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Perhaps we should first look at what sensations mean in the context of this article, then go on to discuss the sensory integration frame of reference from there.Sensations and the Human BodyWe have different sensors that provide information to our brain about our bodies and our environment. The brain uses this information to ensure that we are safe.It does this by sending messages to different parts of our body.Our body uses this information in order to react appropriately. This reaction can be automatic.For example, to pull your hand away from a hot stove. The reaction can also be planed, such as to close the window when you are cold.We have senses that provide information about our body. These are the sense of touch, the sense of proprioception (or position of the body), the sense of movement, and the sense of taste and texture in the mouth. The senses that provide information about the environment are vision, auditory (or hearing) and smell.Sensory IntegrationThe senses need to be developed well to perceive correctly.This is to ensure that the brain processes all of the sensations from the body and the environment effectively.When the brain processes the sensations effectively, its able to provide the correct reactions at the correct time.The process of:perceiving sensations in the body and the environment,the integration in the brain andresponding with the appropriate reactions or behaviouris called sensory integration.Inadequate Sensory IntegrationProblems with this process called sensory integration create problems in the reactions to different stimuli. Thus, problems in this area can cause problems in the behaviour. One notices this in children as they havent learnt effective ways to cope or to avoid.Many adults have problems with sensory processing as well.But, they have learnt to avoid specific stimuli to prevent adverse reactions.For example, many adults do not enjoy noisy environments and need quiet periods during the day or evening.Others do not cope with strong smells or tastes and prefer bland food. Others might be seeking movement and might find it difficult to sit still for periods of time. These adults have often chosen work and hobbies to suit their sensory needs.The person in need of movement might work as a labourer, a teacher, a free-lance journalist.All of which provide the opportunity to move regularly throughout the working hours. Others, also in need of movement, might choose to be active in sport after work.This is seen as normal and appropriate. However, in children, we often find that they do not have the freedom to make these choices. And, worse still, they do not understand their own needs. So, they cannot make the right choices to meet their sensory needs.Typical Symptoms of Inadequate Sensory IntegrationThese children find it difficult to cope in different environments. For example, in a place with a high noise level. (But, they often make a lot of noise because they can handle noises that they can control!)Other children may find it difficult to cope in visually busy places, such as a supermarket. They can have emotional reactions and meltdowns, as they can be overwhelmed by too many sensations. The opposite can also happen.The child might be a seeker and might need more sensations to focus and to pay attention. This child might tend to daydream and to drift off.Resulting in not hearing instructions and not knowing what to do.Many children with sensory integration difficulties avoid activities that they find challenging.And, when they do participate, we see clowning. I think they would prefer to be the clown and have people laugh at them because they try to be funny, rather than to show others the difficulty they have with a specific task.We can help children and adults with these problemsAssess the problem areas. You might use the many check lists available on the internet or book an assessment with an occupational therapist qualified to work with sensory integration problems.Use a sensory diet. Ask your occupational therapist to identify specific sensory rich activities. Provide these at regular intervals throughout the day to encourage focused attention and to avoid sensory overload and meltdowns.Ensure that the childs sensory-motor skills are well-developed. This form the foundation of many other skills and a well-developed foundation will minimize avoidance and clowning. It will ensure that the child can follow instructions, understand how to perform and how to react appropriately. It will create improved self-confidence and successful outcomes when participating in many different tasks at home, in the classroom and on the sport field.Occupational therapists use models and frames of references to facilitate clinical reasoning and guide the evaluation and intervention process.What is the difference between a model and a frame of reference?Model: A model (or practice model) is a broad guide used to organize the occupational therapists clinical reasoning.Models are based on theories (scientific principles used to explain phenomena).All the occupational therapy models are based on the core concept of occupation.The occupational therapy practice models remind occupational therapists to consider the broad picture of each patient and to keep occupation (and the patients occupational performance) as the central focus during evaluation and intervention.Frames of Reference:Frame of references guide the occupational therapists evaluation and intervention.Frames of reference are backed by research and offer evidence-based tools and techniques.Frames of reference provide occupational therapists with specific assessments and intervention tools to guide their treatments.Three Occupational Therapy Practice Models:The Model of Human Occupation (MOHO):MOHO is the most popular and widely researched occupational therapy model.This model was published in the American Journal of Occupational Therapy (AJOT) in 1980 by Kielhofner, Burke, & Heard.MOHO is occupation-focused and client-focused.The Model of Human Occupation has four main concepts:Human occupation is multifaceted occupational performance depends on:The humanThe environmentThe taskEach person is made up of different elements:Volition: motivation to choose an occupation; based on personal causation, values, and interests.Habituation: patterns of behavior; based on habits and roles.Performance Capacity: ability to perform a task; based on mental and physical capacities as well as experiences.Environment can impact occupational performance either positively or negatively; environment can be divided into different categories:Physical environmentSocial environmentPolitical environmentCultural environmentEconomic environmentOccupational performance is doing all the activities that make up a persons lifestylePerson-Environment-Occupation-Performance (PEOP) Model:The Person-Environment-Occupation-Performance Model (PEOP) was developed by Christiansen & Baum and first published in 1991.The PEOP model explains the interconnectedness of the relationship between person, environment, and occupation.In this model, the outcome of the relationship between person, environment, and occupation is defined as occupational performance.The Person-Environment-Occupation-Performance Model (PEOP) has four main elements:Person:Each person has intrinsic factors:Physiological factors: sleep, stress, health, nutrition, strength, etc.Cognitive factors: executive functioning, attention, memory, organization, reasoning, awareness, etc.Psychological factors: theory of mind, emotional state, self-esteem, self-efficacy, etc.Neurobehavioral factors: visual, auditory, gustatory, olfactory, proprioceptive, tactile, motor planning, motor control, etc.Spiritual factors: give purpose and meaning to an individuals lifeEnvironment:The environment is made up of extrinsic factors:Physical factorsCultural factorsSocietal factorsEconomic factorsNatural factorsSocial factorsOccupation:The occupation describes what the person wants or needs to do and is made up of the persons:AbilitiesTasksRoles (social and occupational)ActionsThe main areas of occupation according to the PEOP model are:WorkHome maintenancePersonal careSleepRecreationLeisurePerformance: the outcome of the relationship between person, environment, and occupation is occupational performance or doingCanadian Model of Occupational Performance and Engagement (CMOP-E):The Canadian Model of Occupational Performance and Engagement (CMOP-E) was developed by Polatajko, Townsend, and Craik and published in 2007.The CMOP-E is based on learning, environmental, humanistic, and developmental theories.This model is client-centered and emphasizes the collaboration between therapist and client to facilitate occupation.The Canadian Model of Occupational Performance and Engagement (CMOP-E) has three main elements:Person:Each person has three performance components:PhysicalCognitiveAffectiveSpirituality is the central aspect of each person; spirituality is what motivates individuals to act.Occupation:Occupation is divided into three broad categories:LeisureSelf-careProductivityEnvironment:The environment is divided into 4 categories:CulturalSocialInstitutionalPhysicalThe CMOP-E emphasizes the idea that each of the elements (person, occupation, and environment) is interdependent which means that when one of these elements changes this causes changes in the other two elements.When the relationship between the three elements is harmonious, function is the result.Three Occupational Therapy Frames of Reference:Ayres Sensory Integration (ASI) Frame of Reference:Ayres Sensory Integration Frame of Reference was created by Jean Ayres in the 1970s.According to this frame of reference, each persons body processes and organizes sensory input from within the body and from the environment to produce a meaningful response.When the body is unable to process sensory input effectively, dysfunction results which can lead to issues with development, behavior, and learning.The aim of the ASI frame of reference is to integrate and expand the sensory systems to help an individual process sensory input effectively.The sensory system includes eight senses: tactile (touch), auditory (sound), gustatory (taste), vision (sight), olfactory (smell), vestibular (balance and spatial orientation), proprioceptive (body awareness), and interoceptive (internal sensation).The interaction between all eight sensory systems leads to specific behavior.Occupational therapists may use the ASI frame of reference with children who have sensory processing disorder (SPD) or sensory integration challenges.Occupational therapists who utilize the ASI frame of reference facilitate their patients exposure to a variety of experiences through play that incorporate each of the sensory systems.Over time, exposure to varied sensory experiences leads to an improvement in the bodys ability to process sensory input.The Developmental Frame of Reference:This frame of reference describes the sequence of stages each child grows through over their lifespan.The Developmental Frame of Reference is based on the theories of a number of psychologists including Freud, Jung, Erikson, Gessell, Piaget, Kohlberg, Wilcox, and Gilligan.Frued: Psychosexual theoryJung and Erikson: Psychosocial theoryGessell: Physical & emotional developmental milestonesPiaget: Cognitive milestonesKohlberg, Wilcox, and Gilligan: Moral reasoningIn occupational therapy, the Developmental Frame of Reference is typically used with children who have a developmental delay.Children can experience delays in multiple areas including:Gross motor skillsFine motor skillsLanguage and speech skillsSocial and emotional skillsCognitive skillsDevelopmental delays can be caused by developmental conditions including autism spectrum disorders, Down syndrome, cerebral palsy, language and learning disorders, infection, injury, or unknown reasons.Function results from a childs progression through the stages of development. When a child does not progress through the stages of development or progresses more slowly this results in dysfunction.The progression through the stages of development occurs in a sequential manner.Occupational therapists can facilitate progression through the stages of development through interventions that create the just-right challenge for each individual client.The Behavioral Frame of Reference:The Behavioral Modification Frame of Reference describes the idea that behaviors can be shaped through behavior modification.This frame of reference is based on psychologist B.F. Skinners theory of operant conditioning.Behaviors are learned and can be reinforced by outcomes in the environment.Behavior can be shaped through rewards and punishments.Occupational therapists can use behavioral concepts to guide their interventions and the way that they respond to clients during treatment:Occupational therapists can reinforce positive behaviors by praising the client (e.g. Good job!), smiling, or offering rewards.Backward chaining is a technique used to help clients develop new behaviors; the occupational therapist completes all steps in a task besides the final step which the client completes.Forward chaining is a technique in which the client completes the first step of the task and the occupational therapist completes the remainder of the steps.Token economy is a system that reinforces positive behaviors by providing rewards in the form of tokens (or stickers, food, etc.) Sensory integration (SI) is a framework conceptualized by Dr. A. Jean Ayers, Ph.D. in the 1970s; hence it is currently known as Ayres Sensory Integration (ASI).[1]Ayers "was guided by the principle that 'intersensory integration is foundational to function,'"while dysfunction in sensory integration leads to difficulties in development, learning, and emotional regulation.[1] Therefore, children with sensory processing deficits may find it challenging to regulate their responses to everyday situations such as dressing, playing, mealtime, and social interactions.[2]SI describes how the nervous system integrates sensory input into action. Two structures may be affected in registration and modulation disturbances: the limbic system and the vestibular and proprioceptive systems. The vestibular system is in charge of the sensory information from body movement through space. The proprioceptive system has a role in processing sensory input from joints and muscles. When impaired, it can lead to issues such as hand flapping[3]. Ayres hypothesized that the vestibular system is in charge of deciding whether we will act on a stimulus or not, while the vestibular nuclei register visual stimuli and give it meaning.[1][4]The over or under reaction to tactile or vestibular input may lead to gravitational insecurity or fear of movement, tactile defensiveness, or both. Ayers' identification of the amygdalaplayingan important role in sensory registration has been backed up by recent studies that associate the amygdala with reward associations.[1]For instance, hyperactivation in the amygdala due to eye contact may be why individuals with autism spectrum disorder (ASD) avoid eye contact.Based on Ayer's theory, lack of sensory integration may be one of the underlying causes of the behavioral problems in children with autism.[5][3]Between 90and 95% of children with autism are estimated to have sensory processing difficulties.[6]Ayres hypothesizedthat impairments in sensory processing lead to a motivation deficit and lack of attribution of meaning to a stimulus (poor registration), which in turn inhibits motivation to engage.Ayres also stated that somatosensation is composed of touch and proprioception. Somatosensation strongly connects with other sensory systems. For instance, visual information and motor signals integrate with tactile sensations at the posterior parietal cortex. The integration of these sensory inputs is essential for self-motion, postural stability, and spatial orientation.[4]Individuals with reduced sensory modulation may lack the capacity to filter out redundant stimuli leading them to feel overwhelmed due to poor modulation.Some of the postulates in Ayers framework have not received corroboration at the neurological level; for instance, her ideas on sensory registration and vestibular processing in ASD have not been corroborated through neuroimaging studies.[1]One of the reasons, sensory integration is not strongly validated by the current literature is because some of the available studies have not used sensory integration as stipulated by Ayers.[7]Hence, methodological variations make it challenging to interpret reported data [8]. For example, passive participation requested from the child rather than active participation.[7]Also, studies comparing sensory integration therapy to behavioral interventions have suggested the latter to be more effective in reducing the frequency of self-injurious behaviors.[8]Sensory integration therapy (SIT) is mainly performed by occupational therapists to help children improve their processing and integration of sensory inputs to gain appropriate adaptive response to everyday stimuli.[5]During play, "the just-right challenge" is provided through sensory-motor activities.[6]ASI is commonly used to help in children's developmental, behavioral, and learningissuessuch as ASD, attention deficit hyperactivity disorder, developmental coordination disorders, and childhood obesity.[3][4]SIT positively affects the child's response to sensation by reducing stress, increasing adequate adaptive responses to sensory stimuli, concentrations, and social interactions.[6]SI interventions usually take place in the home, community, schools, and clinics.[7]Sensory integration is mainly an intervention for children with developmental and behavioral disorders. The activities included in SI provide vestibular, proprioceptive, auditory, and tactile stimuli, which in turn organize the sensory system. Such stimuli are provided in play using brushes, swings, trampolines, balls, and other equipment used to elicit proprioceptive, tactile, and vestibular challenges.[5][9]Activities can also involve deep pressure, joint compression, oral moral exercises, and body massage to enhance arousal states.[3]Application of ASI requires that the sensory-motor activities target the particular areas of difficulty that interfere in the child's day to day; hence, sensory integration becomes incorporated into play. Activities usually tackle more than one sensory system at a time and trigger proprioceptors of muscles and joints, receptors in the inner ear, as well as auditory, visual, and tactile receptors on the skin.[9]Outcomes of the interventions are regularly collected, and adjustments to the intervention plan are made as needed (citation). The ultimate goal of SIT is to improve the nervous system's sensory processing, organization, integration, and motor planning.[9]ASI interventions are founded on neuroplasticity, aiming to malleate the nervous system through experience. Guided involvement in sensorimotor activities incorporated in play can promote neuroplastic changes leading to adaptive behaviors as a result of the experiences directed during the intervention. This practice has its basis in the idea that neural networks form as a result of experience.[4]The ASI principle of neuroplasticity has been confirmed by studies that show that rodents raised in enriched environments have modifications in brain organization and conformation. Thus, demonstrating that the brain makes connections as a result of environment and learning.[4]Furthermore, a recent study by Drobnyk et al.suggests that ASI may have a positive effect on children with Rett Syndrome (RTT), improving their rate of grasping. Given that RTT is such a severely disabling condition, even small improvement may be of great benefit.[9]Practitioners of sensory integration state three categories of benefits: improved ability to focus in educational, therapeutic, and social environments, reduced inappropriate behaviors such as self-harmful behaviors, and improved neural functioning occur in activities such as language and reading.[8]Sensory deficits are measured through the sensory profile,which consists of interviews with parents, a review of child evaluation reports, and observation of behaviors. After the assessment of data, goals are created to target areas of concern.[1][2]However, the diagnosis of sensory processing disorders is still challenging. Millet et al. classified sensory disorders into three categories and subcategories: sensory modulation disorder (overresponsive, underresponsive, and sensory seeking/craving), sensory discrimination disorder, and sensory-based motor disability (postural disorder and dyspraxia).[10]Sensory integration is incorporated in occupational therapy interventions that focus on directing the child towards sensory-rich experiences targeting the individuals sensory needs. Over 95% of occupational therapists report incorporating SI in their practice.[6]The therapist adjusts the environment to produce the necessary challenges that will promote self-direction and adaptive response in motor, affective, sensory, and cognitive activities.[2]Kashefimerhr et al. reported that occupational therapy programs using SI show significant improvement in childrens modification of non-functional behaviors, communication, interaction skills, processing and motor skills, and environment adaptation.[5]Review Questions1.Kilroy E, Aziz-Zadeh L, Cermak S. Ayres Theories of Autism and Sensory Integration Revisited: What Contemporary Neuroscience Has to Say. Brain Sci. 2019 Mar 21;9(3) [PMC free article: PMC6468444] [PubMed: 30901886]2.Schaaf RC, Nightlinger KM. Occupational therapy using a sensory integrative approach: a case study of effectiveness. Am J Occup Ther. 2007 Mar-Apr;61(2):239-46. [PubMed: 17436846]3.Schaaf R, Blanche EI. 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[PMC free article: PMC7068139] [PubMed: 32190013]Disclosure: Katherine Guardado declares no relevant financial relationships with ineligible companies.Disclosure: Shane Sergent declares no relevant financial relationships with ineligible companies.Pediatric Occupational therapists use an occupational therapy frame of reference, or sometimes interchangeably called an occupational therapy model, to help conceptualize and plan interventions for the children they treat. A frame of reference is used as a way to understand the client's current functional levels and guide treatment plans and sessions. The use of a specific frame of reference may be determined by the pediatric OT setting. The theory of occupational therapy is complex and can be difficult to understand. This article will explain five pediatric occupational therapy frames of reference and how I use them in my pediatric OT practice. There are five occupational therapy frames of reference that are often used by pediatric occupational therapy practitioners as part of an intervention plan or treatment goals for children with disabilities that we will discuss in this post: Developmental Frame of Reference; Neuro-Developmental Treatment (NDT); Behavioral Frame of Reference; Frame for Development Handwriting Skills; Sensory Integration Frame of Reference. A theory is a well-backed explanation of why something in the natural world is what it is or operates the way it does. For example, Newton's theory of gravity explains why objects are attracted to one another when they are dropped. An occupational therapy theory is a guide from which the occupational therapy frames of reference and models are built. A frame of reference is a conceptual tool that can be used as part of occupational therapy. It also provides a plan for intervention and treatment goals to work towards change in the future. An occupational therapy theory can be described as concepts that are developed over time that are based on scientific evidence, research, and clinical expertise. A theory is used to explain why certain treatments work through how they impact the brain and nervous system. A frame of reference is using the theory as a way to understand the current situation and identify possible solutions. An Occupational therapist or occupational therapy assistant uses an occupational therapy model to help guide OT practitioners in determining and providing interventions and treatments. It is used to organize an occupational therapist's thinking about the person they are working with. The model provides for categorization and organization. It's an idea or theoretical framework around which occupational therapists think when treating their patients/clients. The term occupational therapy frames of reference and an occupational therapy model are often used interchangeably. Here are the frames of reference I used in my pediatric occupational therapy practice with young children. As a child ages, the possible frames of reference to draw from grows as well. The following are five frames of reference that are commonly used in pediatric occupational therapy: A developmental frame of reference is used to identify how a child's level of ability changes across time and setting, as well as the child's ability to engage in activities. When a therapist uses this frame of reference, they are looking at the developmental progression and what skills a child needs to achieve their developmental milestones. I look at the developmental frame of reference as the overall overarching frame of reference in my practice. I have based my books, Pediatric Occupational Therapy Goals, on this frame of reference as well. I believe that for young children, development follows a predictable linear path, and therapy intervention can follow this path for almost all children through elementary age. Neuro-Developmental Treatment (NDT) is an evidence-based treatment for children with developmental challenges. It is used to improve motor difficulties using a variety of techniques to influence motor difficulties such as posture, alignment, muscle tone, and balance. For the children, I treat with motor delays, born prematurely, with cerebral palsy or Down Syndrome, I use an NDT perspective in my treatment plans and interventions after considering the appropriate developmental abilities for the child. Are You an Occupational Therapist Struggling with Self-Doubt and Imposter Syndrome? Discover the essential skills you didn't learn in school to conquer imposter syndrome and transform your practice. The OT Confidence Code is a must-read for all occupational therapists striving to overcome self-doubt and achieve professional excellence. This practical 48-page guide gives clear strategies to master three crucial initial skills you did not learn in school. With actionable advice and real-world examples, this book will help you build confidence, enhance your effectiveness, and reignite your passion for occupational therapy. The behavioral frame of reference is used to identify the relationship between a child's behaviors and his or her environment. The goal of the behavioral frame of reference is to enable children with disabilities to learn new skills and behaviors through positive reinforcement strategies, self-management behaviors, and self-control. The frame of reference focuses on the development of handwriting skills. It examines the underlying skills which go into producing legible, timely handwriting which include posture, ocular motor skills, attention, and visual-perceptual skills, and pencil grasp. This is a great frame of reference when a therapist is learning what underlying skill deficits affect handwriting abilities. Especially for school-based OTs. The sensory integration frame of reference is used to address the needs and deficits that are related to sensory processing. This frame of reference is developed from the work of Dr. Jean Ayers. It focuses on the child's sensory systems such as auditory, visual, gustatory, tactile, vestibular, and proprioceptive sensory systems. Sensory integration also takes into consideration sensory modulation and self-regulation, and praxis abilities. In my practice is use parts of the sensory integration (or sensory processing) frame of reference with many of the children I treat. The sensory integration frame of reference in its purest form involves the use of one-point suspended equipment and is best suited for use in a pediatric clinic. However many parts can be used to guide treatment with children with sensory processing (SPD), feeding, attention, and motor planning difficulties. It can also be helpful when working with children with Autism Spectrum Disorder (ASD) and Developmental Coordination Disorder (DCD). An occupational therapist selects a frame of reference based upon the child's goals, functional performance, and the intervention strategies the therapist is proficient with. Pediatric Occupational therapists use many different frames of reference in their therapy sessions and interventions. Each serves a different purpose and best helps children with different types of difficulties and challenges. In my practice, I use a Developmental Model as my overall frame of reference. Then the Neuro-Developmental Treatment (NDT), Behavioral, Frame of Reference for Development of Handwriting Skills, and Sensory Integration to guide my treatment plans and interventions. Sensory Integration is a theory and frame of reference that describes a process in the brain, and framework for evaluation and intervention. It is based on the main principles of brain function, including: neuroplasticity, development, integration, and feedback. This model of theory was developed in the 1960s by Jean Ayres, a researcher, educator, and occupational therapist. She used her research to identify the sensory and motor constructs for occupation.Sensory processing refers to the ability to take information from our senses (touch, movement, smell, taste, vision, and hearing) and puts it together with prior information, memories, and knowledge stored in the brain to make a meaningful response. These sensory systems are the building blocks to learning. They include:Vestibular System (movement sense) This is the sensory system that responds to changes in head position, body movement through space, and regulates our balance system.Proprioception System (position sense) This is the sensory system that interprets the information you receive from your muscles. It tells us where our body parts are and where our body is in space.Tactile System (touch sense) This is our sense of touch we receive through our skin. It helps one to learn about their body and the environment they live in. We distinguish touch by two different kinds: light (gives the body an alerting message) and deep (gives the body comfort) touch.Sensory processing difficulties may impact a childs ability to participate in their daily occupations. Differences in processing sensory input may impact a childs development of fine, visual , and gross motor skills. It may also impact social participation, motor planning, participation in self-care, academic success, and feeding.Sensory based therapy helps to improve the processing of input within the individual, so that they can be active participants in their daily occupations, or activities. If your brain works anything like mine, you might sometimes find yourself getting confused about what are models, which are frames of reference, and what are concepts or ideas within the field of occupational therapy. I have recently found myself questioning this while working through myAyres Sensory Integration WISE Module 2 Comprehensive Assessmenttraining. As I progressed through the course, I started wonderingwhere Ayres Sensory Integration fitswithin the history of occupational therapy and how it should be classified in relation to theoretical frameworks. From my understanding,Ayres Sensory Integration is a practical frame of referencebecause it provides structured guidelines for assessment and intervention in sensory processing challenges (Ayres, 1972; Schaaf & Mailloux, 2015). It is not just a broad theoretical model buta systematic approachthat outlines specific intervention strategies, making it more aligned with the definition of a frame of reference (Parham et al., 2011). Of course,I did learn all of this at university, but as I have not studied formally sincecompleting my degree in 2006, some of my theoretical knowledge is a bitrusty. I use occupational therapy models and frames of reference in my everyday practice, but revisiting them in a structured way has been a real eye-opener. It has made me realise how easily we absorb these frameworks into our clinical reasoning without necessarily revisiting their underpinning theory. To help clarify my thoughts, I ended up going down a bit of arabbit hole, exploring the differences between models, frames of reference, concepts, and frameworks in occupational therapy. Hopefully, this blog will help break it all down, not just for me, but for anyone else who has ever found themselves wondering the same thing. Occupation refers to the everyday activities that individuals engage in, which bring meaning and purpose to their lives (Wilcock & Hocking, 2015). These activities include self-care, work, leisure, and social participation. Occupational therapy is grounded in the belief that engaging in meaningful occupations promotes health and well-being (Law et al., 1996). For example, a person recovering from a stroke may regain independence by participating in occupations such as cooking meals, engaging in hobbies, or returning to employment. Occupational therapists use a variety of theories and approaches to assess and support individuals in achieving their occupational goals. Occupational therapy is shaped by various theories and ways of thinking that influence how practitioners assess, intervene, and reason professionally. However, terms likemodels, frames of reference, concepts, and frameworksare often used interchangeably, which can cause confusion. In this blog, these terms will be explained with references and examples to clarify their meaning in occupational therapy practice. Amodelin occupational therapy is a broad, conceptual framework that helps practitioners understandwhyoccupation is central to health and well-being (Kielhofner, 2008). It provides a way of looking at the relationship between the person, occupation, and environment, but it does not necessarily provide specific intervention techniques. Model of Human Occupation (Kielhofner, 2008) Looks at volition, habituation, and performance capacity in shaping occupational participation. Person-Environment-Occupation Model (Law et al., 1996) Explains how a persons occupational performance is influenced by the environment. Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) Highlights the interaction between the person, their occupation, and their environment, with spirituality at the core. Kawa Model (Iwama, 2006) Uses the metaphor of a river to represent lifes journey, focusing on cultural and environmental influences. Vona du Toit Model of Creative Ability (du Toit, 1974) Focuses on how people develop creative ability through graded occupational engagement. AFrame of Referenceprovides specific guidance onhowoccupational therapists assess and intervene with clients (Turner & Foster, 2008). It takes theory and translates it into practical ways of working, making it more applied than a model. Biomechanical Frame of Reference (Trombly, 1995) Focuses on physical function, strength, and endurance in rehabilitation. Cognitive-Behavioural Frame of Reference (Beck, 1976) Uses cognitive behavioural therapy principles to address thought patterns, emotions, and behaviours. Sensory Integration Frame of Reference (Ayres, 1972) Focuses on treating sensory processing difficulties. Psychodynamic Frame of Reference (Mosey, 1986) Explores how unconscious thoughts and emotions influence occupational engagement. Reed and Sandersons Model of Adaptation through Occupation (Reed & Sanderson, 1992) Although called a model, it functions as aFrame of Reference, providing structured intervention strategies for adaptation through occupation. Aconceptis a fundamental idea that underpins models and frames of reference (Hagedorn, 1995). Concepts help explain occupational therapy principles but are not structured enough to be considered models or frames of reference. Occupational Alienation (Wilcock, 1998) Feeling disconnected from meaningful activities due to external factors. Occupational Justice (Townsend & Wilcock, 2004) The right of all individuals to access and engage in meaningful occupations. Occupational Deprivation (Whiteford, 2000) When individuals are restricted from participating in meaningful occupations due to societal or environmental barriers. Aframeworkprovides a broad guide for professional reasoning and practice, but it is often less structured than a model or frame of reference (Creek, 2010). The Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) Provides a broad guide for occupational therapy practice. The Occupational Therapy Practice Framework (American Occupational Therapy Association, 2020) Defines the domain and process of occupational therapy practice. CategoryDefinitionPurposeExamplesModelBroad conceptual frameworkExplains why occupation is importantModel of Human Occupation (MOHO), Person-Environment-Occupation (PEO) Model, Kawa ModelFrame of ReferencePractical guidelines for interventionExplains how therapy should be deliveredBiomechanical, Cognitive-Behavioural, Sensory IntegrationConceptFundamental idea or theoryHelps explain specific aspects of occupational therapyOccupational Justice, Occupational DeprivationFrameworkBroad guide for professional reasoningProvides guidelines for assessment and interventionCanadian Model of Occupational Performance and Engagement (CMOP-E), Occupational Therapy Practice Framework (OTPF)ApproachA structured way to implement therapyProvides a method or strategy for applying models or frames of referenceCognitive Orientation to Occupational Performance (CO-OP), Task-Oriented Approach, Strengths-Based Approach This comprehensive chart provides an overview of key occupational therapy models, frames of reference, frameworks, and approaches, categorised by their focus area, historical development, country of origin, and necessary training or licensing. (Please note this is not an exhaustive list.) ModelYear DevelopedCountry of OriginDevelopersRequired Training/LicensingAssociated AssessmentsReference/WebsiteModel TypeVona du Toit Model of Creative Ability (VdTMoCA)1960sSouth AfricaVona du ToitSpecialized training recommended; certification may be required in some regions Creative Participation AssessmentVdTMoCA FoundationModelSensory Integration Theory (Ayres SI)1970sUSAA. Jean AyresCertification required for administering specific SI interventions Sensory Integration and Praxis Tests (SIPT)Sensory ProjectFrame of ReferenceModel of Human Occupation (MOHO)1980sUSAGary KielhofnerFamiliarity with MOHO principles; specific training may be required for certain assessments Assessment of Communication and Interaction Skills (ACIS) Model of Human Occupation Screening Tool (MOHOST) Occupational Self Assessment (OSA)MOHO-IRM WebModelAllens Cognitive Disabilities Model1980sUSAClaudia AllenTraining workshops recommended; no formal licensing required Allen Cognitive Level Screen (ACLS)Allen Cognitive NetworkModelPerson-Environment-Occupation-Performance (PEOP) Model1991USACharles Christiansen and Carolyn BaumUnderstanding of PEOP principles; no specific licensing required No specific assessments; serves as a guide for holistic evaluationPEOP Model ArticleModelOccupational Adaptation (OA) Model1992USAJanette Schkade and Sally SchultzUnderstanding of OA processes; no specific licensing required Occupational Adaptation AssessmentOA Model ArticleModelPerson-Environment-Occupation (PEO) Model1996CanadaMary Law and colleaguesKnowledge of PEO concepts; no specific licensing required No specific assessments; used as a framework for various evaluationsPEO ModelModelCanadian Model of Occupational Performance and Engagement (CMOP-E)1997CanadaCanadian Association of Occupational TherapistsUnderstanding of CMOP-E framework; no specific licensing required Canadian Occupational Performance Measure (COPM)CMOP-E ArticleModelDunns Sensory Processing Framework1997USAWinnie DunnUnderstanding of sensory processing patterns; no specific licensing required Sensory ProfileDunns Sensory Processing ArticleFrameworkKawa Model1999JapanMichael Iwama and Japanese colleaguesFamiliarity with the Kawa metaphor; no specific licensing required Kawa Model assessment involves collaborative drawing and discussionKawa ModelModelCognitive Orientation to Occupational Performance (CO-OP) Approach2001CanadaHelene Polatajko and Angela MandichFormal training recommended; certification may be required for practice Dynamic Performance Analysis (DPA)CO-OP ApproachApproachTransactional Model of Occupation2000sUSATownsend and PolatajkoUnderstanding of transactional perspectives; no specific licensing required No specific assessments; used as a conceptual frameworkTransactional Perspective ArticleModel Understanding the differences betweenmodels, frames of reference, concepts, and frameworksis key to applying theory to practice effectively. Models help us understandwhyoccupation matters, while frames of reference guidehow we intervene. Concepts enhance our understanding of occupational therapy principles, and frameworks providebroad guidelinesfor working in different settings. By integrating these different elements, occupational therapists can provide more effective, client-centred interventions that align with the values of occupational therapy. What are your thoughts? Do you find certain models or frames of reference more helpful in your practice? Let me know in the comments!

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Sensory frame of reference. Sensory integration framework. Sensory integration frame. What is the meaning of sensory integration. What is sensory integration. Sensoric integration.