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THE FOUNDATION

The ICIDH-2: A New Language in Support of Enablement

The need for a common language across professions concerned with persons who live with disabilities has become ever more clear. Traditionally, all professions develop a type of “jargon” that is familiar to all members of the group, but which may be both confusing and off-putting to others, including consumers of rehabilitation or medical services. The use of a single worldwide language to discuss issues affecting the disability community promises to enhance the exchange of new ideas and technology, to promote wider-reaching social policy, and to ensure that the research challenges across disability are examined in a more comprehensive manner. The forthcoming research would be responsive to needs established by and with the disability community, not in terms that were focused on the peculiar interests or traditions of any individual profession.

The new language, although still referred to as ICIDH-2, presents some new terms for identifying conditions and situations that inhibit persons with disabilities from leading the types of lives they would like to choose. Previously, ICIDH referred to the International Classification of Impairments, Disabilities and Handicaps. The new system is structured around social perspectives rather than around pathology, and is intended to focus on healthy functioning rather than on pathology and limitations. This system recognizes that participation in everyday life by persons with disabilities results from the interaction between person and environment. Body structure/body function replaces the term impairments. The new term is intended to convey that although certain persons may have atypical body structures or functions, these do not necessarily impair function or interfere with healthy productive living. Body function or structure refers to changes in the physiological, psychological, or cognitive level of a person.

Activity refers to those tasks or accomplishments, either physical or mental, that are desired by the person and that are at the level of the person. Participation refers to a person’s involvement in life situations within all environments. Examples include participation in school, community activities, community mobility, work, and so forth. The revised ICIDH-2 also includes a classification of environmental factors (e.g., social attitudes, physical, architectural, policy) that affect a person’s participation.

At its annual meeting in the fall of 1998, the American Occupational Therapy Foundation’s (AOTF’s) Research Advisory Council (RAC) discussed the need to formulate some basic questions that would guide its programs in research and influence the funding priorities used in its research grants program. At the same time, the council recognized that questions to be used for such purposes should be written in a universal language that would be advantageous to occupational therapists when seeking external support for research, conveying information about clinical issues to colleagues in related fields and for use in the publications of both the American Occupational Therapy Association (AOTA) and the Foundation.

At a second RAC meeting in which representatives from AOTA volunteer groups and staff members also participated, several language systems were reviewed for their relevance to the task. It was concluded that the ICIDH-2 most nearly accommodated the profession’s need for a language that would enhance, rather than compete with, the concept of occupation, which had been determined to be the core of the profession. It was agreed that AOTF would sponsor a consensus conference and that representatives from all areas of practice, all levels of practice and education, and all types of research methodologies would be included in the collective body of 30 conference participants (see Appendix for roster of participants).

The specific objectives of the conference, which was held in July 1999, were to

1. define the specific practice concerns of the occupational therapy profession in the ICIDH-2 language,
2. establish the research priorities for occupational therapy in direct relationship to these practice concerns, and
3. promote the consistent use of the ICIDH-2 across the profession of occupational therapy.

After 3 days of intensive work, the group reached an enthusiastic consensus on 10 questions. Ten was an arbitrary number, but it was important to keep the questions broad enough to encompass the field’s major questions about occupation and occupational therapy. At the same time, it was important to have few enough questions that they could be used for the many different communications purposes of the two organizations. Examples were written for each question, with the intent of conveying the specific types of research questions the field.
needs to address if answers to the 10 basic questions eventually are to be established.

1. Are occupational therapy interventions effective in achieving targeted activity and participation outcomes and preventing or reducing secondary conditions?
   Examples:
   a. Does employment of persons with mental illness in a community-based business lead to improved participation?
   b. What effect does the development of a daily occupational routine for a person with dementia have on the participation of the client and the client’s caregiver?

2. To what extent does occupation-based intervention promote learning, adaptation, self-organization, adjustment to life situations, and self-determination across the life span?
   Examples:
   a. How does engagement in meaningful activities foster development of roles that facilitate participation?
   b. Is there a set of occupational skills that facilitate transition in roles secondary to spinal cord injury?

3. Are environmental interventions that support occupation effective in preventing impairment and promoting activity and participation at the individual, community, and societal levels?
   Examples:
   a. What is the effectiveness of a training program designed for supervisors in welfare-to-work programs?
   b. What are the effects of specific classroom setups on school performance and behavior in children with attention deficit/hyperactivity disorder?

4. Where, when, how, and at what level (body structure/body function, activity, participation and environment) should an occupational therapy intervention occur to maximize activity and participation as well as cost-effectiveness of services?
   Examples:
   a. What impact do recess clubs have on social participation behaviors of children identified as having limited social skills?
   b. What impact does an occupational health program have on maintaining employee productivity levels and decreasing worker compensation?

5. What measures or measurement systems reflect the domain of occupational therapy and identify factors (body structure/body function, activity, participation and environmental) or document the impact of occupational therapy on these factors?
   Examples:
   a. How do we determine what occupations are meaningful to the client?
   b. What measures or measurement systems identify environmental variables and their impact on activity and participation?

6. How do activity patterns and choices (occupations) both in everyday life and across the life span influence the health and participation of individuals?
   Examples:
   a. How do parents play with their children, and how does this influence the health and participation of children?
   b. How do routines facilitate participation in every day life for persons with head injuries?

7. What is the impact of activity patterns and choices (occupations), both in everyday life and across the life span, on society?
   Examples:
   a. How does a parenting program for homeless mothers decrease child abuse and the tendency to violence?
   b. Do personally designed activity programs for elderly persons help improve their health and well-being and decrease demands on their caregivers and social systems?

8. What are the conceptual models that explain the relationships among body structure/body function, activity, participation and environment? What is the role of occupational therapy within these models?
   Examples:
   a. Does occupational therapy at the impairment level result in increased engagement in activities?
   b. Under what circumstances does occupational therapy at the participation level result in decreased impairment?

9. What factors contribute to effective partnerships between consumers and practitioners that foster and enhance participation of persons with or at risk for disabling conditions?
   Examples:
   a. Does the use of client-centered assessment and goal setting increase quality of life for clients?
   b. Do culturally sensitive settings, materials, and language affect the client’s willingness to engage in and follow through on recommended treatment interventions?

10. What factors support practitioners’ capacities to maximize the occupational performance of the persons they serve?
    a. What is the nature of the clinical reasoning used by the occupational therapy assistant?
    b. In what ways does a client-centered occupation-based curriculum influence intervention strategies a therapist chooses to address in support of the occupational performance needs of the client?

Appendix A
Consensus Conference Planning Committee
Bob Archey, Consultant
Janice P. Burke, PhD, OTR/L, FAOTA
Jean Deitz, PhD, OTR, FAOTA
Nedra Gillette, MEd, OTR
Cynthia J. Hughes-Harris, PhD, OTR/L, FAOTA
Deborah Lieberman, MHSA, OTR/L, FAOTA
Don Lollar, Consultant
Virginia C. Stoffel, MS, OT, FAOTA
Mary Jane Youngstrom, MS, OTR

Consensus Conference Participants
M. Carolyn Baum, PhD, OTR/C, FAOTA
Bette Bonder, PhD, OTR
Elizabeth Cada, MS, OTR/L, FAOTA
Elizabeth B. Crepeau, PhD, OTR, FAOTA
Cathy Dolhi, OTR/L
Joy M. Hammel, PhD, OTR/L, FAOTA
Betty Ristine Hasselkus, PhD, OTR, FAOTA
Sarah D. Herrfelder, MEd, MOT, OTR, FAOTA
Karen Johnson, OTR/L
Barbara Ann Larson, MA, OTR
Mary Law, PhD, OT(C)
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<tr>
<th>Name</th>
<th>Degree(s)</th>
<th>Certification(s)</th>
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</thead>
<tbody>
<tr>
<td>Mary C. Lawlor</td>
<td>ScD, OTR/L</td>
<td></td>
</tr>
<tr>
<td>Susanne Smith-Roley</td>
<td>MS, OTR</td>
<td></td>
</tr>
<tr>
<td>Charlotte Royeen</td>
<td>PhD, OTR</td>
<td>FAOTA</td>
</tr>
<tr>
<td>Barbara Schell</td>
<td>PhD, OT</td>
<td>FAOTA</td>
</tr>
<tr>
<td>Janette Schkade</td>
<td>PhD, OTR</td>
<td></td>
</tr>
<tr>
<td>Debee Slater</td>
<td>MS, OTR</td>
<td></td>
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<tr>
<td>Linda Thomson</td>
<td>MOT, OT, OT(C), FAOTA</td>
<td></td>
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<tr>
<td>Craig A. Velozo</td>
<td>PhD, OTR</td>
<td></td>
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<tr>
<td>Toni Marie Walski</td>
<td>MS, OT(C), FAOTA</td>
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