Participation in the Occupations of Everyday Life

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Participation or involvement in everyday occupations is vital for all humans. As described by the World Health Organization, participation has a positive influence on health and well-being. The presence of disability has been found to lead to participation that is less diverse, is located more in the home, involves fewer social relationships, and includes less active recreation. Occupational therapy is in a unique position to contribute to the development and fulfillment of participation for persons with and without disabilities. This article describes the nature and outcomes of participation. Characteristics to define and measure meaningful participation are outlined. Information about time use will help to develop an understanding of patterns of participation across locations, gender, culture, and the life span. Factors that affect participation within the environment, family, and persons are summarized. Occupational therapy research is needed to examine the complex relationship among person, environment, and participation in occupations. In practice and education, knowledge about participation can enhance the client-centered and evidence-based nature of occupational therapy services.


Definition of Participation

It is useful to consider the origins, or etymology, of the word participation. Participation originates from Latin—derived from participēs meaning part-taking, and pars + capere, meaning to take or to share in. Common English definitions...
include to take part in or become involved in an activity; the state of sharing in common with others; and the act or state of receiving or having part of something (Simpson & Weiner, 2002). Thus, the central concept in participation is involvement or sharing, particularly in an activity. What is important to note about these definitions is the focus on both the nature and the extent of involvement, with qualitative and quantitative implications.

Framework of Participation

The World Health Organization (WHO) has recently focused attention on participation with the development of the new International Classification of Functioning, Disability and Health (ICF; WHO, 2001). The WHO defines participation as involvement in a life situation. In the ICF, participation is categorized into domains: learning and applying knowledge; general task and demands; communication; mobility; self-care; domestic life; interpersonal interactions and relationships; major life areas such as work or school; and community, social, and civic life (WHO, 2001).

The development of the ICF involved occupational therapists from several countries and has important implications for our work. The ICF provides a common language to describe how people live with a health condition, and it will be used in the measurement of health outcomes. The increasing emphasis on participation by the WHO, governments, and health and social systems makes it all the more important that we understand participation, what it means, how we measure it, and what facilitates it. Such an understanding needs to focus across the whole spectrum of human populations, not solely on those with disabilities.

Nature of Participation

The nature of participation is worthy of consideration and reflection. How is it described? What are the outcomes of participation? What characteristics define meaningful participation? How is participation measured? What do we know of the typical patterns of participation?

Current research from the CanChild Centre for Childhood Disability Research has described types of participation (Law et al., 2000). In this typology, participation is defined as involvement in formal and informal everyday activities. Formal activities include structured activities that involve rules or goals and that have a formally designated coach, leader, or instructor (e.g., music or art lessons, organized sports, youth groups). Informal activities have little or no planning and often are initiated by the person him- or herself (e.g., reading, hanging out with friends, playing). Participation occurs across many locations, including environments for work, school, play, sport, entertainment, learning, civic life, and religious expression.

Outcomes of Participation

What is known about the outcomes of participation in everyday occupations? Research has shown consistently that participation in meaningful occupations, particularly work and leisure, has an important, positive influence on health and well-being (Freysinger, Alessio, & Mehdizadeh, 1993; Garton & Pratt, 1991; Larson & Verma, 1999; Law, Steinwender, & Leclair, 1998). Participation is a vital part of the human condition and experience—it leads to life satisfaction and a sense of competence and is essential for psychological, emotional, and skill development.

In children, studies of high risk and resilience have found that participation in extracurricular activities decreases the incidence of behavioral and emotional difficulties (Rutter, 1990; Stewart, Reid, & Mangham, 1997). Competent participation in activities buffers the effect of living with a parent who has a mental illness (Rutter, 1990). Masten and Coatsworth (1998) found that activity participation by youth leads to decreased numbers of school dropouts, improved engagement in school, and more effective social relationships with peers.

Currently in Canada, the National Longitudinal Survey of Children and Youth is surveying 23,000 randomly selected children and youth 4 to 15 years of age every few years (Statistics Canada, 2001). Data from this survey indicate that 87% of these children and youth participated in organized activities outside of school; few differences have been found between genders, with the exception that boys participate more in organized sports and girls more in arts and music and in clubs. Youth who had participated but stopped are three times more likely to have lower self-esteem, have difficulty making friends, smoke, and perform poorly in reading and math (Statistics Canada, 1999).

For adults, recreation and leisure participation is significantly related to the development of social support networks and to quality of life and well-being. Freysinger et al. (1993) found that participation by older adults is positively associated with indicators of mental and physical health as well as with life satisfaction, that participation decreases as people get older, and that participation by men is less than by women. Research indicates that older adults who volunteer live longer than those who never perform community service (Menec & Chipperfield, 1997). Although fewer studies have been done of persons with disabilities, Viemero and Krause’s (1998) study of quality of life of persons with physical disabilities found that life satisfaction was significantly associated with occupational status,
involvement in meaningful activities, and social integration.

A recent headline in the popular literature read, “Believe It or Not—This 91 year old Nun Can Help You Prevent Alzheimer’s” (Lemonick & Mankato, 2001). Although dramatized for the media, Snowdon’s (1997) longitudinal study of nuns indicates that factors such as education and participation in activities that stimulate the brain (e.g., puzzles, learning new skills) may be protective and enhance participation for persons with and without disabilities. Research in occupational therapy also supports the positive effects of engagement in occupation for persons with and without disabilities (Baum, 1995; Baum, McGary, Pankiewicz, Braford, & Edwards, 1996; Clark et al., 1997; Clark et al., 2001).

Although participation is known to enhance life quality, evidence also exists that lack of participation or occupational deprivation leads to poor health and well-being. As Whiteford (2000) stated:

Occupational deprivation is, in essence, a state in which a person or group of people are unable to do what is necessary and meaningful in their lives due to external restrictions. It is the state in which the opportunity to perform those occupations that have social, cultural and personal relevance is rendered difficult if not impossible. It is a reality for numerous people living around the world today. (p. 200)

Indeed, many examples of disruption and deprivation in occupation exist in the world today, including persons who are unemployed, refugees, minorities, living in areas of conflict, and living with disabilities.

Essential Characteristics of Participation

What characteristics define meaningful participation in the occupations of everyday life? A need exists for both satisfaction and individually determined balance in the daily constellation of our occupations (Christiansen, Backman, Little, & Nguyen, 1999; Jonsson, Moller, & Grimby, 1999). To achieve meaningfulness in an occupation, a balance between the challenge in the activity and the skills of the individual is required (Moneta & Csikszentmihalyi, 1996). The goals must be clear to the participant, and feedback about performance must be quick and accurate. Csikszentmihalyi and colleagues have studied how people experience “flow” from participation in occupations and found that flow occurs more often in structured activities where there is more control, such as games, work, sports, artistic activities, and ritual events (Csikszentmihalyi, 2000; Csikszentmihalyi & LeFevre, 1989). For participation to be meaningful, there must be a feeling of choice or control over the activity, a supportive environment to facilitate easy attention to the activity, a focus on the task and not on the long-term consequences, a sense of challenge from the activity, and a sense of mastery. This is what occupational therapists term the “just right” challenge.

How Participation Is Measured

Because participation in occupations is complex, weaving a pattern across time and space, capturing its essence through measurement, is challenging. Participation in occupations has several dimensions: the person’s preferences and interests; what he or she does, where, and with whom; and how much enjoyment and satisfaction he or she finds. In considering person, environment, and occupation, the measurement of participation occurs at the transactions between these domains.

Currently, there is increasing interest and work in the measurement of participation. At a general population level, time-use surveys have been implemented in many countries to gather specific information about how people spend their time. The surveys typically use diary formats or telephone-based recall. The United Nations has a Web site listing of time-use surveys from around the world (United Nations Statistics Division, 2002). The difficulty with time-use surveys is that they rarely provide information about activity preferences, meaning, and enjoyment.

Other measures are being developed and validated for use with adults, including the Craig Handicap and Assessment Reporting Technique (Whiteneck, Charlifue, Gerhart, Overholser, & Richardson, 1992), the Community Integration Questionnaire (Willer, Rosenthal, Kreutzer, Gordon, & Rempel, 1993), the Community Integration Measure (McCull, Davies, Carlson, Johnston, & Minnes, 2001), the Life Habits Assessment (Fougeyrollas et al., 1998), and the National Institutes of Health Activity Record (Gerber & Furst, 1992).

Fewer measures exist for children. One example is a newly developed measure, the Children’s Assessment of Participation and Enjoyment (CAPE; King et al., 2002). The CAPE consists of cards that have drawings of children and youth doing different activities in their time outside of formal school and gathers data about participation frequency, enjoyment, location, and with whom participation is done. Continued development of participation measures is needed across all ages.

Typical Patterns of Participation

It is important for occupational therapists to develop an understanding of patterns of participation across locations, gender, culture, and the life span. What is known about typical patterns of participation?

Larson and Verma (1999) reviewed how children and adolescents around the world spend their time and noted
many differences and changes across countries. For example, they noted that the amount of time spent in children’s play increases as societies transition from nonliterate to literate. Participation in organized sports has risen over the past 2 decades, with time spent in other activities such as hobbies or art and outdoor activities declining. In teenagers, girls participate in fewer activities than boys (Huston, Wright, Marquis, & Green, 1999). Posner and Vandell (1999) found developmental changes in participation, with unstructured activities decreasing over time and social activities increasing. On average, youth spend 20% of their time watching television. Youth in America are spending less time with their parents (Roth & Brooks-Gunn, 2000). The National Longitudinal Study on Adolescent Health in the U.S. found a direct relationship between high rates of smoking, drinking, marijuana use, and fights and not eating dinner with a parent five or more times a week (Council of Economic Advisors, 2000).

For adults, there is information about average time spent in different occupations (see Table 1). Adults increasingly describe themselves as time stressed; work time is increasing, and leisure time is decreasing. Evidence shows that these trends are similar, if not accelerated, in the United States (Robinson, 2002). A national study of time use in the United States is planned to occur over the next 2 years.

For older adults, overall patterns of participation remain similar, but time spent in specific occupations decreases. For example, in the United States, participation in sports events, amusement parks, playing sports, and computers and hobbies begins to decrease after age 55. Participation in exercise programs remains remarkably constant until age 75, along with participation in charity work, home improvement and repairs, and attendance at movies (U.S. National Endowment for the Arts, 1997).

Research indicates that across all ages, a strong association exists between interests and participation. A greater number of interests usually lead to increased participation, although this pattern is nonlinear in nature (Garton & Pratt, 1991).

Life Span and Disability: Effect on Participation

During their lifetime, people are exposed to different occupations and develop likes and dislikes. Customs and expectations from their culture influence what they learn and do every day. Each person has unique interests and occupations through which they find satisfaction. They live in different environments and take on different roles as they grow up. What they do every day, how well they do it, and how much they enjoy the occupations of everyday life depend on their place, age, family, communities, environmental supports, and other issues such as disability. It is important to examine what is known about the effect of disability on participation across the life span.

Children

Studies of children’s activity patterns show that children with disabilities participate in fewer active recreation activities; household tasks; and social engagements, particularly informal social activities, than children without disabilities (Brown & Gordon, 1987; Law et al., 1999; Sloper, Turner, Knussen, & Cunningham, 1990). In a study of youth with and without disability, Henry (1998) found that interests of these two groups had many similarities; the top four interests were listening to music, hanging out with friends, watching television, and talking on phone. However, research also indicates that participation changes as children with disabilities move into adolescence, with fewer activities occurring outside the home (Brown & Gordon, 1987). A current study of the participation of children and youth with disabilities 6 to 15 years of age found that these children participate in a broad range of formal and informal activities (Law et al., 2000). Informal activities are performed more often. There appear to be significant differences in informal activity intensity and enjoyment across age groupings, with participation in informal activities decreasing significantly as age increases.

Adults and Older Adults

Across North America, an average of 15% of adults 25 to 64 years of age report a disability that affects everyday activities (U.S. Census Bureau, 2001). This statistic rises to more than 38% for people over 65 years of age (U.S. Census Bureau, 2001). Adults and older adults with disabilities experience restricted participation and social isolation and engage in more passive activities (Blake, 1995; Dunn, 1990; Idler & Kasl, 1997). In a study of time use of 312 men with spinal cord injury, Pentland, Harvey, Smith, and Walker (1999) found that most time is spent in leisure occupations,
followed by productivity and personal care. Men with spinal cord injury spend 39% more time on personal care, 20% more time in leisure, and 40% less time in productivity than men without spinal cord injury.

In summary, disability has a substantial and prolonged effect on participation across all age groups. A significant association exists between disability severity and social isolation. The presence of disability has been found to lead to participation that is less diverse, is located more in the home, involves fewer social relationships, and includes less active recreation.

Factors That Influence Participation

Knowledge about factors that affect participation can help to develop a more in-depth understanding of how participation evolves. It is important to know what environmental, family, and personal factors facilitate participation. As well, what are the most important barriers?

Environment

Researchers in social ecology have investigated environments and their effects on behavior. Using streams of behavior recording, they discovered that environmental settings such as coffee shops, recreation centers, churches, or bowling lanes lead to persistent behaviors (e.g., level of noise, degree of formality) that remain constant for years in particular settings (Barker, 1978). Over our life span, we learn these patterns of behavior and activity through socialization; therefore, experience in a wide variety of settings is essential for the development of participation patterns and interactions with others encountered in daily life routines.

What do we know about the effects of environments on participation for persons with disabilities? Through his analysis of classification practices used for social restraint (e.g., persons with disability as a minority group), French historian and philosopher Michel Foucault asserted that power and knowledge have been used to develop a society and health care system that marginalizes people who are different from the “norm” (Foucault, 1973, 1975).

Indeed, research has shown that institutional environmental factors (economic, political, attitudinal) significantly affect the participation of persons with disabilities (Law et al., 1999). Issues of poverty, cost of programs, affordable housing, lack of information and physical assistance, lack of inclusion of persons with disabilities in planning, and staff training and attitudes limit participation (Dunn, 1990; Imrie & Kumar, 1998; LaPlante, Kennedy, Kaye, & Wenger, 1996).

The social environment, in particular social attitudes and availability of social support, are particularly important in facilitating participation. One of the most interesting findings is that believing that people could become involved has important positive effects on participation and success in life (King, Cathers, Polgar, MacKinnon, & Havens, 2000). Social support, including a relationship with a caring adult, promotes development and adaptation in children and youth with disabilities (Masten & Coatsworth, 1998). Research on resilience cites major environmental risk factors such as poverty, a violent neighborhood, a peer group that acts as a barrier to participation; protective factors include school experiences, work outside home, participation in extracurricular activities, and a good relationship with other adults (Rutter, 1990). In a study of 2,812 community-dwelling older adults, Idler and Kasl (1997) found a significant association between higher levels of religious participation and social activity and social support—social support has been shown to be a predictor of health and well-being.

Constructing the built environment to suit the needs of the average person restricts accessibility. On a broad level, we must consider societal production of space or the whole organization of our cities and towns, including places of employment, households, shopping districts, and transportation networks. For example, over the past century, changes in economic activity have led to greater spatial separation of work and home, resulting in greater travel distances and transportation difficulties for families and persons with disabilities. Participation is affected by location. For example, Garton and Pratt (1991) found that rural schools had more sports in their school activities but less overall participation. The separation of private and public space, decreased political influence of the family, and accessibility difficulties combine to impede the inclusion of persons with disabilities. Often, institutional attitudes limit accessibility rather than technological capability.

Family

No matter what our age, family and persons close to us have a major impact on our participation. First, family socioeconomic status has been shown to determine participation. For example, children’s participation in sports and other community programs is directly influenced by income, differential availability of opportunities, values, and role models (Law et al., 2000). The presence of psychosocial support from family members or close friends promotes participation. For example, Loomis, Javoransky, Monahan, Burke, and Lindsay (1997) found that a supportive family environment improves employment, mobility in the community, and social activity for young adults with spina bifida.

Families who live with persons with disabilities experience increased demands on their daily occupational routines, leading to changes in patterns of family participation,
with more involvement of small groups within the family in activities rather than the whole family (Crowe, 1993; Laws & Radford, 1998; Mactavish, Schleien, & Tabourne, 1997). Participation also is influenced by family preferences. For example, children with Down syndrome whose families prefer active recreational activities participate more frequently in organized activities (Sloper et al., 1990).

In summary, across the age spectrum, families who function well and provide clear expectations and positive support to persons with disabilities help to reduce the risk of limited participation.

**Person**

Among personal factors, it is common to think that a person’s skills are the most important influence on participation, but other factors are equally influential. Gender is an important factor, particularly for leisure participation (Freyssinger et al., 1993; Garton & Pratt, 1991). A person’s preference for participation significantly affects choice and actual participation. Similarly, sense of control and competence often determine participation and enjoyment (Kimieck, Horn, & Shurin, 1996; Lovell, Datillo, & Jekubovich, 1996).

Skills and abilities, particularly interpersonal, communication, problem solving, and decision making, are important factors in determining participation. Studies of adults and older adults indicate that difficulties in performing activities of daily living (ADL), decreased mobility, and depressive symptoms are associated with less participation; whether they are causal in nature, we do not know (Idler & Kasl, 1997; Patrick, Kinne, Engelberg, & Pearlman, 2000). What the effect of severity of disability and condition has on participation is less clear, as some research, particularly with children, indicates that environmental and family factors are more influential (Law et al., 1999). The impact of functional abilities may be differential. For example, Mancini, Coster, Trombly, and Herren (2000) found that physical variables predicted limited school participation, whereas both physical and cognitive-behavioral factors predicted full participation.

Participation is a complex issue, with many factors influencing the occupations that a person does every day. Examination of the literature is helpful in identifying factors that appear to have the most important relationship and influence on participation (King et al., in press). These include environmental factors (e.g., the physical accessibility of buildings, attitudes of community members), family factors (e.g., parents’ own interests in recreation), and personal factors (e.g., the child’s physical function or social competence). More knowledge is needed about the relative influence of these factors on participation.

**Implications for Occupational Therapy**

Knowledge gained from research about participation is only useful if we look at how it can positively affect occupational therapy education, research, and practice. What are the implications for what occupational therapists do every day?

In the area of research, developing an understanding of how factors work together to influence participation is paramount. The use of qualitative methods and more complex quantitative methods will enable researchers to disentangle the complex relationship among person, environment, and participation in occupations. Without such information, the focus of occupational therapy interventions may not be targeted effectively. For example, the largest part of therapy practice focuses on developing abilities in ADL. Research on participation may indicate that skill in ADL is much less important for participation than program availability or knowledge and beliefs of program staff members. This kind of information provides evidence to support innovative approaches to occupational therapy intervention.

A great tendency exists in research to do only what is considered possible. What can result is research stating the correlations of many variables to each other without examining their relative contribution to outcome. Although this statement sounds harsh, it highlights the need to acknowledge the complexity of the human experience with occupation and to develop research strategies to fit. Researchers also have a responsibility to communicate findings in ways that are easily understood and that can be put into everyday practice.

For education and practice, occupational therapy, at its best, is informed by our values, knowledge, and reasoning about participation in everyday occupations. First, *occupational therapy, at its best, is evidence-based and client-centered*. As Dunn (2000) wrote:

Best practices are a professional’s decisions and actions based on knowledge and evidence that reflect the most current and innovative ideas available. Best practice is a way of thinking about problems in imaginative ways, applying knowledge creatively to solve performance problems while also taking responsibility for evaluating the effectiveness of the innovations to inform future practices. (pp. 1–2)

Evidence indicates that a client-centered approach to occupational therapy practice leads to greater satisfaction with services and improved outcomes for clients and their families (Law et al., 1998).

*Occupational therapy, at its best, focuses on occupations important to each person within his or her environment. Through a focus on choice, therapists facilitate control for persons receiving our services. Participation in occupations...*
is the experience of how everyone seeks meaning in life. It can delight—it can defeat. Participation implies being involved, making choices, and taking risks. Clients of occupational therapy services deserve no less from therapists. There are reliable and valid methods by which clients can identify occupations important to them but with which they are encountering difficulty (McCull & Pollock, 2000). The goals identified by clients may be more challenging for us as therapists: Facilitating play is more challenging than focusing on developing fine motor skills. But the process of a client setting goals focuses occupational therapy intervention, enhances motivation, and saves time. Resilience is fostered when a person has control over his or her participation and can affect how it is shaped within his or her life (Rutter, 1993).

**Occupational therapy, at its best, acknowledges the power of engagement in occupation.** If a clear message has come from research over the past decade, it is that performance of an activity is best learned by practicing the activity itself. Research in motor learning (Ma & Trombly, 2001; Ma, Trombly, & Robinson-Podolski, 1999), critical reviews of interventions (Baker & Tickle-Degnen, 2001; Carlson, Fanchiang, Zemke, & Clark, 1996; Law et al., 1998; Murphy & Tickle-Degnen, 2001), studies of the effect of activity for persons with and without disabilities (Baum, 1995; Clark et al., 1997, 2001; Everard, Lach, Fisher, & Baum, 2000), and information about the effects of disruption in occupation (Whiteford, 2000) all confirm the powerful effects of engagement in occupation. Patterns of social restriction and isolation begin very early, whether early in life or early after a significant disruption in occupation, supporting the need for early intervention (Blake, 1995; Brown & Gordon, 1987).

**Occupational therapy, at its best, recognizes the force of the environment as a means of intervention.** For participation, interests often precede participation, but interests may not lead to participation because of environmental barriers. Focusing intervention on changing environments has potential to enhance outcomes (Law, 1991). For example, Strong (1998) recently found that persons with severe mental illnesses working in an affirmative business environment experienced positive changes in their sense of self-efficacy and participation. Mann, Ottenbacher, Fraas, Tomita, and Granger (1999) found that assistive technology and environmental modifications in the home maintain function and reduce health care costs in frail older adults. In a randomized trial examining outreach services linking adults after traumatic brain injury to community services, Powell, Heslin, and Greenwood (2002) found that this focus of intervention led to significant improvements in activity and participation.

**Occupational therapy, at its best, has a broad intervention focus.** Although occupational therapists spend time focused on specific areas of occupation, such as ADL or work, we rarely look at occupational routine and overall use of time. How a person focuses his or her time in order to participate is an important focus for occupational therapy. A focus on participation enlarges the scope of interventions to include organizations and community agencies where factors that hinder participation can be addressed. Emerging research indicates that this community-based approach may be more effective than institutionally based interventions (Clark et al., 1997; Helewa et al., 1991; Powell et al., 2002). We will understand that there are multiple risk and protective factors for participation; intervention can focus on cumulative protection through decreasing risk, increasing resources, and facilitating protective processes.

**Occupational therapy, at its best, measures outcomes of participation.** A client-centered approach to occupational therapy intervention will naturally lead us to measure outcomes of occupational performance and participation. As outcome measures increase in their sophistication, therapists will be able to evaluate the effects of interventions on participation, an outcome most meaningful to persons with disabilities and their families.

Facilitating participation in everyday occupations is the reason for occupational therapy. As Wilcock (1998) noted: Occupational therapists are in the business of helping people to transform their lives through enabling them to do and to be. We are part of their process of becoming and we should constantly bear in mind the importance of this task. (p. 248)

**Occupational therapy, at its best, focuses on occupations important to each person within his or her environment.** The person receiving occupational therapy services leads the way in making decisions about the focus and the nature of therapy intervention. The relationship among that person, his or her family, and the occupational therapist is a collaborative partnership, the goal of which is to enhance health and well-being through participation.

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