What is Cognition?

Cognition is ‘the process of obtaining knowledge through thought, experience and the senses’ (Oxford English Dictionary 2005). It derives from a Latin verb, the meanings of which include to get to learn, to recognise and to find out.

Cognition is studied in many different disciplines and the meaning varies when applied to psychology, philosophy, linguistics or computer science. For example, in computer science, cognition includes the development of artificial intelligence and robotics.

But our understanding of cognition draws upon health science, neuropsychology and the concept of occupational performance. As therapists, we need to understand how the brain functions and subsequently dysfunctions following neurological insult, in specific cognitive modalities such as attention, memory and purposeful movement. Then we need to apply this knowledge of cognitive body functions to understand how people use them to build skills and to perform activities within the context of their everyday life.

There are different ways to classify cognitive functions and some of these debates will be evident in Part 2 when we seek definitions of ‘individual’ impairments. For the purposes of this introduction, when answering the question ‘What is cognition?’, let us consider two main groups. First, there are the broad cognitive functions which, it could be argued, are the foundation stones for our function, comprising consciousness, orientation, intellect, psychosocial skills, temperament and personality, energy, drive
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and sleep (WHO 2001). Second, there are specific cognitive modalities, the building blocks for our function, comprising attention, memory, psychomotor functions, emotions, perceptual skills across all the senses, higher level skills (executive functioning), praxis and experience of self and time (WHO 2001). Our ability to interact in a meaningful way, within our environment, is dependent on a complex interplay of these skills.

The Functional and Social Impact of Cognitive Impairments

The impact of cognitive impairments on the individual, their partners, family and friends can be significant. The lived experience allows us some insight into the real story.

### The lived experience of cognitive impairments (adapted from Erikson and Tham 2010; Gelech and Desjardins 2011; Lorenz 2010)

| I can get tired, irritable and worried because basic activities need more energy, planning and attention. These difficulties have persisted and sometimes I feel out of control. I wonder about the sort of person I have become but I recognise my old self when I do my previous occupations: ‘I am a customer; yes I can be that for a while’. I use tricks so I can remember to do things like setting the table; sometimes I need them but not always. Living with the effects of brain injury is like living in a fog; sometimes my head is scrambled and the shell of my life is broken. I think about my lost dreams and feel the chaos of my daily life. But I compensate for this; I put labels on things, I use a timetable and all the time I’m developing a new identity. I’m building a new self now, with elements of my old self and new bits, some are good and some are not so good. But I need to accept the death of my old self. |

The need for cognitive rehabilitation may be self-evident. But there is debate about what it is and the contributions made by occupational therapy. Within all forms of rehabilitation, models and frameworks help us to conceptualise the processes involved (Wilson 2002) and to think about how and why we should assess, intervene and evaluate. Of great importance is that they help us, as therapists, to understand and articulate the impact of, for example, cognitive impairments on an individual and their family.

To this end, Chapter 1 will start with a brief debate on what comprises cognitive rehabilitation and the unique role for occupational therapy within the process. Specific theoretical frameworks and models will be described in terms of their usefulness to aid our clinical reasoning and then applied to the occupational therapy process, to demonstrate the need to embed our clinical practice within the theory base. Finally, this chapter will summarise why it is essential for occupational therapists to understand the nature of cognitive impairments.

The Scope of Cognitive Rehabilitation

Cognitive rehabilitation draws upon theories from a number of disciplines including neuropsychology, occupational therapy, speech and language therapy and special education; therefore it is not the exclusive domain of one profession. A single definition of
cognitive rehabilitation remains elusive; indeed, it has been questioned whether the term itself should be replaced by ‘rehabilitation of individuals with cognitive impairments’ (Sohlberg and Mateer 2001). This is of particular relevance to occupational therapists where the focus of rehabilitation belongs with the individuals in their context, rather than ‘treating’ impairments per se.

But Wilson (2002) argues that, in its broadest sense, cognitive rehabilitation should be defined as a process which focuses on real-life, functional problems and is collaborative, involving the individual, their relatives, the multidisciplinary team and the wider community.

In his seminal paper, in 1947, Oliver Zangwill (an influential British neuropsychologist) also spoke about the need to ‘join forces’ for the rehabilitation of psychological aspects in cases of brain injury. He outlined three activities comprising the scope of psychological rehabilitation: compensation, substitution and direct training. They are worthy of a brief exploration here as the different levels of intervention proposed by Zangwill (1947) resonate with current clinical practice, as will be explored further in Chapter 3. Zangwill defines direct retraining as an attempt to re-educate and remediate the actual impairment, more successful, he noted, in physical aspects of therapy. Substitution seeks to offer an alternative solution to solve the problem but in practice is likely to be a refined version of the final activity. Compensation aims to introduce new internal or external approaches to solve problems, despite the persistence of the underlying impairment.

Current evidence-based guidelines support comprehensive holistic rehabilitation using compensatory strategies, including Zangwill’s concept of substitution, to manage the risks associated with cognitive impairments in multiple sclerosis (NICE 2014); to help people with their occupational performance post stroke (Gillen et al. 2014); or to compensate for any impairment affecting activities or safety (Intercollegiate Stroke Working Party 2016).

Cognitive Rehabilitation and the Role of Occupational Therapy

Occupation is defined as a ‘group of activities that has personal and sociocultural meaning, is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure’ (Creek 2010). But there are a number of definitions to expand upon and challenge our understanding of occupation in the literature, a debate of which is beyond the scope of this text. However, at the heart of the concept is the understanding that occupations are everything people do to occupy themselves while contributing to the communities in which they live (Law et al. 1997, p. 32).

That any health problem can have implications for all aspects of life, and not just the physical and mental state of the individual, is now an accepted view. It is endorsed and embodied within the World Health Organisation’s definition of health (1946) as: ‘... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.

By accepting the definitions of occupation and health given above, it can be appreciated that the occupational components of an individual’s life become central to health and well-being.
For individuals with neurological damage, cognitive impairments are often the source of functional problems but they are unseen, difficult to manage or misunderstood. Poor task performance, in the absence of motor deficits, may originate in poor object recognition or an inability to sequence. The man who cannot recognise his partner’s face may be mistakenly labelled with memory loss rather than prosopagnosia. The older woman who does not respond to questions may have an attention problem which is often confused with deafness. Also there are several possible reasons which may account for a previously independent widower, who lives alone, being unable to organise his daily routine.

Disorders of brain structure or function, inherited or acquired, may give rise to difficulties in the ways in which people think, feel and/or act. These difficulties can cause loss of, or difficulties in, the abilities to acquire or maintain skills. This results in changes in the social, economic and home circumstances of the individual and his family, some of which were outlined in ‘The lived experience,’ above. Within the context of occupation, cognitive deficits are likely to impact on some, if not all, aspects of life. Occupational therapy forms a significant component of rehabilitation.

Occupational therapists engage with people as patients, clients, students, workers and family members, in a range of environments such as hospitals, community resource centres, schools, the workplace and the home. Hence, occupational assessment becomes paramount to investigate the full impact of cognitive deficits upon the life of the affected individual, and also upon the people with whom he/she relates and interacts.

The scope of cognitive rehabilitation arguably embraces virtually all aspects of life. Assessment is only one part of a process that seeks to enable an individual to function optimally within his or her usual environment(s), to maintain health and well-being, and engage in valued occupations (Crepeau et al. 2003). The causes (for example, traumatic brain injury, cerebrovascular disease, infection) and the nature of cognitive deficits may require intermittent or long-term engagement with rehabilitation and/or support services, at any point in life.

**Cognition, Occupation and the International Classification of Functioning, Disability and Health**

Effective therapeutic intervention requires a means of gathering and organising information (a framework). This needs to address not only neurological functioning but also the individual’s capacity for and ability to engage and participate in necessary and valued occupations. It requires the means to address the interrelationship of the person and his occupations with the environments and contexts in which they occur.

Occupational therapists have become accustomed to working within frameworks derived from theoretical models of practice and profession-specific theories of human occupation. In parallel, since 2001, the World Health Organisation (WHO) endorsed a framework and detailed classification for the description of all aspects of health and related factors, for use across a range of organisations and within multidisciplinary teams.

The International Classification of Functioning, Disability and Health (ICF) (WHO 2001) is a multipurpose system of classification developed through international collaboration, including disability rights groups and carer organisations, that codifies
health and health-related aspects of human life. Its chief aim is to provide a common language of concepts, definitions and terms for examining health and the individual’s ability to function within their sociocultural context. It is designed to do so in a way that transcends other unidisciplinary models or frameworks and provides for:

- clear communication between professionals, different agencies, the public and service users
- comparison of data from disparate sources (different countries, different healthcare disciplines);
- systematic coding for health information systems.

In so doing, the ICF also provides a framework for systematic examination and communication of the relationship between disorders of health, the ability to undertake occupations, and the interaction of the individual with the environment.

The ICF is introduced here as a means to facilitate and enhance the assessment, rehabilitation and support of people with cognitive impairments. It is a biopsychosocial framework, as outlined in Figure 1.1, but also a detailed classification that allows a holistic and comprehensive approach to identifying, measuring and intervening with health-related difficulties for any individual, considering health in relation to activities, participation and contextual factors (environment and personal factors).

The use of the ICF has been endorsed by the World Federation of Occupational Therapists, with strong evidence to demonstrate that it has already been adopted by occupational therapists and multidisciplinary teams worldwide (Jelsma 2009; Pettersson et al. 2012). The National Clinical Guidelines for Stroke for England and Wales also recommend the framework and classification as a basis for multidisciplinary team (Intercollegiate Stroke Working Party 2016). And, in the UK, the College of Occupational Therapists has utilised the ICF language in the SNOMED clinical terminology OT subsets. SNOMED CT stands for the Systematized Nomenclature of Medicine Clinical Terms; it is available in more than 50 countries and has been adopted as the standard

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**Figure 1.1** The International Classification of Functioning, Disability and Health (ICF). Source: WHO (2001). Reproduced with permission of the World Health Organisation.
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clinical terminology for the NHS in England. Further harmonisation between the ICF and SNOMED CT in relation to occupational therapy is planned (Austin 2011). Therefore, the use of the ICF is globally endorsed within our profession, within health and social care teams and between different agencies.

The ICF is structured in two parts. Part 1 classifies and defines body structures and functions, and human activities and participation (in life situations). Part 2 classifies and defines contexts of human function – environmental (external influences) and personal (or internal) influences. The entire classification, which is updated as it evolves, is available to browse online at http://apps.who.int/classifications/icfbrowser/.

Within each component of the ICF, all terms are clearly defined and broken down further. All elements are coded so that, for example, within the component of ‘Body functions’ we find ‘Mental functions: specific mental functions,’ within which b140 is the code for ‘Attention functions’ defined as: ‘Specific mental functions of focusing on an external stimulus or internal experience for the required period of time.’ Further classification detail is provided for some categories so, returning to the attention example, it is further subdivided into:

- b1400 Sustaining attention
- b1401 Shifting attention
- b1402 Dividing attention
- b1403 Sharing attention
- b1408 Attention functions, other specified
- b1409 Attention functions, unspecified

The ICF in Relation to Occupational Therapy Frameworks

From a rehabilitation perspective, the ICF categorises and codifies all components of a person’s life that could be affected by health status, or could in turn have an effect upon health. In the case of people with impairments of cognitive functions, it facilitates the assessment of and intervention planning for consequent activity limitations and participation restrictions. It also enables the exploration of environmental facilitators and barriers within an individual’s context. It has been shown to enhance holistic thinking within the stroke multidisciplinary team and clarify team communication and roles (Tempest et al. 2013). Therefore, it is an effective framework and classification to use when seeking to raise awareness of the nature and impact of specific cognitive impairments within the multidisciplinary team. But there are limitations, including the as yet unclassified personal factors component, which warrants an occupational therapy-specific model or framework to be used in conjunction.

Within its framework, the ICF includes all those human activities, tasks and roles that conventionally fall within the professional domain of occupational therapists. The UK College of Occupational Therapists (COT) considers the ICF useful to ‘shift the concept of health and disability from cause to impact by considering the issues and problems for individuals within their own context rather than by medical diagnosis’ (COT 2004, p. 3). In support of this assertion, it can be seen that the classifications used by the ICF usefully parallel current occupational therapy concepts and definitions of humans as occupational beings.

Frameworks of practice utilised by occupational therapists have incorporated large sections of the ICF into their structures, making it possible to translate profession-specific information into, and draw such information out of, this multiagency, multidisciplinary
and internationally recognised format. But because of its multipurpose, multiprofessional nature, the ICF cannot and does not seek to incorporate all possible variations upon categorisation of the human state. Therefore, to do this, each healthcare profession will require focus and specificity upon different aspects and will need its own language and concepts.

In short, the ICF is inadequate to articulate everything we do. So, the Occupational Therapy Practice Framework (OTPF), produced by the American Occupational Therapy Association (AOTA 2014), will also be considered.

In contrast to the ICF, the OTPF specifies the need for occupational therapists to analyse activities in terms of their properties and demands upon the individual, as well as the individual’s ability to perform the activity. Hence, performance skills, performance patterns and activity demands are components of and demands upon human functioning that do not map neatly onto the ICF framework. However, they reflect the enhanced detail and performance-related information needed by occupational therapists in the analysis of an individual’s functional needs and performance difficulties. This further justifies the need to use the ICF, within a multidisciplinary team context, and a profession-specific framework in conjunction with each other. The OTPF articulates the domain/remit of occupational therapy as well as detailing the occupational therapy process as summarised in Figure 1.2.

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Figure 1.2 Occupational Therapy Practice Framework (OTPF). Source: AOTA (2014). Reproduced with permission of AOTA.
The ICF and the OTPF frameworks will be used to inform our discussions about the role and functions of occupational therapy in cognitive rehabilitation. There are other frameworks that could also be considered, for example, the European Conceptual Framework for Occupational Therapy (Creek 2010). Readers are encouraged to consider which occupational therapy-specific framework or model, in conjunction with the ICF, best meets the needs of their specific clients and services.

**Applying Theoretical Frameworks**

Most students and practitioners of occupational therapy use a range of theoretical models and frameworks to delineate, organise and understand the occupational needs and problems of the individuals and groups of people with whom they work. The ICF and the OTPF help us to organise large and sometimes disparate amounts of information in a systematic way, and to identify the relationships between them. What these frameworks do not do is provide theories or explanations about why a particular phenomenon or relationship exists, nor do they promote or guide the therapist as to all the tools, methods or techniques they might use to address an individual's occupational needs and problems. These latter functions are served by theories of cognition, rehabilitation and the tenets of the occupational therapy profession. These are explored further in Chapter 3 and throughout Part 2.

The use and value of the ICF and OTPF can be illustrated by a case example. First, the applicability of the ICF will be considered.

### Case study

Mr B is a 35-year-old man who sustained a traumatic brain injury when he was knocked off his bicycle by a car. He sustained some soft tissue injuries (bruising and cuts) but these resolved quite quickly. He worked serving customers in a fast food restaurant, and lived with his parents. Mr B was discharged home after two weeks in hospital and referred to the community rehabilitation team which included an occupational therapist. At initial interview, Mr B identified some difficulties with his memory. His parents had observed changes to his behaviour – a lack of initiative in self-care and domestic tasks, and a tendency to be forgetful and easily distracted from the task in hand – which Mr B did not acknowledge. Further specific assessments identified some difficulties with recall and recognition, problem solving, abstract thinking and calculation. Other aspects of cognition, for example short-term memory, sequencing and simple maths skills, were within normal limits.

### Activity

Using the ICF framework and classification, organise these cognitive impairments and their implications for occupational performance (activities and participation level) and identify the things in the environment that help (facilitators) or hinder (barriers). See how using the ICF enables us to articulate the relationship between the disability, functioning and the contextual factors of Mr B’s life.
Why are Frameworks Useful?

This case study illustrates the use of the ICF framework and classification to identify, systematically, the many interrelated factors, not just the health condition, which impact upon Mr B’s occupational performance. From this point the unique skills and knowledge of the occupational therapist are essential to explore, understand and diagnose the interaction of these elements as well as their individual contributions to his difficulties.

In addition to the basic framework of components and definitions, the ICF identifies two components of any individual’s activity and participation that together determine his ability; these are termed capacity and performance.

‘Capacity’ is a qualifier which refers to a person’s capability, i.e. their highest or best level of performance in a standardised environment (for example, in a laboratory or rehabilitation kitchen). ‘Performance’ refers to a person’s actual performance within the contexts of his normal environment (for example, in his local shop or his own kitchen). In Mr B’s case, he may be able to produce a cooked meal within the familiar environs of his own kitchen, due to being prompted by visual and contextual cues that are present, but may be unable to do so in an unfamiliar rehabilitation kitchen. This highlights the importance of assessing both components of an individual’s abilities, as limited capacity for a particular activity would not necessarily predict limited performance. Conversely, successful performance of an activity could not be assumed to indicate normal capacity.

Applying this issue to clinical practice, a neuropsychological test of object recognition might identify a limitation in this cognitive process. This would need further exploration in the person’s usual environment and contexts to determine the extent and impact of the deficit on everyday life.

Chapter 2 further considers the debate about assessment at the level of impairment, and whether this is always warranted, if a person does not exhibit any activity limitations or participation restrictions even though impairment may be present.

Why an Occupational Therapy Framework is Important for Effective Rehabilitation

The ICF identifies capacity and performance as dimensions of carrying out activities and participation. It also acknowledges the influence that contexts may have upon the individual’s situation (for example, physical environment or economic status) and identifies that these can act as either facilitators or barriers to a person’s ability to function (WHO 2001). But beyond the definitions of capacity and performance, the ICF does not offer any further framework for the analysis of human abilities. It does suggest measurement scales for rating levels of impairment, activity limitation and participation restriction, but these are generic and do not allow for describing the nature of a problem in any given area. It allows description of a difficulty but not diagnosis of its precise nature or cause.

Occupational therapists therefore need an occupational framework to further identify and diagnose the precise nature of an individual’s occupational difficulties – and strengths – in order to plan effective treatment or other interventions. The OTPF (AOTA 2014) provides a structure by which:

- personal factors, e.g. values, beliefs, body functions of an individual can be further defined
contextual and environmental aspects can be fully analysed

- performance skills (motor, process and social) and patterns (habits, routines, rituals, roles) a person needs to carry out occupations can be analysed.

Without such knowledge, it would be difficult to analyse fully the impact of any given impairment (of body structure or function) upon an individual’s occupational performance. To illustrate this, let us consider the example of driving a car.

Most adults have a general appreciation of what driving a car entails and the skills it requires, whether or not they know how to drive. Most of us, if asked, would identify that driving requires the ability to:

- co-ordinate arms and legs
- see clearly
- know and apply the rules and laws of the road
- operate the controls of a car.

However, what are less obvious are the demands the activity makes upon the individual in terms of performance skills, and how contexts can influence these. Such performance skills would include the ability to:

- maintain energy and an effective pace of performance
- sustain attention and selectively attend to important visual, auditory and tactile information
- utilise knowledge (using short-term, procedural and topographical memory) to achieve desired goal (reach destination safely)
- organise self and the immediate environment for effective operation of the car
- initiate, sequence and terminate the tasks involved in driving appropriately
- maintain position and produce co-ordinated sequences of movements, working bilaterally and unilaterally to operate controls
- notice, respond and adjust to changing conditions and unexpected events.

The extent to which these performance skills are needed or used at any time in a period of driving would change according to the context and environment, including the road conditions, local geography and the actions of other road users.

The OTPF identifies performance skills, performance patterns and client factors as being interrelated dimensions, emphasising that it is not only the individual’s personal attributes (body structures and functions) that determine ability, but the environment and characteristics of the activity or role itself that are important to its execution. This highlights three things.

- Occupational therapy emphasises performance rather than capacity; that is, the person’s ability to ‘do’ or function in his or her normal environments and contexts.
- Occupational therapists recognise that the nature, content and context of an activity will also influence how it is performed, and therefore affect the demands it makes of an individual.
- When working to resolve a person’s occupational difficulties, it is not just the individual’s own health and abilities that need to be addressed but also the contextual aspects of his performance, because these may be acting as facilitators or barriers to performance.
Hence, it can be seen that combining the two frameworks provides a systematic mechanism by which the occupational therapist can:

- analyse the characteristics and demands of any given task, activity or occupation
- determine the individual’s impairments, activity limitations and participation restrictions that need further investigation and assessment
- determine the individual’s residual intact body functions which can be utilised within the therapeutic process to maximise occupational performance
- analyse the impact, both positive and negative, of the individual’s physical, social and attitudinal environment.

**Why Knowledge of Cognition is Needed for Analysing Occupations, Tasks and Activities**

The individual mental functions that constitute cognition involve complex neural mechanisms in themselves (perception or memory, for example), but always operate within a larger complex of integrated and interrelating functions. Perception requires memory because without memory, we would not learn what objects are and therefore not be able to recognise them. Conversely, establishing memories requires perception because without perceptual processing, we could not attach meaning to an experience.

Let us return to the example of driving a car, and think about the activity of driving down a busy street. The driver will need a mental map of the route he is taking. This requires memory and the ability to constantly take in the scene around him and compare it to his ‘mental map’ (or satellite navigation system), in order to know how far he has got. In other words, he must be able to perceive incoming visual information, integrate it with stored knowledge (or other incoming information) and use this to plan his next actions.

In addition, he must at all times maintain attention to the activity of driving the car – using the controls and checking his speed and position on the road. He must monitor events around him: pedestrians, other vehicles, traffic lights and signs. He may also simultaneously be conversing with a passenger, listening to a radio or disagreeing with his satellite navigation system.

To achieve all this, our driver must be capable of:

- attention – sustained, selective and shifting
- perception – visuospatial, auditory, tactile
- use of working, short-term, procedural and topographical memory
- motor planning and execution of skilled movements (praxis skills)
- executive functions: problem solving and rapid decision making.

This analysis of driving demonstrates the fundamental importance of cognitive processes, their integration and interaction. The earlier example of Mr B also illustrated the importance of individual cognitive functions in daily living, when loss of a single function such as calculation could lead to inability to maintain a job.

**Why Knowledge of Impairment is Important**

So far, it has been established that knowledge of cognitive processes is important in the analysis of occupational performance and the diagnosis of occupational difficulties (activity limitations and participation restrictions). But it is also important for
occupational therapists to go further and be able to differentiate the relative contributions of different cognitive impairments in any given occupational difficulty.

In the case of Mr B, his problems with completing complex tasks could have one or several causative factors.

- Difficulties with recall might prevent him from remembering a set of instructions.
- Problem-solving deficits might result in inability to apply rules to novel problems.
- Lack of drive might mean he is easily discouraged from attempting something that appears difficult.

Knowledge of the possible sources of difficulty enables the therapist to identify which aspects of cognition need assessing, and how to decide upon the best intervention for this dysfunction. If Mr B’s difficulty was arising predominantly from his poor recall, then provision of written instructions would enable him to succeed. But if the major difficulty was his problem-solving deficit, it would require intervention that enabled him to learn rules and practise their application in a graded programme of tasks that gradually increased in complexity.

Hence one activity limitation could have several possible causes, and require a different intervention approach depending upon those causes. Selection of intervention without knowledge of cognition, careful occupational analysis and assessment of impairments could result in an unsuccessful outcome.

Putting Knowledge and Frameworks Together

Frameworks such as the ICF and the OTPF provide us with tools to analyse human function, activities and the influence of environment and other contexts upon occupational performance. Skills of activity and occupational analysis provide the means to identify the components of human performance and the demands of the activities in which humans engage. Neuropsychological theories, case studies and research methodology provide an understanding of cognitive systems and their underlying processes. Neuropsychological tests provide health professionals with tools to measure impairments. Occupation-focused tests enable therapists to measure the impact of cognitive impairments on functional performance within specific environments.

When cognitive impairments occur as a result of trauma or disease, the knowledge, skills and tools of neuropsychology may act in combination with frameworks (which help us to structure and organise information) to provide a means to:

- consider the possible nature of cognitive impairments from the location and extent of the brain damage
- screen or specifically test for cognitive impairments
- identify and analyse the cognitive components of activities and occupations
- analyse and assess activity limitations and participation restrictions
- consider and select effective intervention methods and strategies
- determine the outcomes of intervention
- consider the individual’s longer term needs within their social context.
SUMMARY

1) Cognitive deficits impact upon every aspect of life and can create difficulties in all areas of occupation. Because of the central role of cognition in human functioning, occupational therapists must have an understanding of cognition, and how cognitive abilities contribute to occupational performance.

2) The World Health Organisation framework and classification of health and health-related states can be used to organise, define and examine the relationships between all areas and levels of human functioning. This includes cognitive functions, their associated body structures and their relationship to human activities and participation. The ICF aids clarity of communication across the neurological multidisciplinary team but on its own is insufficient to articulate what we do as occupational therapists.

3) The concepts incorporated within the ICF make it complementary to and compatible with the OTPF. This is a professional framework that guides occupational therapists in their analysis and understanding of human occupation and occupational performance difficulties.

4) Together with knowledge of cognition and cognitive impairments, these frameworks can be applied, within the clinical reasoning process, to guide comprehensive analysis of occupational performance needs and deficits. This in turn facilitates appropriate and effective assessment of cognitive deficits, intervention planning and outcome measurement.

References


