range of points of performance break down, such as a slowness to complete the activity, disorganisation of the kitchen, increased effort when lifting pans or carrying items or an inefficient sequencing of the activity steps. These points of performance break down alert the occupational therapist to strategies that might assist the person to carry out the task more efficiently and safely. The intervention occurs while the person conducts the activity and strategies are developed to support them to cook their meal. This may involve grading the activity to make it simpler, changing something in the environment, introducing equipment or teaching skills associated with cooking the meal. This contrasts with attempting to improve the body functions first, such as engaging them in a range of memory games or sequencing activities that have nothing to do with cooking.

Activity

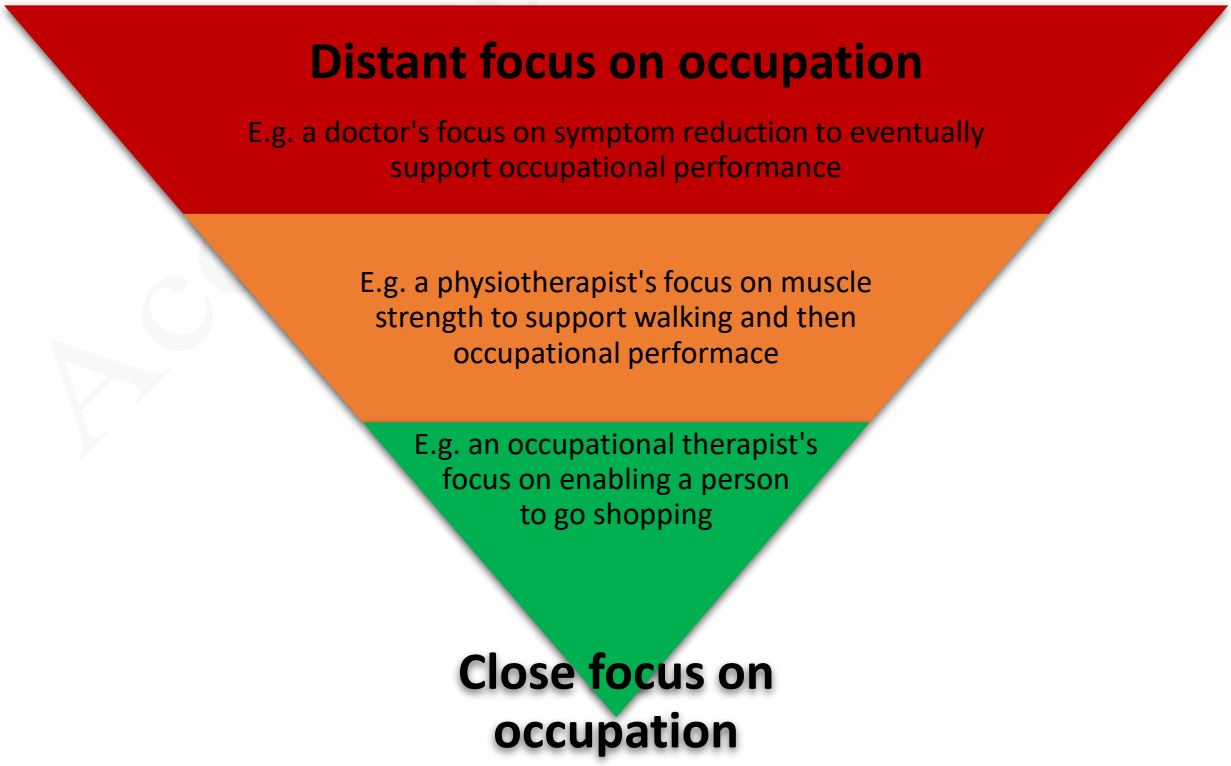
- Think again about a person you (or a supervisor) have worked with. Consider what took place in your interaction with them. What elements of intervention were:
  - Occupation-based?
  - Environment- based?
  - Body-function/structure based?
  - Had a different basis?

The closeness of occupation to practice

If you practice in a way which is occupation-centred (capturing elements of occupation-focused and occupation-based practice), then you inevitably remain very close to the person's occupations. If, however, your focus shifts from occupation (handwriting for homework) to preparatory activities (squeezing theraputty, rubber band finger games) required before doing an occupation, then your practice becomes more distant to occupation (and using top-to-bottom-up reasoning). Figure 2.6 illustrates this continuum.

It could be argued that all health care professionals are focused on enabling people to do their occupations so that they can participate fully in their lives. For example, a doctor may be focused on symptom reduction (e.g., pain) or cure related to a body function or structure (e.g., shoulder surgery), so that the person is well enough to participate in his/her life roles such as golfer or home handyperson (bottom-up reasoning). A physiotherapist may wish to improve walking, so works on lower limb muscle strength training, so that the person can use stairs at home to undertake his/her daily life tasks (top-to-bottom-up reasoning). Therefore, the *ultimate aim* for all health care professionals is to enable people to live their lives.

Figure 2.6: Distant and close focus on occupation by various professions



What makes occupational therapists different is that their *primary and close focus* is occupation (i.e. doing occupations is seen within their practice). We understand that it is important for a person to develop or maintain his/her occupations for health and well-being. When an occupational therapist moves away from occupation to focus on developing or maintaining a body function (e.g. squeezing theraputty, rubber band finger games), then their role may overlap and be indistinguishable from that of other professionals.

For example, after having a stroke that left Colin with right sided weakness and sensory loss, he needed to be able to sign cheques to pay his bills. He became increasingly anxious about not being able to keep his financial affairs up to date. His previous therapist had him use an exercise book and practice lines of meaningless loops and circles such as *oooooooooooooooooo, eeeeeeeeeeeeeeeeeee, ololololololole, lllllllllllllllll, lelelelelelele* etc. He felt frustrated at this repetition and the childish nature of this preparatory handwriting activity.

There are many ways of paying bills. However, Colin's usual method was writing cheques and he was anxious about using electronic banking. As a first step, the new occupational therapist and Colin decided to work on his cheque writing, but also begin to investigate electronic banking options. The occupational therapist helped him to learn to sign his name by practicing his signature with a larger diameter pen and using blank photocopied cheques that had been enlarged and then gradually photocopied in reduced size until he could use a regular cheque book. The signature line was made into a rectangular box with bold outlines for practising and the therapist helped him to use cognitive strategies (based on the CO-OP approach; Rodger & Polatajko, 2017) regarding where to start and finish letters and how to not write over the already written letters. He also went on to do the crosswords that he enjoyed so much, with the occupational therapist also photocopying these to be larger and helping him develop strategies to keep the letters in the squares.

What is important is that people should not have to wait too long to re-engage in occupations, as our belief is that *doing* will support health and well-being, as well as body function recovery. If an occupational therapist moves away from their focus on occupation to engage in other roles, then the client may miss out on opportunities to re-engage in occupations that

are meaningful to them, potentially negatively impacting self-efficacy, competence, and life satisfaction and elongating periods of helplessness and dependence.

Activity

- Think about the common assessment and intervention tools / techniques or programmes you use or are aware of. Try to map them onto Figure 2.3 as to how close or distant they are to occupational engagement.

Link between occupation-centred practice and participation

There is an increasing recognition within some areas on the importance of participation to health and well-being. Indeed, this is part of what makes up health as described in the International Classification of Functioning, Disability and Health (World Health Organisation, 2001, see Chapter 3).

The focus within much of occupational therapy practice is on enabling the performance of activities, such as helping a child to kick a football. Once the child has developed this skill they may have met their immediate goal in relation to occupational therapy. For example, the goal might be: *For Johnny to kick a football towards the goal, 7 out of 10 tries after three weeks*. However, this is not sufficient for him to participate meaningfully in a football team. A lot of other skills are required to play football; running after the ball without falling over, kicking the ball while running rather than from a stationary position as practiced in therapy, knowing how to be part of a team and knowing the roles of all the player positions etc. The occupation of playing team football and role of team player/member is much larger than just kicking a football from A to B. Hence, the occupational therapist needs to be cognisant of the many skills required to engage in this occupation and be a fully participating team member.

Coster and Khetani (2008) suggested that participation in life situations can be thought of as a set of organised sequences of activities directed toward a personally or socially meaningful goal. We need to consider how the child will then use his or her skills to participate in the school playground playing football with peers. Bonard and Anaby (2016) suggested that:

> *"participation can take on both objective (in terms of frequency) and subjective dimensions involving experiences of meaning, belonging, choice, control and the feeling of participation" (p.188).*

A focus on participation requires consideration of occupational performance in context. For this it is vital that the occupational therapist understands not only the occupational challenges of a person, but also where and with whom (physical and social environment) the occupational performance is to take place. Working within naturalistic environments helps the occupational therapist to see first-hand the opportunities and challenges associated with participation.

For example, to link occupational performance (kicking a ball from A to B) with participation (playing football) we consider where and when occupation typically takes place. We may be familiar with a football club that is less competitive and more inclusive to children with motor difficulties that we can introduce to the parent. We may spend some time with a coach explaining the child's challenges due to his/her coordination difficulties, and how to enhance his/her performance and acceptance within the team. The focus here is on facilitating real life participation as a team and club member, enhancing friendships as well as the initial focus of enhancing skill performance regarding kicking goals.

Chapter summary

The unique occupation-centred perspective of occupational therapy is what sets occupational therapists apart from other health care professionals. As occupational therapists, we need to promote the importance of occupation and participation to health and wellbeing in how we act, what we say and in the services we provide.

Being aware of our reasoning can support the development of occupational therapy practice which is centred on occupation. Top-down reasoning means that your focus throughout the occupational therapy process is on occupation. When we revert to bottom-up and top-to-bottom-up reasoning (which may appear to align more closely with other health care professions' views) it can dilute the effectiveness of occupational therapy.

Understanding the differences between occupation-focused and occupation-based practice as a way of reflecting on occupational therapy services and ensuring our unique perspective is maintained. This is a complex process within many health, social care and education areas where there is often a focus on curing or fixing the underlying impairment in preparation for occupation.

How close or far away occupation is to our practice has implications for the people we work with and for our own professional identity. If we as occupational therapists do not advocate for the importance of occupation to health and wellbeing, our role can easily turn into one of filling gaps in services and being assistants to other professionals.

Chapter 3, and indeed the remainder of this book, is dedicated to the unpacking of occupation-centred practice and its practical implementation in a variety of settings. Chapter 3 specifically focuses on providing an overview of occupational therapy models, theories and frames of reference. This is to provide you with some background information which will support your reasoning and guide your practice.

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