

**EXPLORING OCCUPATIONAL THERAPISTS' VIEWS ABOUT NUSSBAUM'S CENTRAL
HUMAN FUNCTIONAL CAPABILITIES:
AN EXPLORATORY SEQUENTIAL MIXED METHODS STUDY**

by

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ABSTRACT

BACKGROUND: The 21st century marks a shift in the perspective of care of people with disabilities with greater attention to individual human rights. An innovative approach related to human rights that provides a basis for conceptualizing and framing the rights of people with disabilities, is the Capability or Capabilities Approach. Developed by Sen and extended by Nussbaum, the approach advocates that fundamental human rights can be viewed as claims to certain basic capabilities. Nussbaum has proffered ten so-called Central Human Functional Capabilities (CHFCs).

OBJECTIVE: To explore the views of Canadian occupational therapists (OTs) related to the CHFCs and their understanding and perceived relevance, with respect to their professional practice.

METHODS: An exploratory sequential mixed methods design including an initial qualitative phase that informed a subsequent quantitative phase. Phase One consisted of semi-structured interviews with OTs (n=14) in British Columbia, Canada. The findings from Phase One generated 11 categories with 22 themes and 75 sub-themes. These findings informed the development of a questionnaire to survey Canadian OTs, nationally. A cross-sectional survey, registered with the Canadian Association of Occupational Therapists was conducted in Phase Two to determine the applicability of Phase One findings about the CHFCs to a broader group of OTs from across Canada. The survey was hosted at the website Fluid Surveys®. We sampled 780 OTs with a response of 109 (14%).

RESULTS: Respondents understood the CHFCs as reflecting occupational therapy values. They perceived the CHFCs as relevant and consistent with established models of and approaches to occupational therapy practice including professionally-valued constructs of human rights and social justice as well as health and client-centered care.

CONCLUSION: These findings unify and advance the conceptual bases for occupational therapy models and approaches by enabling OTs to better fulfill their professional mandate of addressing their clients' needs from an overarching human rights perspective.

Importantly, these results align occupational therapy services with client-centered practice, and human rights initiatives of the United Nations and World Health Organization. Our findings could be used by other health professions and across cultures to establish whether the Capabilities Approach is applicable across professional practices and health services.

PREFACE

This research was approved by the University of British Columbia, Behavioral Research Ethics Board (Reference number: H11-00570) on February 6, 2012. I conceived the project described in these chapters, designed the study and analyzed and interpreted the findings with the guidance of Drs. Elizabeth Dean, Susan Forwell, and Shafik Dharamsi. Specific chapters of this dissertation are in preparation for publication. All chapters have multiple authors.

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LIST OF ABBREVIATIONS

| | |
|-------|---|
| CAOT | Canadian Association of Occupational Therapists |
| CHFCs | Central Human Functional Capabilities |
| CIHI | Canadian Institute for Health information |
| OT | Occupational therapist (except where the abbreviation OT(s) was/were used in quotations by participants to mean either occupational therapy or occupational therapist(s)) |
| QoL | Quality of life |

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DEDICATION

To my mom, dad, and Hussein

for all their love and support

1 INTRODUCTION, LITERATURE REVIEW, AND RATIONALE FOR THE THESIS

1.1 Introduction

Disability has been described as “the most urgent problem of social justice” (Nussbaum, 2006, p. 1). The link between disability and social exclusion is strong. People with disabilities are more likely to experience social and economic deprivation than able-bodied people. Children with disabilities are much less likely to be literate and more vulnerable to being malnourished and dying prematurely. People with disabilities are less likely to be employed; women with disabilities are vulnerable to physical violence and sexual abuse (Quinn et al., 2002, Turmusani, 2003; UK Department for International Development (DFID) Report, 2000; Barnes, 1991; Beresford, 1996). The extension of human rights to people with disabilities on the basis of equality with people who are able-bodied is a compelling perspective that provides a rational means of improving the lives of people with disabilities. This extension of human rights to meeting the needs of people with disabilities from the perspective of health care practice, specifically, rehabilitation services, is novel.

A variety of rehabilitation services has been implemented globally to respond to the needs of over 600 million people with disabilities in the world today. According to the literature, the four established models for rehabilitation service delivery include the biomedical model, community-based rehabilitation, independent living, and client-centered rehabilitation (McCull et al., 1997). Rehabilitation service delivery from the biomedical model tends to view disability as a problem at the level of the individual, and defines disability in terms of impairments. Impairments are associated with a variety of medical needs for people with disabilities, and specialized expertise is needed to recognize and respond to these needs (Bickenbach, 1993). The biomedical model in providing rehabilitation services depends upon “trained professionals and well-equipped facilities” (McCull et al., 1997, p. 511). This model has been criticized however on the grounds that many dimensions of disability are absent (Oliver, 1990, 1999; Marks, 1997; Williams, 2001; Shakespeare, 2001, 2006; McLean & Williamson, 2007).

Community-based rehabilitation has emerged in developing countries as an effective and efficient method of providing rehabilitation services to people with disabilities globally over the last twenty-five years. Community-based rehabilitation is a model of community development designed to empower people with disabilities within their communities (Peat, 1998; Mitchell,

1999; Kendall et al., 2000). In community-based rehabilitation, intervention has shifted from institutions to homes and communities, and is carried out by families and community programs. Interventions associated with community-based rehabilitation include education, vocational training, social rehabilitation, and prevention (Peat, 1998, p. 27). Community-based rehabilitation has been considered as a strategy “for equalization of opportunities and social integration of all people with disabilities” (International Labour Organization, United Nations, Educational Scientific and Cultural Organization, United Nations Children’s Funds, World Health Organization, 2004, p. 2). Community-based rehabilitation is implemented through “the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational and social services” (International Labour Organization, United Nations, Educational Scientific and Cultural Organization, World Health Organization, 2002, p. 1).

Independent living and client-centered rehabilitation reflect new attitudes toward rehabilitation service delivery. One of the philosophical assumptions in these models of rehabilitation services is that each person is of considerable and unconditional worth, each having the capacity to determine his or her destiny (McColl et al., 1997). In the independent living model, people with disabilities are described as being handicapped by society’s failure to provide appropriate services to facilitate their full participation in society. Therefore, restrictions imposed by society, such as social attitudes and barriers, create the disability (Williams, 2001, p. 128). The independent living model views people with disabilities as equal members in society who “are demanding the right to take the same risks and seek the same rewards” (Brisenden, 1986, p. 177). This model does not view disabilities as deficits, but rather as conditions of life. The independent living model advocates that “individuals are disabled by inaccessible buildings, lack of access to education, unemployment, and hostile attitudes” (McColl et al., 1997, p. 516). Further, the independent living model views people with disabilities as “rational, informed consumers of the service” (p. 516). For the most part, they are able to control the resources that affect their lives and are able to make informed choices about their needs. The independent living model aims to ensure that people with disabilities have access to housing, health care, transportation, employment, education, and mobility so they can participate in life fully (McColl et al., 1997).

In client-centered rehabilitation, “the clients know what they want from therapy and what they need” (Law, 1998, p. 92). In other words, they are the experts on their service needs, and can make choices and have control over all available service delivery (McColl et al., 1997). Rehabilitation therapists are viewed as facilitators who create an environment to assist change, enhance self-esteem, and promote independence and empowerment of people with disabilities (Law, 1998; McColl et al., 1997).

In Canada, the occupational therapy profession is an established rehabilitation profession that is committed to client-centered services (Canadian Association of Occupational Therapists [CAOT], 1991, 1997; Law, 1998). The profession focuses on maximizing clients’ capacity for complete physical, social and emotional functioning in all domains of their lives, which is referred to as their capacity to engage in their life occupations (more broadly defined than gainful employment). The profession of occupational therapy and its established competencies are described in Appendix A. Client-centered practice within the context of client-centered services has been advanced as a guide for occupational therapists (OTs) since the 1980s (Law, 1998). Despite the emphasis on client-centered practice, some barriers have been identified at the client, therapist and organizational levels (Law et al., 1995; Sumsion & Smyth, 2000). Implementing strategies to determine barriers to client-centered practice has been advised by various scholars (Sumsion, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001; Restall & Ripat, 2003). At the level of the therapist, education to enhance knowledge and understandings about the meaning of client-centered philosophy has been advocated. It has been suggested however that the skills of such health practitioners are often inadequate to practice fully in a client-centered manner (Wilkins et al., 2001).

Client-centered practice has been criticized at a number of levels. One criticism has been based on the ambiguity of its principles and the challenges regarding the ethical notion of autonomy. The core value of client-centered practice is patient’s autonomy (Law, Baptiste, & Mills, 1995; Law, 1998). Although patients’ rights and autonomy can provide the foundation for ethical decision making in rehabilitation practice (Kerkhoff et al., 1997; Brockett & Bauer, 1998), it has been challenged in terms of coming “into conflict in situations of actual practice” (Kruse, 2006, p. 372). Zeidman (1998) questions the neutrality view in client-centered practice: “Whether or not neutrality is a laudable goal, it is not possible to achieve. In fact, when we utilize the services of professionals, we expect and demand the benefits of their training,

experience, wisdom and advice” (p. 908).

Some investigators argue that health professionals have to not only consider the autonomy principle, but also the beneficence, nonmaleficence and justice principles in order to have an active role in ethical decision-making, rather than a passive role (Atwal & Caldwell, 2003). Scott (1998) in “*Professional Ethics: a Guide for Rehabilitation Professionals*” believed although these principles needed in caring for patients and could serve as a practical guide for health care practice, the implementation of these guiding principles appears challenging because there are “significant actual and potential conflicts of interests” (p. 21). One case in point where such conflict would exist, is confronting an individual verbalizing suicidal thoughts, and the role and responsibilities of health professionals.

Although community-based rehabilitation, independent living and client-centered models are distinct with respect to how they frame the provision of rehabilitation services, these models are similar in that they view people with disabilities as those with rights rather than impairments. Broadly speaking, in the 21st century, people and increasingly those receiving health services are becoming aware of their rights and demanding these be respected. Similar to other health service providers, OTs may better fulfill their professional mandate by having a solid understanding of their clients’ human rights and needs in order to provide appropriate services for their clients in a rational and reasoned manner. One approach related to human rights that may provide a meaningful basis for conceptualizing the rights of people with disabilities is the Capability or Capabilities Approach¹, otherwise known as the “Human Development Approach” (Nussbaum, 2007, p. 21). This approach, developed by Sen² and extended by Nussbaum³ has been recognized as an important theory for analyzing “women’s human rights, the rights of people who are poor and more recently, the rights of people with disabilities” (p. 21). The Capabilities Approach has been included in the

¹ Sen typically *uses* the term Capability Approach, but Nussbaum uses the term Capabilities Approach.

² Amartya Sen (1933-), an Indian economist and philosopher, who was winner of the 1998 Nobel Prize in Economics. He is Lamont University Professor and Professor of Economics and Philosophy at Harvard University.

³ Martha Nussbaum (1947-), an American philosopher, with a particular interest in ancient philosophy, law and ethics. During the 1980s Nussbaum began collaboration with economist Amartya Sen on issues of development and ethics. With Sen, she promoted the "capability approach" to development. She is currently Ernst Freund Distinguished Service Professor of Law and Ethics at the University of Chicago.

annual Human Development Reports of the United Nations Development Program and has been reported by over 500 national human development reports since 1990 (Robeyns, 2006; Nussbaum, 2007). Aligning the value of human development and its constructs such as those articulated by Nussbaum could provide a meaningful and useful approach in health care, in particular, rehabilitation.

1.2 Literature Review

1.2.1 Practical Rehabilitation Service Approaches

This section reviews three principal approaches to the provision of rehabilitation services for people with disabilities, namely, the biomedical, social, and socio-political (otherwise known as human rights) approaches. In the early twentieth century, rehabilitation services for people with disabilities were dominated by the biomedical approach. In the late twentieth century, the social approach to rehabilitation services dominated. In recent years, with the contemporary disability rights movements inspired by the Universal Declaration of Human Rights, the human rights approach to rehabilitation services has emerged.

Biomedical Approach

During the nineteenth century, people with disabilities were often ostracized in society and housed in institutions including shelters, hospitals and workhouses. Such practices continued well into the twentieth century (Braddock & Parish, 2001). Over the past century, the biomedical definition of disability emerged. According to the World Health Organization (2001), disability within the biomedical approach is defined as a problem at the level of the individual that is directly caused by a disease or some other health condition “which requires medical care provided in the form of individual treatment by professionals” (McLean & Williamson, 2007, p. 12).

The essence of disability in the biomedical approach is that people with disabilities are abnormal or have something wrong with them (Bickenbach, 1993; McColl & Bickenbach, 1998). In this approach, disability is understood as sickness, and people with disabilities tend to be considered as invalids (Hughes, 2002, p. 58). People are regarded as disabled on the basis of

being unable to function as “normal” people (Marks, 1997, p. 86; McLean & Williamson, 2007, p. 12). The normal-abnormal dichotomy is the basis of the biomedical approach which is problematic in the context of disability. Accordingly, this dichotomy is not unbiased but is associated with normality being related to “virtuousness”, and abnormality with guilt and “shame” (McLean & Williamson, 2007). Therefore, when impairment is negatively construed, people with disabilities are subjected to negative social responses (Shuttleworth & Kasnitz, 2006). In this approach, disability is viewed as “a defect inherent in the individual” and people with disabilities are regarded as “defective” rather than physically different (Bickenbach, 1993, p. 87). Since disability is associated with illness or impairment, people with impairments may be viewed as needing correction (McColl & Bickenbach, 1998). Finally, the biomedical approach depends on “trained professionals and well-equipped facilities” (McLean & Williamson, 2007; McColl et al., 1997, p. 511). Early on, the biomedical approach to rehabilitation services referred to the International Classification of Impairments, Disabilities and Handicaps (ICIDH). The ICIDH developed by the World Health Organization as an international instrument for the purpose of classifying problems or functional incapacity (World Health Organization, 1980). The ICIDH distinguished between the terms “disability,” “handicap,” and “impairment”. It defined impairment as an anatomical, mental, or psychological loss, or some other abnormality. A disability was any restriction or lack of ability to perform an activity in the manner or within the range considered normal. A handicap was a disadvantage resulting from impairment or disability. Consequently, the ICIDH gave substantial authority to rehabilitation professionals and disempowered people with disabilities by professionalizing disability.

Several advantages and disadvantages underlie the biomedical approach to the provision of rehabilitation services. The advantage of this approach is that it is reasonable for rehabilitation professionals to identify the essential goals for their patients. In other words, this approach can be considered as the basis for “diagnosing disability, influencing treatments, and guiding access to disability benefits” (Herr et al., 2005, p. 291). The disadvantage is that this approach fails to reflect a comprehensive view of disability. Scholars and disability advocates have argued that disability is more than impairment. In their perspectives, people with disabilities experience greater disability as a result of negative attitudes and social and environmental barriers than from functional losses. Consequently, this approach has not only been criticized on the grounds that it imparts considerable power to medical professionals,

disempowers people with disabilities, and depends on experts, but also because many dimensions of disability, such as social, economic, and cultural, are absent (Liachowitz, 1988; Oliver, 1990, 1999; Longmore, 1995; Williams, 2001).

Social Approach

Over the latter part of the last century, the social definition of disability emerged in industrial countries. The construct of disability within the social approach is largely associated with social oppression and barriers (Oliver, 1990). Disability is not strictly associated with impaired body parts, but rather with addressing an oppressive social environment. If disability is associated with social oppression, then people with disabilities can be viewed as “the collective victims of an uncaring, discriminatory society” (Williams, 2001, p. 128). In this view, society and its institutions through legislation, and social attitudes and barriers are thought to create disability. Therefore, society’s failure to provide appropriate services potentially may exclude certain people, hence, disable them.

From the perspective of the role of the social environment in creating disability, rehabilitation services have a primary role in addressing social and environment challenges and removing barriers. The social approach to rehabilitation services is inherent in the independent living and community-based rehabilitation models, which have emerged from critiques of rehabilitation services based on the biomedical approach (Batavia & McKnew, 1991; Lysack & Kaufert, 1994). Despite their common beginnings, these models have distinct historical contexts and, in turn, distinct underlying social and political conditions.

The independent living model emerged in response to a need to remove social and environmental barriers to living independently, for working-age people with disabilities in the United States in the early 1970s (Batavia & McKnew, 1991; Lysack & Kaufert, 1994). The independent living model aimed to ensure people with disabilities had access to housing, health care, transportation, employment, and education, and could be mobility. These aims were achieved through self-help and peer support, research and service development, and referral and advocacy (McColl et al., 1997).

Community-based rehabilitation was introduced by the World Health Organization at the Alma-Ata conference in 1978 and arose in developing countries in response to the lack of financial resources and experts (Lysack & Kaufert, 1994). One of the assumptions of community-based rehabilitation was that improving the quality of life in a limited way for all

people with disabilities is superior to greatly improving the quality of life for a few people. Therefore, community-based rehabilitation attempts to make services accessible to more people with disabilities and their families in the most cost-effective and culturally appropriate ways (Miles, 1996; McColl et al., 1997; Peat, 1998; Mitchell, 1999; Kendall et al., 2000; Turmusani et al., 2002).

Compared to the biomedical approach, the social approach may better describe the experiences of people with disabilities, and help elucidate deficiencies of the biomedical model in relation to people with disabilities.

Several disadvantages underlie the social approach to the provision of rehabilitation services. First, a common criticism is that it neglects the role of impairment. The social approach distinguishes between the impairments that people have and the oppression, which they experience (**Shakespeare & Watson, 2001**). The distinction between impairment and disability is central to the social approach (Shakespeare, 2006). Impairment itself is relevant to many people with disabilities. Impairment can cause pain and difficulties that are not solely attributable to disabling factors in society. Second, in some cases, even when environments are accessible and there is no unfair discrimination on the basis of disability, many people with disabilities would still be disadvantaged (p. 66). Third, the social approach cannot respond to the complete range of “special needs” of people with disabilities. Needs vary among people with disabilities. Some people need more than others in their societies given they have different capabilities and limitations. Fourth, fully accessible and barrier-free facilities are a central goal of the social approach, but there are challenges to creating a fully accessible society. Therefore, ‘a barrier-free’ society may appear to some as a utopian ideal.

Socio-political Approach: Human Rights Approach

The paradigm shift in disability policy from the biomedical to the human rights approach of disability is reflected in the United Nations Convention on the Rights of Persons with Disabilities. “The Convention on the Rights of Persons with Disabilities is the response of the international community to the long history of discrimination, exclusion and dehumanization of persons with disabilities” (United Nations, 2007, p. III). The United Nation’s “Convention on the Rights of Persons with Disabilities” advocated that people with disabilities are people with rights (p. III). This convention was seminal in elucidating

contemporary views of disability through shifting the perspective from a biomedical to a socio-political one (Herr et al. 2005, p. 62).

The construct of disability from a socio-political approach is viewed as a complex interaction of biological, psychological, cultural and socio-political factors (Bickenbach, 1993, 2003). Although the social approach broadens our understanding and appreciation of disability, capturing a broad picture of this construct does not appear to be a matter of simply adopting a single approach. The socio-political approach is broader and more inclusive than the biomedical approach. It provides a means of examining various dimensions of disability in conjunction with the biomedical approach.

Assumptions underlying the socio-political approach are reflected in the World Health Organization's International Classification of Functioning, Disability and Health (ICF) which is distinct from and an extension of its earlier version, the ICIDH. In the ICF, disability serves as an umbrella term for impairments, activity limitations and participation restrictions (ICF, 2001, p. 3). The "ICF attempts to achieve a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective" (p. 20). The ICF depicts the process of functioning and disability across domains (body functions and structures, activity and participation) and the inclusion of "contextual factors" (personal and environment) expands the construct of disability.

At the global level, the profession of occupational therapy has adopted the ICF of the World Health Organization and its definition of health. The ICF is becoming a generally accepted framework in medicine as well as the rehabilitation sciences (Stucki, 2005). As stated, the ICF consists of three key components, namely, body functions and structures, activity, and participation. Some aspects of the ICF are thought to need further development and research to better elucidate the determinants of functioning and health (To'ra & Dahl, 2002; Imrie, 2004). As well, the ICF has been criticized by the disability research and disability rights communities on the grounds that several dimensions of individual rights and of life satisfaction are absent (Herr et al. 2005; Imrie, 2004). The terminology reflected in the ICF is limited to health terminology. For example, because of their races, sex, religions and other socioeconomic characteristics, people may be restricted in their execution of a task in the environments in which they live. Although the ICF is predicated on the World Health Organization's definition of health (i.e., health is a complete state of physical,

social and emotional well-being, including being able to participate fully in one's community and life), some advocates for people with disabilities fail to recognize this central fact. Thus, race, sex, religion and other socioeconomic characteristics are not viewed by some as health related restrictions of participation as classified in the ICF. In fact, some disability rights critics have rejected the ICF as being no more than a "repudiated medical model" in that it does not seem to them to be a practical means of understanding the complexity of disability (Herr et al. 2005, p. 61). Thus, despite its general acceptability by the rehabilitation professions, the ICF is viewed by some others as not completely reflecting a human rights perspective.

In the socio-political approach, the three elements of the concept of disablement, i.e., impairment, disability, and handicap, are integrated to formulate disability as a rights issue (Bekhenbach, 1993, p. 232). According to this perspective, disability is a problem of equality. But what does equality mean? Bekhenbach described equality as having three dimensions: equality of respect, equality of opportunity, and equality of capability. Equality of respect was conveyed as "a respect in which everyone is relevantly equal, a respect which is unaffected by any manifestation of human difference" (Bekhenbach, 1993, p. 243). Equality of opportunity was derived from John Rawls's discussion on principles of justice; the priority of basic equal liberties and fair opportunity for all citizens (Rawls, 1972). According to Rawls, a just society must protect equal basic liberties and fair equality of opportunity for all citizens (Rawls, 2001).

Sen argued that equality of opportunity can be better understood in terms of "equality of what" (Sen, 1980). According to Sen, "equality of what," means equality of capabilities. The idea of "capability" means "the opportunity to achieve valuable combinations of human functionings, i.e., what a person is able to do or be" (Sen, 1992, 1999, 2004, 2005; Nussbaum, 2000, 2006).

1.2.2 Capabilities Approach

The concept of human rights has been understood in various ways. One way that appears consistent with contemporary philosophy of occupational therapy is the Capabilities Approach. The Capabilities Approach can embrace the language of rights and the main conclusions of the international human rights movements, as well as the content of many international human rights documents (Nussbaum, 2011, p. 67). The idea of capability is central to understanding human rights (Nussbaum, 2000; Sen, 2005). According to the Capabilities Approach, human rights can

be seen as claims to certain basic capabilities or as entitlements to capabilities (Sen 1999, 2005; Nussbaum, 2000, 2006).

Sen's priority in developing the Capability Approach was to provide a framework for the conceptualization of human development and for the analysis and assessment of poverty. Sen viewed the Capability Approach as having two core concepts: functionings and freedom. Functionings is the achievement of the individual, what he or she achieves through being or doing. Functionings is 'beings and doings' such as being nourished, being confident, or taking part in group decisions. Functionings includes all types of functioning, from basic ones to complex ones. Freedom is the second core concept of the Capability Approach. In Sen's view, freedom is "a person's ability to get systematically what he would choose" (Alkire, 2002, pp. 5-6). Thus, capability, for Sen, is a kind of freedom to achieve alternative functioning combinations.

Sen initially conceptualized the Capability Approach in the context of poverty. According to Sen, poverty can be conceptualized in terms of "capability deprivation". In his perspective, income is not the only means of determining one's capabilities (Sen, 1999, pp. 87-88). In assessing poverty, Sen considers that the relationship between income and capability is strongly affected by parametric variations such as the person's age, sex, social roles, location (prone to flooding or drought), and epidemiological environment (based on disease in a region); and by other variables over which a person has limited control. Therefore, according to Sen, not only personal characteristics such as disability or illness reduce one's ability to earn an income, but they also make it harder to convert income into capability because a person who is more disabled or seriously ill may need more income for aid and treatment to achieve a level of functioning comparable to a person without such disability or illness (Sen, 1999, p. 74). Finally, in terms of capabilities, deprivation results from the interaction among the resources available to a person, personal characteristics (e.g., impairment, age, and sex) and the environment. Thus, poverty can be viewed as a person's failure to achieve basic capabilities or the failure to choose what he or she values.

Similar to poverty, disability can be logically viewed in terms of the failure of a person with a disability to achieve basic capabilities (Welch Saleeby, 2002; Mitra, 2006; Terzi, 2005). Although deprivation can result from the nature of an impairment, it may not be the only cause. In light of the Capability Approach, the relationship between impairment and capability may be

more consequential than impairment alone. In addition, this relationship may be affected by the age of the person, his or her sex, geographical location, and culture. In summary, disability can be defined in terms of the failure of a person with a disability to achieve basic capabilities, or the failure to choose what he or she values.

Capabilities Approach in Practice

The United Nations Development Program has published the *Human Development Report* annually since 1990; the content of this report is partly based on the Capability Approach (UNDP, 1990–2008; Robeyns, 2006; Alkire, 2002). In the *Human Development Reports*, human development is defined as “a process of enlarging people's choices”, which is achieved “by expanding human capabilities and functionings” (UNDP, 2000, p. 17). Today, over “500 national-level human development reports” use the Capabilities Approach as a basis for discussing “regional, national and local development strategies” (Robeyns, 2006).

In addition to the *Human Development Reports* which put the Capability Approach into practice, several recent studies have assessed this approach empirically. Robeyns (2006a) addressed the current applications of the Capability Approach, specifically, general assessments of the human development of a country (Drèze & Sen, 2002; Ranis, Stewart, & Ramirez, 2000); identification of the poor in developing countries (Laderchi, 1997; Klasen, 2000, Qizilbash, 2002; Asali, Reddy, & Visari, 2005); poverty and well-being assessments in developing countries (Balestrino, 1996; Phipps, 2002; Chiappero-Martinetti, 2000); the assessment of gender inequalities (Sen, 1985; Robeyns, 2003; Chiappero-Martinetti, 2003); theoretical and empirical analyses of policies (Schokkaert & Otegem, 1990; Lewis & Giullari, 2005; Dean et al., 2005; Terzi, 2005); critiques on social norms, practices and discourses (Olson, 2002 ; Robeyns, 2005c); and an analysis of the deprivation of people with disabilities (Zaidi & Burchardt, 2005; Kuklys, 2005).

There have been few studies of the Capabilities Approach based on qualitative methods (Arends-Kuenning & Sajeda, 2001; Alkire, 2002; Anand et al., 2005). Zimmermann (2006) argues that the Capabilities Approach has largely been studied within quantitative methods. But the importance of examining Capabilities Approach qualitatively has largely been ignored. Zimmermann argues that researchers need to seriously consider the use of qualitative methods in studies of the Capabilities Approach to obtain a rich and detailed understanding of constructs such as freedom and opportunities which are core concepts of the Capability Approach.

Capabilities Approach and Disability

In recent years, there has been increasing literature reporting the usefulness of the Capability (Capabilities) Approach for understanding, analyzing, and assessing disability. In 2002, Baylies reviewed human rights discourses related to disability and argued that the Capabilities Approach may provide a better framework “for identifying the responsibilities of governments and external agencies in genuinely equalizing opportunities” (p. 725).

Terzi (2005) argued that the Capability Approach is “an ethical, normative framework based upon justice and equality” (p. 197), which provides an essential view for reconceptualizing disability and special needs. Terzi (2006) believes that the Capability Approach is an appropriate framework for “assessing the relevance of impairment and disability in designing just and inclusive institutional and social arrangements” (p. 203). She believes that the capability perspective on disability provides appropriate directions for inclusive educational policies to respect human diversity and to consider the special needs of children with disabilities. Terzi (2007) provides a conceptual framework based on the Capability Approach for a just distribution of opportunities and effective access to educational functionings for children with disability and special educational needs. Following the increasing literature on conceptualizing equity in education within a social justice framework, Polat (2011) discusses the theoretical relationships between inclusion in education and social justice. Polat draws on Nussbaum’s Capability Approach which brings disability into the social justice debate to develop an index of inclusion in Tanzania. Robeyns (2006) believes that the central aim of educational policy must be to expand people's capabilities.

Mitra (2006) believes that the Capability Approach helps to understand disability at the conceptual level, namely, potential and actual disability. Accordingly, disability may result from an individual's personal characteristics, resources, and environment. Further, Mitra believes that the Capability Approach can be considered a useful framework for analyzing the employment and the standard of living of people with disabilities.

Sherlock and Barrientos (2002) argued that Nussbaum's Capabilities Approach can be considered a useful tool for understanding the condition of older people in developing countries. Gilroy (2006) suggested that the Capabilities Approach could be a valuable tool for providing a

framework for evaluating the environments of older people and the level of support that they provide.

Some researchers have been interested in the applicability or compatibility of the Capability Approach within the ICF or social model. Welch Saleeby (2007) believes that together the Capability Approach and the ICF help to understand disability. This approach, according to her, helps practitioners to evaluate what people with disabilities are actually able to do in their lives. Morris (2009) believes “the capability approach provides an alternative framework to the ICF for examining inequalities in well-being and social arrangements” (p. 92). Morris believes that including a capability perspective for measuring participation may be more helpful than “measuring only ‘capacity’ and ‘performance’ as proposed by the ICF” (p. 92). According to Morris, the goal of services should be to equalize children’s capability sets by removing barriers to enable participation and giving children a degree of choice and freedom, therefore, a key outcome in evaluation services is increasing children’s capabilities, rather than performance. Reindal (2009) claims that a modified version of the social model is more compatible with the Capability Approach than the ICF.

Trani, Bakhshi, Noor, and Mashkoor (2009) discussed disability policy in Afghanistan and that it has had rather limited impact. Trani et al. suggested that Sen's Capability Approach can be considered as a relevant framework for designing disability policy and implementation. Orton (2011) explored whether the Capabilities Approach offers a potential framework for new thinking in relation to policy in the United Kingdom. After reviewing this policy on employment, work and welfare, Orton concluded that “the capabilities approach is best thought of not as offering a detailed road map for policy, but as providing a critically different conceptualization of the purpose and principles of public policy” (p. 352).

To conclude, in a review of the literature, the Capabilities Approach is generally considered a tool for social justice in the context of disability. Despite the growing literature on the Capabilities Approach, its application has been largely overlooked within the context of the rehabilitation professions, including occupational therapy, and their practices.

Central Human Functional Capabilities

Sen’s Capability Approach was deliberately incomplete (Alkire, 2002; Sen, 2004). His main concern was showing how the Capability Approach can be shared among scholars, even those

with opposing philosophical ideas. A common conceptual base enables scholars from various backgrounds to work on common issues (Alkire, 2002; Robeyns, 2005a).

But the questions of what are basic capabilities, and how can they be identified, operationalized, and put into practice, have remained at the core of the Capabilities Approach (Alkire, 2002; Gasper & Staveren, 2003; Robeyns, 2005b, 2006; Deneulin, 2008).

Nussbaum attempted to address these questions. She detailed the Central Human Functional Capabilities (CHFCs) with the intention of providing a basis for “constitutional principles that should be respected and implemented by the governments of all nations, as a bare minimum of what respect for human dignity requires”. Nussbaum’s description of CHFCs was an effort “to summarize the empirical findings of a broad cross-cultural inquiry” (Nussbaum, 2000, p. 5). She advocated that the list that resulted should be considered as “a list of very urgent items that should be secured to people” (Nussbaum, 1997-1998). Nussbaum’s CHFCs include (Nussbaum, 2000, pp. 78-80):

1. **Life.** Being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living.
2. **Bodily Health.** Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.
3. **Bodily Integrity.** Being able to move freely from place to place; having one’s bodily boundaries treated as sovereign, i.e. being able to be secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.
4. **Senses, Imagination, and Thought.** Being able to use the senses, to imagine, think, and reason – and to do these things in a “truly human” way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing self-expressive works and events of one’s own choice, religious, literary, musical, and so forth. Being able to use one’s mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to search for the ultimate meaning of life in one’s own way. Being able to have pleasurable experiences, and to avoid non-necessary pain.

5. **Emotions.** Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by overwhelming fear and anxiety, or by traumatic events of abuse or neglect. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.)
6. **Practical Reason.** Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience.)
7. **Affiliation. A.** Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another and to have compassion for that situation: to have the capability for both justice and friendship. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.) **B.** Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails, at a minimum, protections against discrimination on the basis of race, sex, sexual orientation, religion, caste, ethnicity, or national origin. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.
8. **Other Species.** Being able to live with concern for and in relation to animals, plants, and the world of nature.
9. **Play.** Being able to laugh, to play, to enjoy recreational activities
10. **Control over One's Environment. A. Political.** Being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association. **B. Material.** Being able to hold property (both land and movable goods), not just formally but in terms of real opportunity; and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure.

Critical Review of the Capabilities Approach

Although there is not any literature to specifically criticize Nussbaum's Central Human Functional Capabilities, the Capabilities Approach itself has confronted some objections and critiques. This section examines various critiques of this approach. First, we review some of John Rawls' advocates and also Ronald Dworkin's critics of the Capabilities Approach. Second, we examine some of the opponents to this approach with respect to its universal applicability and cultural considerations. Third, we review criticisms related to the cosmopolitan approach.

Strict critical ideas are from adherents of Rawls' theory of justice, for instance, Thomas Pogge (2002a) argues that although the Capability Approach has "done much to advance the discussion of social justice ...", it cannot be justified as a comprehensive theory of justice (p. 71). He maintains that a theory of social justice must clarify its principles; as Rawls developed "justice as fairness" based on the two principles of justice: the priority of equality and fair opportunity for all citizens (Rawls, 1971). In the same vein, Joshua Cohen (1998) has criticized one of the main claims of the Capability Approach, that "the facts of diversity complicate our understanding of equality" (p. 288). He argued that Rawls's "primary-goods comparisons will suffice" in that case (p. 288). Rawls described primary goods as "what persons need in their status as free and equal citizens, and as normal and fully cooperating members of society over a complete life" (Rawls, 1999, p. 54). Rawls's primary goods are "things which a rational man wants; whatever else he wants" (Rawls, 1971, p. 92).

In response to these Rawlsian critics, Robyns (2009) argues that these criticisms are overstated difference between the Capabilities Approach and Rawls's justice as fairness. In this way, she continues, Rawls argues that interpersonal comparisons for social justice is based on social primary goods, the main claim of the Capability Approach is that in making interpersonal comparisons based on the dimension of capabilities (Robeyns, 2009). She asserted that "rather than pitting both theories against each other as rivals, it is possible to understand the capability approach and justice as fairness as complementary and potentially converging theories" (p. 398).

Another critic is Ronald Dworkin, who argues that the Capability Approach is unclear and "the false goal of equal welfare or well-being" (2000, p. 303). He claims that Sen's view of capability is vague as it either collapses into equality of welfare, or into equality of resources (p. 286).

Responding to Dworkin's critique, Sen argues that the distinction between capability and

achievement shows equality of capability is not the same as equality of welfare. He also argues that the equality of resources is not the same as the equality of capability:

Since resources are ‘merely useful and for the sake of something else’ (as Aristotle put it), and since the case for equality of resources rests ultimately on that ‘something else’, why not put equality of resources in its place as a way of getting to equality of the capability to achieve- if the congruence between the two does actually hold? (Sen, 2009, p. 265).

Other critics, however, argue that the Capabilities Approach is indifferent to cultural diversity. For example, Gasper (1997) argues that the Capabilities Approach needs to pay more attention to “culture” and “the individual”. Also, Skerker (2000) believed that universal applicability of Nussbaum’s Capabilities Approach has some limitations, particularly with respect to religion (p. 409).

Nussbaum, however, asserted that the Capabilities Approach is “fully universal”, because it is based on “the freestanding moral core of a political conception, without accepting any particular metaphysical view of the world, any particular comprehensive ethical or religious view, or even any particular view of the person or of human nature” (Nussbaum, 2000, p. 76). Also rejecting the critique concerning inappropriateness of a conception of person in the Capabilities Approach, Nussbaum states that capabilities should be considered as “important for each and every citizen, in each and every nation, and each is to be treated as an end.” (p. 6)

Presenting the Capabilities Approach as “a form of universalism that is sensitive to pluralism and cultural difference”, Nussbaum provides a strong critical response to the objection based on cultural arguments (Nussbaum, 2000, p. 8). According to Nussbaum, the Capabilities Approach does not ignore cultural differences; it is rather attempting to avoid cultural relativism. The idea of relativism, as Nussbaum states, is clearly in conflict with the modern world. She argues that “Why should we follow the local ideas, rather than the best ideas we can find? ... Most local traditions take themselves to be absolutely, not relatively, true.... So in asking us to follow the local, relativism asks us not to follow relativism” (p. 49). Thus she maintains, “the cultural argument fails; nor can it be rescued by an appeal to moral relativism” (p. 49). Nussbaum believes that we need local knowledge in order to understand the problems people face. But this is completely different with the claim of paternalism to treat people with insufficient or unequal respect. Nussbaum writes,

People are the best judges of what is good for them, and if we prevent people from acting

on their own choices, we treat them like children.... the variety of ways citizens actually choose to lead their lives in a pluralistic society, and therefore to prefer a form of universalism that is compatible with freedom and choice of the most significant sorts (Nussbaum, 2000, p. 51).

She argues that we should reject paternalism “because there is something else that we like, namely each person’s liberty of choice in fundamental matters” (Nussbaum, 2000, p. 53).

Some critics such as Anthony Burns (2013) emphasized the ambiguous relationship between Nussbaum’s Capabilities Approach and the cosmopolitan tradition. According to cosmopolitan thinkers, there are various versions of cosmopolitanism. Pogge (2002 b) distinguishes between two versions of cosmopolitanism: legal (strong), and moral (weak). He writes,

Legal cosmopolitanism is committed to a concrete political ideal of a global order under which all persons have equivalent legal rights and duties - are fellow citizens of a universal republic. Moral cosmopolitanism holds that all persons stand in certain moral relations to one another. We are required to respect one another’s status as ultimate units of moral concern - a requirement that imposes limits on our conduct and, in particular, on our efforts to construct institutional schemes. This view is more abstract, and in this sense weaker than, legal cosmopolitanism (p. 169).

Nussbaum (2011) believes “Because the Capabilities Approach is a form of political liberalism, it is not a comprehensive doctrine of any sort. It is therefore mistaken, and a serious misreading of my political views, to call it a form of cosmopolitanism” (p. 92). Despite Nussbaum’s claim, Burns argues that Nussbaum can be related with a weak form of cosmopolitanism. While it is hard to support legal (strong) cosmopolitans, moral (weak) cosmopolitans are defensible. One can argue that the weak version of cosmopolitanism “can be accepted by almost anybody – excepting a few racists and other bigots” (Miller, 2002, p. 84). However, although the Capabilities Approach is not based on any comprehensive doctrines including cosmopolitanism, as Nussbaum says, it can be endorsed by many comprehensive doctrines: “Cosmopolitans can probably accept most of what I recommend, but one does not have to be a cosmopolitan to accept the idea that all citizens should have a minimum threshold amount of the ten capabilities” (Nussbaum, 2011, p. 93).

Although there are some important arguments among these critics, it seems that the Capabilities Approach is able to answer a range of questions. By making a distinction between capabilities, functionings, and freedom of choice, it shows its boundary with Rawlsian’ theory of justice and Dworkin’s equality of welfare and equality of resources. Also, it shows that this

approach has no conflict with cultural differences but it is against cultural relativism. Furthermore, it shows although it is not based on any comprehensive doctrines, many cultural and religious traditions or moral cosmopolitans can endorse it.

1.3 Rationale for the Thesis

Disability has become a human rights issue (UN, 1993, 2007). People with disabilities in much of the world lack the support to ensure their basic human rights are respected, and their fundamental capabilities are maximized. They are more likely to experience failure in their capabilities, as articulated by Nussbaum, including living a normal life expectancy, being healthy, being able to move freely from place to place, being able to experience self-expressive and creative activities, having attachments to people and things, being able to plan for one's life, being able to show concern for other human beings and engage in various forms of social life, being able to live with concern for and in relation to the world of nature, being able to laugh, play, to enjoy recreational activities, being to participate effectively in political choices that govern their lives; having the right to political participation, and having the right to seek employment on an equal basis with others (Nussbaum, 2006). People with disabilities, "like other human beings, have needs in the areas covered by all the capabilities" (p. 169).

Rehabilitation programs "should be based on the individual needs of people with disabilities and on the principles of full participation and equality" (United Nations, 1993). Rehabilitation professions such as occupational therapy have a particular commitment to functional independence and participation in life in an environment that is both enabling and respectful of an individual's right to live, work and play without imposed restriction. For the purposes of this research, we argued that the contemporary values of occupational therapy practice are consistent with maximizing people's functional capabilities embedded in the Capabilities Approach, hence, consistent with promoting the rights of people with disabilities. Therefore, we queried whether Nussbaum's ten CHFCs have a role in enhancing OTs' knowledge about a client's basic needs and rights, such that they could be used systematically to inform and guide a client's management to maximize his or her functional capabilities. We planned to elucidate the perspectives of Canadian OTs related to their understandings of the ten CHFCs put forth by Nussbaum, and their perceived

relevance to professional practice. This exploration and examination of the Capabilities Approach in an applied health context could help align health care specifically occupational therapy services with human rights initiatives of the United Nations and the World Health Organization, based on adherence to universally accepted principles. This type of exploration has the potential to be extended to other health care professions and across cultures.

1.4 Thesis Chapters

To explore the views of Canadian OTs about their understandings and perceived relevance of Nussbaum's ten CHFCs to the profession and their practices, the study consisted of two phases. Phase One consisted of semi-structured interviews and Phase Two consisted of a national online survey. The overall dissertation is organized into five chapters. Chapter 1 presented the introduction to the study, reviewed the literature on common rehabilitation service approaches and the Capabilities Approach, and the general aims of the work. Chapter 2 describes the study's methodology and presents the exploratory sequential mixed methods design as the best-fit design, and overviews its two phases. With respect to Phase One, Chapter 3 describes the qualitative methodology selected for collecting and analyzing the data, and describes the findings. With respect to Phase Two, Chapter 4 describes the online survey for collecting and analyzing the quantitative data, and presents the survey results. Chapter 5 discusses the mixed qualitative and quantitative findings, and the main findings overall, their implications, and the strengths and limitations of the study overall.

2 METHODOLOGY

2.1 Study Design

This chapter describes the methodological and epistemological perspectives that frame the study, specifically, the methods guiding the study and the rationale for the use of mixed methods and a pragmatist approach to the research.

2.1.1 Purpose of Statement

The purpose of the exploratory sequential mixed methods design of this study was to explore and understand the views of occupational therapists (OTs) about their understandings and perceived relevance of the Central Human Functional Capabilities (CHFCs) with respect to their professional practices. Phase One of the study consisted of a qualitative exploration of the views of OTs about the CHFCs based on interviews. Findings generated from the qualitative study informed the development of a questionnaire survey that was used to collect data from a larger population of Canadian OTs. Phase Two of this study consisted of a quantitative description of their views and thoughts regarding the qualitative findings generated in Phase One. Data from both phases were mixed for the final analysis designed to provide a more complete description of OTs' views regarding the relevance of the ten CHFCs to OT practice.

Based on the purpose of the research and the research questions, the researcher chose a pragmatist approach to the inquiry using mixed methods to gather data. The following section describes the mixed methods design and justifies the philosophical underpinnings of a pragmatist approach for this research.

2.1.2 Research Questions

The design described above was selected to address the following research questions:

1. What are OTs' understandings of the ten CHFCs?
2. How may these capabilities be relevant to the contemporary practice of OTs?

These questions were addressed in both the qualitative and quantitative phases of this thesis.

2.1.3 Mixed Methods Design

Mixed methods research is “an approach to knowledge (theory and practice) that attempts to consider multiple viewpoints, perspectives, positions, and standpoints” (Johnson et al., 2007, p. 113). Mixed methods designs have become increasingly popular among rehabilitation researchers this past decade (Creswell, 2003; Plano Clark, & Creswell, 2008).

Mixed methods designs described as “the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority, and involve the integration of the data at one or more stages in the process of research” (Creswell et al., 2003, p. 212). These designs take advantage of both qualitative and quantitative methods to enhance the credibility of the research findings through integration of data from two data collection methods (Patton, 2002; Ivankova et al., 2006). The reason for combining qualitative and quantitative methods begins with the recognition that different methods have different strengths (Morgan, 1998).

Morgan (1998) cited that some researchers have criticized mixed methods designs on the ground that quantitative and qualitative approaches stem from various paradigms and assumptions about the nature of knowledge. From the critics’ point of views, mixed methods researchers have not deeply considered issues and concerns of each paradigm (Morgan, 1998). They asserted that quantitative approaches stem from positivism tradition that seeks objectivity, and that qualitative approaches stem from the interpretative paradigm that recognizes the existence of multiple realities and meanings (Morgan, 1998).

Researchers have argued that the use of mixed methods becomes a technical task of choosing appropriate methods by trying to combine the strengths of both approaches within one framework, rather than trying to combine conflicting paradigms. They assert that mixed methods designs enable researchers to maximize the ability to bring various strengths together in the same study (Morgan, 1998; Johnson & Turner, 2003; Johnson & Onwuegbuzie, 2004).

Mixed method researchers do not advocate one approach over another, they view qualitative and quantitative approaches as being compatible rather than opposed. For them, all approaches are valuable (Teddlie & Tashakkori, 2003). An advantage of mixed methods designs is that these designs enable “the researcher to simultaneously answer confirmatory and exploratory questions, and therefore verify and generate theory in the same study” (p. 15). Therefore, both qualitative and quantitative methods appear to be valid means of generating and verifying theory.

2.1.4 Exploratory Sequential Mixed Methods

An exploratory sequential mixed methods design was selected as best fitting the purpose of this study. The design consisted of an initial qualitative data collection and analysis followed by a quantitative data collection and analysis (Creswell & Plano Clark, 2007, 2008). According to Creswell and Plano Clark (2010), the four major types of mixed methods designs are the triangulation design (where two methods are used to obtain triangulated results in the same study (p. 77); the embedded design (where a second source of data is used to enhance the study); the explanatory design (where quantitative methods are used to explain the results), and the exploratory design (where qualitative methods are used to explore a phenomenon in depth) (p. 59).

An exploratory mixed methods design is considered when “measure or instruments are not available, the variable are unknown, or there is no guiding framework or theory” (Creswell & Plano Clark, 2007, p. 75). Researchers employ this design when they need to “generalize results to different groups, to test aspects of an emergent theory or classification or to explore a phenomenon in depth and then measure its prevalence” (p. 75).

According to Morgan (1998), it is important to determine “a priority decision” and “a sequence decision” when using mixed methods design. The priority decision establishes the principal method for collecting data. Priority can be given to one method over the other, or both methods can play equal roles in a study. Many factors influence the priority decision, e.g., the purpose of the study, the research questions, the researcher’s background, and resources (Plano Clark, & Creswell, 2008; Creswell, 2009). Priority in this study was given to the qualitative phase because the topic was new and little is known (Morgan, 1998). Thus, the results from the qualitative phase (Phase One) informed the quantitative phase (Phase Two).

The sequence decision concerns “the order in which the qualitative and quantitative data are used” (Morgan, 1998, p. 366). The sequence decision is based on timing considerations (Creswell & Plano Clark, 2007). Timing refers to when one source of data is collected and analyzed before the collection and analysis of the other source of data (Creswell, 2009; Creswell and Plano, 2008). In an exploratory sequential design, the qualitative data are collected and analyzed first, follow by the quantitative data. The rationale for this design was that the quantitative data and their subsequent analysis provide a general understanding of the area of

interest. Its advantages include opportunities for the explanation of the qualitative results. This design can be especially useful for exploring or developing new idea (Hanson, et al., 2005) as was proposed for this study.

The initial qualitative phase allowed determination of OTs' understandings and views about the ten CHFCs and in what way these capabilities are described as relevant to occupational therapy practice. The qualitative data of Phase One were used to develop the survey questionnaire for Phase Two. The quantitative data of Phase Two were used to further explain the data overall. All data were then examined together in a process of data integration, in order to comprehensively address the research questions.

2.2 Overview of the Research Phases

The main purpose of this study was to explore and describe the views of Canadian OTs with respect to their understandings and perceived relevance of Nussbaum's CHFCs to their professional practices. An exploratory sequential mixed methods study was conducted in two phases. Phase One focused on how the Nussbaum's CHFCs may be relevant to contemporary occupational therapy practices. Semi-structured interviews were conducted with 14 OTs in British Columbia, Canada, who had indicated their willingness to participate in order to explore their views related to the ten CHFCs, and provided insight into how each of the capabilities might be operationalized within the context of the practice of occupational therapy. Findings generated from Phase One (the qualitative study) informed the development of a survey instrument that was used to collect data from a larger population of OTs. A cross-sectional survey of a population of OTs practicing in Canada was conducted in Phase Two to confirm and extend the categories that emerged from Phase One. Data from both phases were then mixed in the final analysis to provide a more complete description of the OTs' views about the ten CHFCs in relation to occupational therapy practice.

3 THE VIEWS OF OCCUPATIONAL THERAPISTS ABOUT THE CENTRAL HUMAN FUNCTIONAL CAPABILITIES WITH RESPECT TO THEIR PROFESSION AND PRACTICE: A QUALITATIVE STUDY

This chapter describes the qualitative methodology for Phase One of the study. It describes the strategies used to collect and analyze the data, and describes the qualitative findings.

3.1 Study Design

Qualitative methods are said to be useful when describing a point of view, when the variable will not be identified easily, when the topic needs to be explored and explained with detailed descriptions, and when the topic is new or little is known (Morse, 1992; Creswell, 1998, 2003). Qualitative researchers are committed to incorporating many truths and multiple realities, rather than one truth and one reality. They are committed to elucidating ranging perspectives and reporting their observations in a “rich literary style” (Streubert & Carpenter, 2011, p. 22). In addition, if a research idea deals with “imprecise concepts” or intends to study issues in depth and in detail, this then leads better to qualitative rather than quantitative methods (Flick, 2002, Patton, 1990).

As the notion of “the relevance of Central Human Functional Capabilities (CHFCs) to occupational therapy practice” is new to the profession of occupational therapy and little is known, *Phase One was designed to be qualitative* to allow the topic to be explored and explained with detailed descriptions.

The qualitative phase of this study did not precisely match the five commonly reported qualitative traditions; namely, ethnography, case studies, phenomenology, narrative research, and grounded theory (Creswell, 2003). The ethnographic design was not a component of this study because cultural issues and observation were not its focus. Nor could it consider a phenomenology design, as this inquiry did not seek to understand and describe the phenomenon of experiences. The study was neither consistent with being classified as a case study nor narrative research, because it did not intend to report stories; nor did it constitute grounded theory as it did not intend to develop a new theory.

As this study was not guided by established qualitative traditions, a generic qualitative approach was used. Caelli, Ray, and Mill (2003) noted that many terms used in qualitative research literature do not match an explicit qualitative approach; such as “interpretive

description” defined by Thorne et al. (1997) or “basic or fundamental qualitative description” described by Sandelowski (2000), they are generic qualitative approaches. Caelli et al. (2003) defined generic qualitative studies as “those that present some or all of the characteristics of qualitative endeavor but rather than focusing the study through the lens of a known methodology they seek to do one of two things: either they combine several methodologies or approaches, or claim no particular methodological viewpoint at all” (pp. 3-4).

Given the overall purpose of this study was to explore the views of occupational therapists (OTs) about the CHFCs, the Phase One was approached from the interpretive description, which focuses on the understandings and perceptions of the participants (Thorne, 2008).

3.1.1 Interpretive Description

“Interpretive description” as a methodological approach employed in this phase enabled us to address the research questions in a way that was not addressed by the five commonly reported qualitative traditions. Interpretive description methodology developed by Thorne, Kirkham, and MacDonald-Emes (1997) refers to “noncategorical qualitative research approaches that are derived from an understanding of nursing’s philosophical and theoretical foundations” (pp. 169-170). Although interpretive description was developed in nursing science, it has recently been employed within the health professions as well (Hunt, 2009).

Interpretive description methodology recognizes the influences of the theoretical basis for the study, and the knowledge and practice of the discipline (Thorne, 2008). As described in Chapter 1, the theoretical framework for this study was derived from the Capabilities Approach literature, characteristics of rehabilitation services, and the importance of client-centered practice in Canada. Interpretive description uses the theoretical structure of the research as a frame for the data collection and analysis. Therefore, in this study, Nussbaum’s ten CHFCs were used as a frame for data collection and analysis. The researcher’s experience as an OT and her academic background in philosophy provided a unique lens through which to explore and interpret the data.

This methodological approach enabled the researcher to examine the views of OTs by identifying the shared realities of their experiences; and, to integrate the themes that emerged with the collective knowledge underpinning occupational therapy.

One characteristic of interpretive description is the use of the researcher's theoretical background and experience as a framework for the data collection and analysis. Thus, this study was informed by several sources: (a) the researcher's examination of the literature of the Capabilities Approach; (b) several research projects that she had conducted during her graduate studies that examined social justice in health care, and (c) her experiences as an OT.

3.1.2 Reflexivity and Researcher Positionality

Researchers who conduct qualitative research must address the reflexivity and their theoretical positioning. Reflexivity refers to the process of how researchers have influenced the research (Dowling, 2008). In other words, it means "sensitivity to the ways in which the researcher and the research process have shaped the collected data, including the role of prior assumptions and experience, which can influence even the most avowedly inductive inquiries" (Mays & Pop, 2000, p. 51). As there is no personal neutrality in conducting a research (Asselin, 2003), researchers need to be aware of their "motives, presuppositions, and personal history that leads him or her toward, and subsequently shapes, a particular inquiry" (Caelli, et al., 2003, p. 9).

Therefore, the researcher in the present study adopted reflexivity by writing a journal to assist in her understanding of her prior assumptions and attitudes (Dowling, 2008). Writing about her background and identifying my assumptions in carrying out this research, shaped her reflections about the work and understanding and interpretation of the results.

Her perspective during this research has been greatly affected by her previous experience as an occupational therapist (OT), and graduate studies in philosophy at Concordia University.

From 1995 to 2000, she was working as an OT with the Iran Welfare Organization. During that time, the biomedical model was the predominant model in rehabilitation services, and health professionals treated people with disabilities as people with illness and impairment. She observed that the biomedical framework could not fully address the concerns of her clients. The majority of her clients were suffering from poverty and lack of access to basic needs more than their disabilities.

The complexities of problems that people with disabilities in developing countries such as her country (Iran) experience, led her to extend her knowledge outside occupational therapy practice. Her aim was to explore the relationship between poverty and disability. She learned that poverty and disability have been identified as part of a "vicious circle" in the international

development literature; disability increases the risk of poverty and circumstances of poverty raise the risk of disability.

During her master's program, she was fascinated with the idea of justice. Her understanding of justice has been influenced by John Rawls's idea of "justice as fairness". Rawls defined "justice as fairness" as the priority of equality and fair opportunity for all citizens. Her mind was preoccupied with how to extend justice to people with disabilities so they have equal opportunities to achieve their goals.

During her doctoral program, she planned to explore further these issues of interest to her. She became familiar with an important theory, related to world poverty, the so-called Capability Approach. It provided her with a sound basis for thinking about the multidimensional nature of poverty and disability. She learnt that poverty could be understood as deprivation of basic human rights; and, human rights can be seen as claims to the CHFCs.

She thought about the applicability of the CHFCs to occupational therapy practice. Thus, she became interested in exploring the views of her colleagues with respect to their perceived relevance of the CHFCs to professional practice. She interviewed OTs related to this topic. Throughout her research interviews, she was challenged to reflect on her own notions and assumptions of the CHFCs. So early in her research, she believed it was important to write about her understanding of the CHFCs to clarify her personal assumptions.

She assumed that occupational therapy program plays a crucial role in reducing poverty and promoting basic rights by expanding the basic capabilities of people with disabilities. Also, she assumed that Nussbaum's CHFCs framework have implications for health practitioners. Given the creative nature of occupational therapy practice, she assumed OTs could identify strategies for expanding, improving, and creating the functional capabilities of people with disabilities. Finally, she believed the outcome of this research would enable OTs to better reflect on issues related to human rights and their role in promoting equal opportunities across people with varying needs. Her assumptions were written down during the initial interviews and they influenced her during her research as a whole.

3.1.3 Selected Sampling

Purposive sampling was employed for Phase One, the qualitative study, in accordance with an interpretative paradigm. The sample of OTs selected for participation consisted of those who

were thought to be able to best assist in enhancing the understanding of the meaning, relevance and applicability of the CHFCs to occupational therapy practice. Selecting a purposeful group of participants helped to maximize the chance of acquiring a range of perspectives based on the participants' diverse experiences, educationally and professionally (Patton, 2002; Minichiello et al., 2004). Specifically, participants were selected to represent a range of interests and positions in relation to the profession of occupational therapy. The researcher sought to gather the most varied and insightful information possible from the participants to reflect potential diversity of opinion about the relevance and applicability of the CHFCs to occupational therapy practice.

There are no strict criteria for sample size determination in qualitative methods. Sample size is often justified when no new information seems to emerge (the saturation point). Morse (2000) stated that reaching saturation "depends on a number of factors, including the quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the use of shadowed data, and the qualitative method and study design used" (p. 3).

Initially, the researcher's supervisory committee agreed that a sample of 8 to 12 interviewees would capture an appropriate sample size to obtain various perspectives. Because the topic of this study was new, reaching a clear saturation point took longer. The researcher continued interviewing participants until data saturation has been achieved (n=14). Estimating the number of participants in Phase One of this study depended on the scope of the research questions, the clarity of questions, the difficulty of the topic, and study design. As well, writing field notes and reviewing audio files assisted with decisions related to further sampling and attaining saturation.

3.1.4 Qualitative Phase Recruitment

As a recruitment method, the researcher used a purposive and a maximum variation sample. The researcher sought to gather the most varied information possible from the participants to reflect the possible diversity of opinions. Purposive sampling included contacting professors at the University of British Columbia (UBC) Department of Occupational Science and Occupational Therapy to assist with identifying potential participants. As well, the UBC Occupational Science and Occupational Therapy Academic Fieldwork Coordinator provided information to access OT practice coordinators at the GF Strong Rehabilitation Center, Mount Saint Joseph Hospital, Saint Paul's Hospital, Vancouver Community Health Services, and

Vancouver General Hospital Acute Care Services, all of which were within the Greater Vancouver metropolitan area.

The researcher established the following criteria for participants for Phase One: They were working in BC and were able to communicate in English. In order to have a sample group as representative as possible in the field, some participants worked in clients' homes and in community settings, while others worked in hospitals, institutional, schools, and private clinic settings.

3.1.5 Description of Participants

The description of the 14 participants appears in Table 3.1. The researcher attempted, unsuccessfully, to recruit men as participants to the study, so all participants were women. Eleven OTs were educated in Canada. Although each participant had experienced working in multiple settings, six had worked in hospitals, and five had worked mainly in clients' homes or community settings, two had worked in hospitals and communities, and two were working at the university.

In this study, the researcher initially decided to recruit OTs from a range of settings and professional roles including practice, educators, faculty members, and administrators in British Columbia. At the same time, consideration was given to participants' age, duration of experience, and practice settings. The ages of participants ranged from 27 to 64 years. Participants graduated from occupational therapy training between 1967 and 2010. They had worked as OTs between 2 and 34 years *and in a range of settings*.

3.2 Data Collection

3.2.1 Semi-structured Interviews

Consistent with interpretive description, interviews have become the primary source of data in many fields of qualitative inquiry to produce meaningful answers to research questions (Thorne, 2008, p. 78, p. 86). The primary source of data collection in Phase One was through one-on-one, face-to-face, open-ended, semi-structured interviews.

Comparable to administering structured interviews, in the semi-structured interviews, the researcher asked the same questions, in the same order for all participants (Morse, 1992, pp.

361-362). One advantage of using semi-structured interviews is comparability of the data, because they were obtained through consistent use of an interview guide (Morse, 1992; Flick, 2002). Flick (2002) points out that if collecting concrete statements about an issue is the aim of the data collection, semi-structured interviews are the most efficient means of doing so. As the purpose of Phase One was to explore the OTs' views about the ten CHFCs with respect to their understandings and perceived relevance of these capabilities to their professional practice, the semi-structured interview method was understood to be the most appropriate method. This method enabled the researcher to use the interview guide to ask each participant the same questions, and generated additional questions during the interview when needed to clarify the participants' meanings and views.

3.2.2 Designing the Interview Questions

Pilot interviews with two OTs were conducted to generate feedback about the interview guide, which is generally considered to be a list of questions or a series of issues that the researcher brings to an interview (Johnson & Turner, 2003, p. 305). Pilot interviews provided feedback about the clarity and logical ordering of the interview questions, the duration of the interview, as well as allowing the researcher to evaluate her interviewing technique. Finally, an interview guide was finalized based on the issues raised through the pilot interviews. Interview questions were designed to address the initial research questions: 1) What are OTs' understandings of the ten CHFCs, and 2) How may these capabilities be relevant to the contemporary practices of OTs (Appendix B). The interview questions were therefore designed based on 11 parts (10 CHFCs, and one general views about the 10 CHFCs). Each part has two categories based on the two research questions (OTs' understandings, and the relevance).

3.2.3 Conducting the Interviews

Following the pilot study, the researcher interviewed 14 OTs who indicated they were willing to participate in the study. At the initial meeting, the consent form (Appendix C) was reviewed with each participant, and then she was requested to sign the form. Prior to each interview, the participants were informed about the study and its requirements, and informed that they were free to discontinue the interview or refuse to answer any question. On meeting with each

participant, the researcher provided further instruction to them. Permission to record the interview was obtained. Informed consent was reviewed, assuring participants that their participation was voluntary and their responses would be confidential. They were informed that the interview would be tape-recorded and transcribed and that some of the information they provide might be quoted anonymously in the study results. The participants were interviewed once, in a quiet environment of their choice (for example, at their workplace, at their homes, or at my office). The informed consent, demographic questions, and a copy of the interview guide were sent to participants a week prior to the interview date to allow time for reflection on the topic.

The interviews were audio recorded and transcribed verbatim from the digital recordings. Interviews were conducted between February 10, 2012 and March 20, 2012. Each interviewee participated in an interview that lasted 40 to 60 minutes. The researcher maintained memos while conducting the interviews and while listening and reading the transcripts. Interview recordings were transcribed by a professional transcription service with an agreement of confidentiality and removal of information identifying the participants. In addition, the researcher listened to all interview recordings and re-read the transcripts several times to ensure accuracy.

3.3 Data Analysis

Data analysis began as the data were collected and this served as a basis for further data collection (Streubert & Carpenter, 2011; Minichiello et al., 2004; Creswell, 2003).

Analysis of the data began with reflecting on the researcher's assumptions related to CHFCs and their relevance to occupational therapy practice. Based on interpretive description, the preliminary phase of data analysis is a time that the researcher reacts to the initial pieces of data that seem interesting and labeled them as 'meaning units' (Thorne, 2008, p. 143). For example, the researcher reflected on a part of the transcript that seemed meaningful to her:

“...it sort of reflects some approaches that we have already been introduced to, either as students, or I guess as students, and may be even just sort of societal, just some level of common knowledge, I guess.” (Participant 1, p. 1)

In interpretive description, “the hard work of data analysis relies on the intellectual practices associated with seeing possible relationships among pieces of data you are gathering and then

considering the manner in which these relationships play out (or don't) across the growing and evolving wider data set" (Thorne, 2008, p. 138). So, the researcher asked herself: why do I interpret this part as a meaningful unit? What does it mean for me? Does it provide meaning for my research questions? Such questions allowed the researcher to reflect on the 'meaning unit', and to break it down into a shortened meaning unit and start coding (Thorne, 2008).

In interpretive description, one of the types of coding that is widely recommended is open coding (Thorne, 2008, p. 145). Therefore, the transcriptions of the initial interviews were reviewed and open-coding undertaken prior to subsequent interviews with participants. Thematic analysis was used to segment and categorize the data. The following section describes the process used for thematic analysis.

3.3.1 Conducting Thematic Analysis

Thematic analysis involves the identification of prominent or frequent themes in the literature to summarize the findings of interviews under thematic headings. Thematic analysis allows clear identification of prominent themes as well as organized and structured ways of dealing with the themes (Dixon-Woods et al., 2005; Boyatzis, 1998; Braun & Clarke, 2006).

This analysis procedure in Phase One enabled the researcher to:

- systematically reduce and manage, organize and summarize data; and interpret them based on deductive thematic analysis (related to the ten capabilities),
- quantify emerging themes for Phase Two of her study which aimed to extend and confirm the thematic categories to a larger population, and
- transform the qualitative data into quantitative data (Boyatzis, 1998).

The process for analysis of the data consisted of: 1) familiarization, 2) reducing the raw information, 3) generating initial codes (first cycle coding), 4) reviewing themes, 5) identifying themes within subsamples, 6) comparing themes, 7) creating themes, 8) ensuring the credibility, and 9) producing the report.

There are two approaches to thematic analysis, inductive and deductive. This research used both processes. First, the deductive approach was applied to examine the data, and then the nine-step process was used to inductively develop themes based on the guidelines of Braun & Clarke (2006) and Boyatzis (1998).

As there is no one way to conduct thematic analysis, there is no one set of guidelines. Braun and Clarke (2006) provide a six-step process for analysis that includes: familiarizing yourself with your data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. Boyatzis (1998) uses five steps to inductively develop themes: reducing the raw information, identifying themes within subsamples, comparing themes across subsamples, creating themes, and determining the reliability of themes.

Although the nine-step process was followed as systematically as possible, analysis is not a linear process of simply moving from one step to the next. The process of thematic analysis required moving back and forth within the data to establish a comprehensive set of themes (Braun & Clark, 2006).

Familiarization

Becoming familiar with the data involves ‘repeated reading’ of the data, and reading the data in an active way, searching for meanings, patterns and so on. The researcher read the data set in its entirety before beginning the coding.

Reducing the Raw Information

To codify is to arrange the data in a systematic order (Saldana, 2009). The raw information was reduced to a manageable size (Boyatzis, 1998). This involves preliminary identification of a priori themes, in this case, the ten CHFCs guided the coding of the data. To summarize, the researcher reduced the data based on 11 parts (10 capabilities and 1 general view). Each part consisted of 2 categories based on the two main research questions (OTs’ understanding and perceived relevance).

Generating Initial Codes

Coding is the process of generating ideas and concepts from raw data. In interpretive description, “the idea of attaching “code” to a piece of interview transcript or file derives from assumptions that one knows what the element entails, what other kinds of things might be similar and what it ought to be distinguished from”(Thorne, 2008, p. 144).

The coding process refers to the steps taken to identify, arrange, and systematize the ideas, concepts, and categories uncovered in the data. Coding consists of identifying potentially interesting events, features, phrases, behaviors, or stages of a process and distinguishing them with labels (Benaquisto, 2008).

During the coding process, memo writing was used and was an essential part of the analysis (Appendix D provided an example of analytic memo writing). It was used to elaborate and reflect on ideas that emerged from the data during the coding process. The researcher integrated memo writing throughout data collection and processing.

In thematic analysis, the unit of analysis is inclined to be “more than a word or phrase” (Boyatzis, 1998). It is not easy to derive a simple answer to the question of what amount of a data set should be considered as a theme (Braun & Clarke, 2006). Researcher judgment is necessary to determine what a theme is (Sipe & Ghiso, 2004; Braun & Clarke, 2006). In this step, the researcher chose the parts of the data set that best addressed the interview questions, in terms of establishing themes. Then, she queried whether each theme shed light on new discoveries, insights, and connections about the participants’ thoughts (Saldana, 2009).

The researcher coded the data manually to feel “close” to the data (Creswell, 2012, p. 240). Labels were written in the margins of transcripts, and memos were written as ideas emerged. The researcher used more than one method for first-level coding which included (Saldana, pp. 50-51):

Attribute Coding: used for essential information about the demographic characteristic of the participants, for example, age and gender.

In Vivo: referred to a word or short phrase from the actual language. This technique “helps us to preserve participants’ meanings of their views and actions in the coding itself” (Charmaz, 2006, p. 55).

Process Coding: used for ongoing action/interaction, response to situations, or problems). For example, when the phrase “it is important to listen to clients” emerged, it was coded as “Listening to clients”.

Emotion Coding: used to label the participants’ emotions and experiences. For examples: “...I don’t know” was coded as “Uncertainty”.

Values Coding: used to reflect participant’s value, attitude, and beliefs, for example, “Affiliation capability is key to living”.

Evaluation Coding: used to understand whether the participants made a positive (+) or negative (-) comment or recommendation (REC) tag was noted. For example, “...that not only it’s relevant, it may be helpful” reflects a positive view (+), while “...I don’t think it’s relevant to

daily practices in OT” reflects a negative view (-). When a participant provided a recommendation, for example, “there should be a guide for action” the (REC) tag was noted.

In the initial coding stage, as many potential themes as possible were coded as it was difficult to predict what might be interesting later. Key phrases or words that captured the main ideas of the participants’ responses to a specific question were highlighted, and any statements that the researcher felt were strongly communicated.

At the end of this phase, the codes were analyzed to consider how they would fit into an overarching theme. “A theme is a phrase or sentence that identifies what a unit of data is about and what it means” (Saldana, 2009, p. 139).

Reviewing Themes

This stage consisted of the code refinement. In this stage, themes were categorized based on main topics, themes, sub-themes, useless, and ‘miscellaneous’ themes (Braun and Clarke, 2006). The researcher labeled some themes such as “OTs’ understandings of Life Capability”, or “Relevance of Life Capability to occupational therapy practice” as the main themes. Or, “Affiliation Capability is about social relations”, “Control over One’s Environment Capability is about making decisions” as sub-themes. Some themes did not seem to be useful in addressing the research questions, such as: “People with disabilities usually have a lot of grieving”, so the researcher categorized these as being less meaningful themes. Some themes did fit into main themes or sub-themes, such as “people with mental health issues are treated differently”, “many people with mental health issues live at the poverty line”, and “Bodily Integrity Capability is related to occupational therapy practice in developing countries”, so these were temporarily labeled as ‘miscellaneous’ themes with the potential of informing an essential theme or being a new theme.

According to Braun and Clarke (2006), “the outcome of this refinement process can be seen in the thematic map” (p. 91) in relation to the entire data set. The researcher went back and forth within the data set to further refine the categories until a thematic map emerged. A thematic map helped to translate categories into themes.

As Braun and Clarke suggested, it is impossible to provide clear guidelines on when to discontinue data collection. Therefore, the researcher discontinued when she noted refinements were no longer adding anything substantial. At the end of this stage, she had an idea about the themes that emerged, namely, a set of themes and sub-themes that were relevant to the study

research questions. A total of eleven thematic maps were generated through this analysis. As an example, a representative thematic map for the Emotions Capability is shown in Appendix E.

Identifying Themes within Subsamples

The two samples of OTs (those who work in the area of mental health and those who work in pediatrics) were selected to identify themes within these practice areas (Appendix F provides an example of how themes within subsamples can be identified).

Initially, the comparison of the transcripts was done with color coding to show differences and similarities between the two samples (Appendix F). Participants from the two samples noted that CHFCs: 1) reflect occupational therapy models or approaches such as client-centered approach or the Canadian Occupational Performance model (shown in grey), 2) are applicable in occupational therapy practice (shown in yellow), 3) are interesting (shown in dark blue), 4) are about basic human rights and needs (shown in blue), 5) are important to OTs work with mental health (shown in purple), and 6) are about improving an individual's function which reflects the goal of occupational therapy practice (shown in green). No differences were found between the two subsamples.

Comparing Themes across Samples

First, the themes that emerged from two samples of OTs were compared and contrasted. Then, each transcript was re-read by the researcher to ensure the themes applied across the data set. She would make notes in the margins for later reflection about a theme's relevance.

Creating Themes

The themes that showed a distinction between the two samples of OTs, were rewritten for maximum clarity. The researcher asked herself such questions as:

- Can I read each of the transcripts and clearly see that a given theme is present or absent?
- Is the theme presented with the fewest concepts possible?
- Have I reduced the number of themes as much as possible without losing their meanings?

If there was no clear differentiation between the themes, it was dropped from further analysis. This process clearly defined what the themes were and what the themes were not as noted by Braun and Clarke (2006).

Ensuring Credibility

As part of the transcription process the integrity of the data was preserved by listening to the transcriptions several times as previously described, and using an additional transcription service to double check the transcripts to ensure accuracy.

Various strategies have been suggested to ensure the credibility of qualitative research findings. Creswell (1998) recommends that at least two of following eight procedures be incorporated:

1. Prolonged engagement and persistent observation in the field;
2. Triangulation, which makes use of multiple and different sources, methods, investigators and theories to verify study findings;
3. Peer review or debriefing, in which a peer asks the investigator hard questions about methods and interpretations to enhance the credibility;
4. Negative case analysis, in which the researcher refines the working hypothesis as the inquiry advances in light of disconfirming evidence;
5. Clarifying researcher bias, in which the researcher clarifies past experiences and biases so that readers understand the researcher's position and any assumptions;
6. Member checks, in which the researcher has participants verify findings and interpretations;
7. Rich, thick description, which allows readers to determine whether the finding can be transferred to other settings; and
8. External audits which allow an external consultant to examine the process and findings of the study.

For the purpose of the present research, four of these strategies were thought to be most relevant to the data set, namely, thick description, clarifying researcher bias, peer review, and triangulation.

Thick Description is a method for enhancing the quality of research by quoting the participants' exact words. This method was employed to allow the reader to determine the accuracy of interpretation.

Clarifying Researcher Bias is indicated because the researcher is the key instrument of the data collection, and her biases may threaten the credibility of data (Patton 2002; Creswell, 2003). Although there is no personal neutrality in conducting a research, it is important "to assume he or she knows nothing about the phenomenon under study and start gathering data from a fresh

perspective with his or her “eyes open” (Asselin, 2003, p. 100).

Steps were taken to identify the personal biases of the researcher, in her role as the primary investigator. A few methods were applied in this study to minimize the risk of researcher bias in the data analysis. First, her biases and assumptions were identified and documented. Second, memo writing provided an opportunity to reveal her biases and assumptions.

According to Krefling (1991), writing a field journal is a way that researchers can be aware of their biases and assumptions. The field journal “reflects the researcher's thoughts, feelings, ideas, and hypotheses” (p. 218). Through this stage, the researcher decided to write her assumptions and any thoughts that might impact on the research process. Her reflections revealed that she had some assumptions about the relevance of the CHFCs to occupational therapy practice. These assumptions included: 1) CHFCs can enhance client-centered occupational therapy practice, 2) CHFCs would be well-defined concepts for OTs, 3) CHFCs was a new approach for OTs, and 4) OTs struggled to explain how the CHFCs could be relevant to occupational therapy practice. Some assumptions were challenged during the interviews, thus encouraged her to remain open to the experiences and perspectives of the participants.

Based on her assumptions, the researcher attempted to minimize her biases. For example, during the interviews, she learned that although the Capabilities Approach was a new approach for OTs, they did not perceive the CHFCs as new concepts in the context of occupational therapy.

Ahern (1999) described the importance of identifying anything new or surprising in the data collection or analysis. Some of the unexpected data that the researcher identified included: the range of definitions of the CHFCs provided by the study participants, and the diversity of their professional settings and practice areas. Finally, the researcher attempted to minimize her biases in order to explore the experiences of the participants in an authentic manner and enhance the credibility of this research.

Peer Review although Creswell (1998) suggested that using a peer-review strategy helps the researcher to ensure the credibility of qualitative research findings, some scholars believe peer-review can be subject to biases. Mahoney (1977) criticizes the assumption that peer-review can be considered as “an adequate and objective process” (p. 174). He asserted “confirmatory bias is the tendency to emphasize and believe experiences which support one's views and to ignore or discredit those which do not” (p. 161).

Thus, peer-review can prejudice not only because there are distinct areas of science and schools of thought, but also because of the irrational component of the nature of science. Kuhn (1962) shows how extra-scientific factors such as social, political, and religious factors influence the outcome of scientific debates.

Accordingly, some reviewers might be influenced by their adherence to a certain opinion and opposite view to others, and reject other views based on irrational elements. Consequently, in the current research, it was difficult to choose unbiased reviewers. Therefore, a member of the supervisory committee agreed to review the researcher's decision-making process regarding the selection of relevant themes from the quotes. The researcher created records detailing the various stages of analysis and the rationale for her decisions with respect to coding and creation of themes. The member of the supervisory committee also wrote summaries of the meetings with the researcher and the decision making process.

Triangulation Denzin (1978) identified four types of triangulation: data triangulation, investigator triangulation, theory triangulation, and methodological triangulation (Plano Clark & Creswell, 2008, p. 21). Data triangulation and investigator triangulation were used to collect data in this study. Patton (2002) provided examples of data triangulation such as “comparing what people say in public with what they say in private”, and “comparing the perspective of people from different points of view” (p. 559). In this study, triangulating data from various sources (OTs who work in the area of mental health and OTs who work in pediatrics) and the different points of view (occupational therapy practitioners, educators, faculty members, and administrators) helped the researcher present the results from multiple perspectives. Investigator triangulation involved comparing the line-by-line coding of responses with a member of the supervisory committee. The areas of agreement and disagreement were identified and examined across themes.

Producing the Report

The findings of Phase One provided an enriched understanding of the relevance of the CHFCs to occupational therapy practice. The findings of this qualitative phase included 11 parts and 22 categories consisting of 75 themes when written into a cogent report of findings. This is detailed in the 3.4 section.

3.3.2 Trustworthiness

There are varying views about how rigor can be achieved in qualitative research. Some qualitative researchers, such as Altheide and Johnson (1998) and Leininger (1994), claimed that reliability and validity are relevant to quantitative research and entirely inappropriate terms in qualitative inquiry (Morse et al., 2002). According to such researchers, reliability and validity stem from positivist paradigm that seeks objectivity, while qualitative approaches stem from a post-positivist paradigm that acknowledges the existence of multiple realities and meanings (Morgan, 1998; Winter, 2000).

Other qualitative researchers assumed new criteria for ensuring rigor and determining reliability and validity in qualitative research (Morse, 2002). They suggested using terms such as 'trustworthiness', 'worthy', 'relevant', 'plausible', 'confirmable', 'credible' or 'representative', believing that these are more appropriate terms in qualitative research (Winter, 2000).

Lincoln and Guba (1985), for example, replaced reliability and validity with “trustworthiness”. According to them, trustworthiness consists of four aspects: “credibility (parallel to internal validity), transferability (parallel to external validity), dependability (parallel to reliability), conformability (parallel to objectivity)” (Markula & Silk, 2011, p. 205). We explain these aspects within specific methodological strategies for determining rigor in Phase One of our study.

To increase credibility, the researchers can ask themselves “How can one establish confidence in the ‘truth’ of the findings of a particular inquiry? (Lincoln & Guba 1985, p. 290). As discussed earlier, credibility in Phase One is enhanced with the use of strategies such as thick description, clarifying researcher bias, and triangulation (see *Ensuring Credibility* section).

To increase transferability of the findings of a qualitative study, it is useful the researchers ask themselves the question of “How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)” (Lincoln & Guba 1985, p. 290). Researchers can apply some strategies; such as thick description and purposeful sampling, to enhance transferability of the data (Jensen, 2008). The researcher in the present study provides the reader with a full description of the 14 participants (see *Participation Description* section and Table 3.1.) and by quoting the participants’ exact words. Also, purposive sampling was employed to enhance the understanding of the meaning, relevance and applicability of the CHFCs to occupational therapy practice to the participants, and to

maximize the chance of acquiring a range of perspectives based on the participants' diverse experiences, educationally and professionally (Patton, 2002; Minichiello et al., 2004).

Participants were selected because they most represent the research design to enhance the potential that readers can assess the degree of transferability to their given context.

Qualitative researchers are concerned with the dependability of their work rather than replicating it. Lincoln and Guba (1985) cited that in qualitative research, the researcher has to ask the question of "How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects (respondents) in the same (or similar) context?" (p. 290). Bozinovski (1995) noted "any techniques which bolster credibility (e.g., triangulation) will also improve dependability" (p. 131). In our study, the researcher used triangulation to enhance the creditability and dependability of the data (see *Ensuring Credibility* section).

Dependability also means that the research cannot be absolutely assumed a priori (Jensen, 2008). The researcher can enhance dependability of a qualitative inquiry by describing the changes in context and circumstances, and providing rationale for doing the changes. The researcher needs to "track all of the notes that differ from the design in the proposal" (Jensen, 2008). Dependability in this phase also was enhanced by changes to the recruitment procedure (the researcher first used a maximum variation sample to gather the most varied information possible from the participants to reflect the possible diversity of opinions. The researcher attempted, unsuccessfully, to recruit men as participants to the study, so she used purposive sample). Initially, the researcher's supervisory committee agreed that a sample of 8 to 12 interviewees would capture an appropriate sample size to obtain various perspectives. Because the topic of this study was new, reaching a clear saturation point took longer, so the researcher continued interviewing participants until data saturation has been achieved (n=14). Also, in the proposal, we used a thematic analysis method based on a five-stage process described by Ritchie and Spencer (1994) (i.e., familiarization, identifying a thematic framework, indexing, charting, and mapping and interpreting) for analyzing the data in Phase One. For more accurate analysis, the researcher decided later to use the nine-step process by combining the guidelines of Braun and Clarke (2006) and Boyatzis (1998) for conducting thematic analysis. The researcher's supervisory committee reviewed all modifications, and the rationales for changes to ensure the dependability of this phase of the study.

Conformability is concerned with “How can one establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and the conditions of the inquiry and not by the biases, motivations, interests, or perspectives of inquirer?” (Lincoln and Guba 1985, p. 290). According to Bozinovski (1995), “triangulation and keeping a reflexive journal also increase the likelihood of conformability (p. 132). To ensure conformability in this phase, steps were taken to understand the CHFCs from the perspective of the research participants by providing quotes from the interview transcripts, using triangulation, and identifying the personal biases of the researcher and minimizing them (see section 3.3.1 *Conducting Thematic Analysis*).

3.4 Findings

This section is organized into eleven parts. The first ten parts describe OTs’ views as related to each of the ten capabilities, namely, Life; Bodily Health; Bodily Integrity; Sense, Imagination, and Thought; Emotions; Practical Reason; Affiliation; Other Species; Play; and Control over One’s Environment. The eleventh part describes the OTs’ views of Nussbaum’s ten CHFCs, overall. The findings are described in relation to the two research questions for each capability. Within each capability, the themes that emerged are described in detail. These are as follows:

1) Life Capability

Question I) What are OTs’ understandings of Life Capability?

Themes:

- basic human rights
- quality of life
- longevity

Question II) How may Life Capability be relevant to occupational therapy practice?

Themes:

- quality of life
- working with people with mental health issues
- working with seniors
- acute care, palliative care, and end of life care

2) *Bodily Health Capability*

Question I) What are OTs' understandings of Bodily Health Capability?

Themes:

- basic human right
- health promotion
- interconnected with the Life Capability

Question II) How may Bodily Health Capability be relevant to occupational therapy practice?

Themes:

- promoting health and preventing diseases
- feeding and/or eating
- addressing physical health for those with mental illness
- advocating for adequate shelter and basic nutrition
- uncertainty about managing reproductive health

3) *Bodily Integrity Capability*

Question I) What are OTs' understandings of Bodily Integrity Capability?

Theme:

- basic human rights

Question II) How may Bodily Integrity Capability be relevant to occupational therapy practice?

Themes:

- client-centered approach
- an advocacy perspective
- providing (emotional) trauma-informed care
- addressing mobility issues
- referring clients to resources

4) *Sense, Imagination, and Thought Capability*

Question I) What are OTs' understandings of Sense, Imagination, and Thought Capability?

Theme:

- expressing oneself in various ways

Question II) How may Sense, Imagination, and Thought Capability be relevant to occupational therapy practice?

Themes:

- self-expression
- people with mental health issues
- children with disabilities

5) Emotions Capability

Question I) What are OTs' understandings of Emotions Capability?

Themes:

- basic needs and rights

Question II) How may Emotions Capability be relevant to occupational therapy practice?

Themes:

- people with mental health issues
- children with disabilities
- all those seen by OTs
- finding support systems
- helping people manage their emotions
- teaching anxiety management skills

6) Practical Reason Capability

Question I) What are OTs' understandings of Practical Reason Capability?

Theme:

- making personal decisions

Question II) How may Practical Reason Capability be relevant to occupational therapy practice?

Themes:

- a client-centered perspective
- providing educational and supportive strategies

7) Affiliation Capability

Question I) What are OTs' understandings of Affiliation Capability?

Themes:

- basic needs and rights
- social relations

Question II) How may Affiliation Capability be relevant to occupational therapy practice?

Themes:

- helping clients to identify their interests
- developing friendships, social network, and social skills
- advocating for their clients
- working with clients with mental illness

8) *Other Species Capability*

Question I) What are OTs' understandings of Other Species Capability?

Theme:

- the environment

Question II) How may Other Species Capability be relevant to occupational therapy practice?

Themes:

- relationship with animals and nature affects health
- a spirituality perspective
- a client-centered perspective
- an environmental perspective
- is not the main focus of occupational therapy practice

9) *Play Capability*

Question I) What are OTs' understandings of Play Capability?

Themes:

- human happiness
- preserves quality of life
- achieves a work/life balance

Question II) How may Play Capability be relevant to occupational therapy practice?

Themes:

- a primary therapeutic approach in pediatric practice
- a therapeutic approach when working with persons with mental health issues
- its importance for everyone

10) *Control over Ones' Environment Capability*

Question I) What are OTs' understandings of Control over Ones' Environment Capability?

Themes:

- decision-making
- a basic human right
- political opinions

Question II) How may Control over Ones' Environment Capability be relevant to occupational therapy practice?

Themes:

- developing decision-making
- helping clients gain and retain employment
- advocating for their clients

11) General Views

Question I) What are OTs' general understandings of the ten CHFCs?

Themes:

- a new approach
- a range of occupational therapy practices
- more theoretical than practical
- more related to mental health practice
- The construct of function is common to the CHFCs as well as OT models
- They overlap

Question II) How may CHFCs be relevant to occupational therapy practice?

Themes:

- the Canadian Model of Occupational Performance
- the Human Occupational Model
- the Person Environment Occupation Model
- a client-centered approach
- a recovery approach
- a human rights model
- Maslow's hierarchy of needs
- a social justice model
- an advocacy approach

3.4.1 Life Capability

This part aims to explain the views of OTs of the Life Capability related to the two research questions:

Question 1) What are OTs' understandings of Life Capability?

The participants were asked about their understandings of the Life Capability based on Nussbaum's definition and three themes emerged: Basic human right; Quality of life; and Longevity of life. The following describes the quotes that support these themes.

i) A basic human right

One of the perspectives from which the majority of participants addressed Life Capability was to see it as "basic human rights". Here basic human rights include both rights and needs, meaning everyone has the right to life as a basic human right and to have basic needs met.

Right to life as a basic right was described as the right to live to the end of a normal human life, right to be free from dying early, deadly violence, suffering, and famine. A number of participants indicated that Life Capability is relevant to OT practice. They described it as a basic human right.

I think that's sort of a basic principle. (Participant 1, p. 1)

I think that it's a general human right, and so to me, it's a right...(Participant 5, p. 2)

Life Capability was also described as a basic need that is consistent with survival and having access to basic things; such as, foods, shelter, and health. Life Capability was said to be necessary for achieving healthy well-being.

...the basic things that are required for health, access to housing and water and medical care, and food. (Participant 13, p. 1)

ii) Quality of life

The second perspective from which some participants addressed Life Capability was to see it as "quality of life".

...it's also I think the quality of life. (Participant 2, p. 3)

...[it] is certainly about, well it is quality of life. (Participant 5, p. 2)

..it is a basic quality of life that everybody should be able to achieve. (Participant 7, p. 1)

There were multiple meanings of quality of life from the point of view of the participants. Participant 3 described it as,

...it should be more about the quality of life as opposed to the length of life. (p. 2).

While participant 12 described quality of life as,

...I think there's much more of an understanding and approach to looking at the life and the quality of life and if it's worth living or not ...(p. 2)

The term "Life worth living" was ambiguous for some participants. Participant 8 critiqued it from the perspective of bioethics.

The other thing that frightened me was the term "life is so reduced as to be not worth living". It doesn't say according to the person of whose life is being discussed. Who decides when a life is worth living or not? Who decides if that person must stay alive because their life is worth living or doesn't need to stay alive because it isn't worth living? (p. 2)

The phrase "life worth living" also was critiqued from the perspective of the tension between universalism and cultural doctrine. Participant 7 referred to the differences between western and eastern cultures that largely influence the western understanding of "life worth living".

...I always critique things from a universal perspective of how relevant is this to everybody, because presumably it's a western developed theory and so how relevant is it to people who live in non-western contexts or to indigenous people. (Participant 7, p. 1)

iii) Longevity of life

The third perspective from which some participants addressed Life Capability was to see it as longevity. Some participants noted that Life Capability is about both quality of life and longevity. They asserted that the lifespan of people with disabilities may be shortened. For example, participant 2 noted that,

We know that people living with mental health issues are not living a long life. They are living a shorter life ... they're dying a lot more early than typical population. Life is reduced, so therefore, it's the longevity of life but it's also I think the quality of life. (p. 2)

Participant 5 also mentioned suicide as an example of dying prematurely in people in mental health issues.

In mental health, dying prematurely might be related to suicide. (p. 2)

Some pediatric OTs also asserted that Life Capability is about "a normal life expectancy".

Participant 4 expressed that,

Obviously, we want to be able to live a normal life and, you know, feel that is worth-living, but I am working in pediatrics with children with a huge variety of either diagnoses or disabilities, or, there's a lot of cases where those kids would not be living at, sort of quote: "a normal life" or, that there is a good chance that they going to be dying

prematurely, and yet I would still hope that they're having a life that is worth-living, and that there is lots of great things for them in their life, despite the fact that their lifespan may be shortened. (p. 3)

In addition to disability itself that reduces life expectancy, some participants indicated that some socioeconomic factors affected life span.

...there are a lot of people in our society, in Canada for example, whose life expectancy is less, based on their social economic status, living conditions, ethnicity maybe, gender, right?...yeah so, and those people, are they able to live to the end of their life of normal length, not dying prematurely? (Participant 7, p. 2)

Question II) How may Life Capability be relevant to occupational therapy practice?

The results described the four themes on the relevance of Life Capability to occupational therapy practice. These were: Quality of life; Working with people with mental health issues; Working with seniors; Acute care; and Palliative care and end of life care. The following describes the quotes that support these themes.

i) Quality of life

Almost all participants agreed that increasing and improving clients' quality of life is a priority of occupational therapy practice. They asserted that the Life Capability could be relevant to occupational therapy from quality of life perspective.

[Life Capability is relevant to occupational therapy] only if you look at it from the quality of life perspective. (Participant 3, p. 3)

Some participants asserted that OTs' focus is on promoting the quality of life of their clients rather than the longevity.

... OTs would go further to not just to live a human life of normal length, but OTs, I think understand that it's to promote people's quality of life. It's not just to encourage people to live length of lifespan, in fact we more focus on quality more than quantity. If somebody in fact has disability or progressive illness and cancer or whatever, something that you know they're going to deteriorate very soon and there's not much that we can do, then the OT is not going to be focusing on the normal focus, not trying to have them live a certain number of years but actually whatever number of years that they have, try to promote their quality of life. (Participant 1, p. 1)

Some participants who work in acute care also agreed that OTs attempt to maximize the quality of people's lives even if they are dying.

OT's about the quality of life, not the length of life, now those two go together, but I work on a ward where people are dying and it becomes, it strips it down to the basics of what's important to the person, and its quality not length. (Participant 8, p. 2)

One participant noted OTs maintain the clients' quality of life by providing a supportive environment as described in the following:

I think so because the whole idea is what we want to do is maximize the quality of people's lives and that we do that through prevention, through restoration, but I also think that we work in palliation and that we are concerned with the quality even when someone is at the end of life, and it doesn't matter where on the age range that is, that we have a view about what's comfortable for that person and we work with that person to try and decide that so that time at any stage of the spectrum of life is maximizing that person's goals that they set for themselves, and we facilitate that. (Participant 10, p. 3)

Participant 9 explained that occupational therapy programs and public health have overlapping goals with respect to increasing the clients' quality of life.

I think OT and public health have a lot of links in terms of being able to, we're trying to educate clients, or doctors or whoever to, about increasing health through all stages, so diabetes prevention or whatever it might be, trying to encourage people to eat well, live healthy, etc., to try increase their quality of life. (p. 2)

Some participants stated that OTs increase the quality of life through promoting health and preventing injury. Participant 13 noted that OTs have roles in the area of chronic disease management, and implementing self-management programs.

Well first of all we have a role in, I think in primary health care, so making sure that people are living actively and well, if they are well and maintaining their health, and then if they are in the whole area of chronic disease management, we have a role as well. Again, helping people live well with a chronic disease and be involved in self-management programs and have access to the information that they need to live well, so yeah, I saw it really compatible with OT [occupational therapy]. (p. 3)

Some participants expressed that OTs try to maintain their life as high quality as possible by giving the clients tools and strategies to participate. Participant 3 mentioned that OTs help their clients use assistive technology, such as wheelchairs, to improve social participation and exercise control over their environment.

Well, most of our kids may technically not be able to participate in some things because of their disabilities, but they still may want to. Especially, you know, when the younger children are often influenced by their peers, or it's such an important time for social interaction and so, we want to, whether it's putting the equipment in place or compensative strategies or something helping them to still be able to participate in all those things and I think that is a part of quality of life. (p. 3)

Quality of life is about improving a life worth living from a few participants' point of views. Some participants stated that OTs have important roles in helping people “adjust to a major trauma” and cope with their disabilities.

...so we're mostly seeing people after the ill-effects after the disease or an accident, but certainly from this “so it's not reduced to be not worth living”, that's a huge role that we play, helping people adjust to a major trauma or a major loss of independence. (Participant 13, pp. 2-3)

ii) Working with people with mental health issues

Some participants who described Life Capability as longevity asserted that it is relevant to OTs who work with mental health illness as it impacts on their work, and their clients' health and wellness issues.

So people I know who live with mental health issues, literature indicates that people die 25 years earlier as a result of having mental health issues, so definitely that [Life] Capability has huge impact for the kind of work that we do and it has impact in particular around health and wellness issues. (Participant 2, pp.1-2)

As cited before, some participants noted that people with mental health illnesses' lifespan may be shortened, and they are dying earlier compared to typical population. Suicide was mentioned as an example for dying prematurely in people with mental health illnesses. Occupational therapists develop interventions to help people have a longer life through exploring their world and their perceptions related to Life.

But I guess also if you're working in mental health, so looking at some individuals who are suicidal and working with them, exploring what their perceptions are, and what their rationale is. Why do they see that as a real option and then being able to help them look at other options? (Participant 6, p. 1)

In mental health practice, a number of participants noted, OTs help clients enjoy a longer life through meaningful engagement in occupation and providing various perspectives about what constitutes meaningful engagement.

But, as an occupational therapist, working with them on establishing what is going to be the most meaningful occupations for them to be pursuing, given their time. And strategies for maybe having a different perspective around how they're dealing with that. So if it's someone who's depressed, perhaps, and lacking motivation to do anything, because of the imminent, they have a medical condition and they think life has ended as they know it, and helping them to explore...well really, there's other things they could be doing, and what would be meaningful for them – like to explore that with them. Perhaps to have the different perspective. And maybe to be more meaningful for them...(Participant 6, p. 2)

Some participants mentioned that OTs support clients to have a longer life by helping them overcome various barriers. For example, reducing side effects of medications, and helping clients to be employable and have housing.

I think it's to develop interventions that help people have a longer life, so to take away some of the barriers, because people who are on medication, we know that they may have increased heart troubles, they may gain weight, so part of it is to take away if we can, as some of the impacts of that medication to some somehow reduce the negative determinant such as poverty, so to help people have an income, for people who live on substance abuse, to ensure people to get things like housing. (Participant 2, p. 3)

iii) Working with seniors

Some participants asserted that Life Capability is relevant to OTs who work with elderly when using appropriate accessibility and fall prevention strategies to promote the elders' Life Capability. For example,

Absolutely, I think that aging and dementia and being able to care for our elderly and our seniors with dignity and compassion is very much part of our role as an OT [Occupational therapist]...[we] looking at being able to offer appropriate accessibility. (Participant 4, p. 1)

I think probably just being able to support life, generally through provision of say like fall prevention strategies in the home to prevent people from falling which increases chances of early death or things like that, so there's different things we do in the environment for example that might help...(Participant 9, p. 2)

Some participants noted that the philosophy of residential care is to preserve life worth living. Occupational therapists prevent further medical problems in residential care and attempt to balance prevention and freedom. Participant 12 described how OTs can improve the residents' abilities in the following,

..[It] would be a philosophy in residential care – to look whether one's life is worth living and not having people die prematurely from, for example: bladder infections that are easily curable, and pressure sores that could be prevented, so there's a lot of this approach to preventing some of the other untoward consequences of illness and immobility. (p. 2)

Participant 12 stated that although OTs can develop many interventions to increase their clients Life Capability, there are barriers. For example:

...but it's so very difficult, just because the workload is high everywhere. (p. 2)

iv) Acute care, palliative care, and end of life care

Some participants who addressed Life Capability as longevity perceived that maintaining life and enhancing the Life Capability is more related to occupational therapy practice in acute care, palliative care, and end of life care settings.

Well, the goal is basically to have a normal life expectancy, so doing whatever you can to facilitate that, I would think. Maybe if you were in a more acute care model; that would be probably maybe a higher priority. Where you'd actually kind of work on specific strategies for that... if you were working on palliative care team, or working on a HIV/AIDs program, ...you would actually be going through some very specific strategies that would maintain life, and longevity. (Participant 6, p. 2)

Participant 10 mentioned that OTs' main focus is to increase people's quality of life through reducing their pains and stresses in palliative care.

...I also think that we work in palliation and that we are concerned with the quality even when someone is at the end of life, and it doesn't matter where on the age range that is, that we have a view about what's comfortable for that person and we work with that person to try and decide that so that time at any stage of the spectrum of life is maximizing that person's goals that they set for themselves, and we facilitate that. (p. 3)

Also, participant 6 stated OTs' increase people's quality of life through exploring what actually would be meaningful for the clients and helping them to achieve their goals in palliative care.

So someone who has HIV or someone who's in a palliative care situation, they have cancer, their life is probably going to be shortened. But, as an occupational therapist, working with them on establishing what is going to be the most meaningful occupations for them to be pursuing, given their time. (pp. 2-3)

One participant highlighted the ways that OTs are involved in the end of life care by helping individuals to be comfortable and supporting end of life care.

I think that one in particular is quite relevant to palliative care. We're looking at sort of helping individuals be able to be comfortable, especially in the end component of human life and looking at how we can do to help, whether it's health promotion as well, to look at increasing the amount of life that people have, by preventing diabetes and things like that, as well as the palliative care aspect in supporting life in the end. (Participant 9, p. 2)

3.4.2 Bodily Health Capability

This part describes the themes that emerged from the analysis of the interviews in answering the two questions:

Question 1) What are occupational therapists' understandings of Bodily Health Capability?

Three themes emerged: Basic human right; Health promotion; and Interconnection with the Life Capability. The following describes the quotes that support these themes.

i) Basic human right

According to participants, the Bodily Health Capability refers to the right to be physically healthy, to have shelter and sufficient food, and is essential and worth achieving in OTs' interventions.

My general understanding it's sort of, it's the basics, you know, it mentions: shelter, and I think working in pediatrics, you see this a lot, that you want before we can even attempt to look at what the OT goals are, we need to know that our kids have a safe place to live, that they have food, loving caregivers. The basic needs, exactly... (Participant 3, p. 3)

That's absolutely an OT value. If people's basic health needs are not being matched with food and shelter, for sure... (Participant 4, p. 2)

...it [Bodily Health Capability] is a basic human right and function... (Participant 5, p. 2)
People with disabilities are more likely to experience failure in being healthy and being able to meet their basic needs. Suggesting Participant 2 stated: "So many of our clients are not in good health." (p. 2)

ii) Health promotion

One of the perspectives from which some participants addressed the Bodily Health Capability was to see it as health promotion, wellness and lifestyle management as in:

Bodily Health, I think probably just similar to Life or with health promotion. (Participant 9, p. 2)

Well, good health, I think this reminds me a wellness, good health being adequately nourished like that...they remind me how OT concern with people kind of lifestyle and life style management. (Participant 1, p. 2)

Some Participants described Bodily Health Capability as the physical conception of health that includes nutrition, exercise, and sleep.

To me it seemed to be a very physical concept of bodily health, body as is in physical...(Participant 7, p. 3)

So having good health is again... Certainly I know, within mental health, we talked a lot about nutrition, exercise, and sleep as just the basics of good health. (Participant 5, p. 2)

iii) Interconnected with Life Capability

Some participants indicated that Bodily Health Capability was to overlap with the Life Capability as both are about basic rights and needs as well as related to health promotion.

...it relates to the life capability. (Participant 2, p. 3)

For Bodily Health, I think probably just similar to Life or with health promotion.

(Participant 9, p. 2)

That kind of fits in with Life. I guess I kind of rolled them both in. (Participant 13, p. 2)

Question II) How may Bodily Health Capability be relevant to occupational therapy practice?

The results described the five themes that emerged from the analysis of the OTs' perspectives on the relevance of Bodily Health Capability to occupational therapy practice. These were: Promoting health and preventing diseases; Feeding and/or eating; Addressing physical health for those with mental illness; Advocating for adequate shelter and basic nutrition; and Addressing reproductive health. The following describes the quotes that support these themes.

i) Promoting health and preventing diseases

Some participants mentioned that the Bodily Health Capability is more relevant to occupational therapy from an international perspective. They indicated that enhancing the Bodily Health Capability is related to OTs and other health professionals who work in poor areas. For example:

I was in Africa and I was working with mothers who knew nothing about being able to offer clean drinking water to their babies, boiling water, rehydration. They had no concept of how to meet basic very, very basic health care needs for their young children under a year of age, so I found myself in a role of being able to advocate for health and prevention availability through making appropriate suggestions. I don't think its unique to OT I think anybody in any health care profession, nursing or physician would be doing the same but, I have done that as an OT in the past. (Participant 4, p. 4)

Some participants asserted OTs have significant roles in health promotion, diseases prevention, weight management, and obesity prevention areas. *Participant 12 mentioned* OTs' roles in healthy living programs in the community including managing chronic disease, and promoting exercise and smoking cessation.

“Being able to have good health”, this is an area that I think there is a huge role for OT but very few OT's have jobs in that area. So, for example, we have a healthy living program here in the community and it's around, a lot around managing chronic disease,

and it's around, you know, managing your respiratory problems, and it's also around the determinants of health so eating right, exercise, stopping smoking, that kind of thing, and I feel very strongly that OT's have a huge role in this. (p. 3)

One participant highlighted OTs try to ensure that their clients have appropriate nourishment through education programs.

... being adequately nourished, [OTs] doing swallowing assessments, doing, educating families and whatnot, on the importance of eating and living well, which helps with management with a whole bunch of chronic diseases. (Participant 9, p. 2)

Participant 12 indicated that OTs are involved in lifestyle management.

So I believe, OTs to my knowledge, being a real facilitator, not in prescribing what they should eat but how they're going to eat what they're supposed to or what they want to and how they're going to integrate that into a healthy lifestyle. So I think that there's a huge role...(p. 3)

Participant 10 mentioned that OTs not only help clients have a healthy lifestyle but also promote the health of families.

...in the nursery which is a highly abnormal environment for a neonate. The baby's not supposed to be here yet. OTs are involved in creating an environment that supports normal development and that also supports family interaction and promotes health for the family but also the baby, so we are part of that team that tries to, I'm not going to use the word normalize, because it's never going to be a normal environment, but tries to have an environment that is supportive of a healthy life, as much as possible. (p. 3)

Participant 13 declared that OTs provide the necessary skills for their clients to engage in self-care, leisure, and productivity to effect healthy lifestyles.

...I mean we do have a role in that as well and being able to have good health, I mean that's a part of our self-care, teachings and chronic disease management or general education once somebody has an illness, at this site, my three sites...I would see it, I mean if someone is living with a chronic disease, for example making sure that managing their life style, so balancing productivity, self-care, and leisure. (pp. 2-3)

ii) Feeding and/or eating

Participant 4 asserted that OTs work with children who are not reaching their developmental milestones adequately and have problems maintaining bodily health.

Children with autism tend to have feeding challenges. They tend to have difficulties with metabolizing nutrients ... that children with autism have difficulties maintaining good bodily health. They tend to be very sick which is tied in to nutrition and food allergies and how the brain is processing, what's happening with diet. (p. 2)

Participant 6 stated that OTs have major roles in addressing feeding issues to help maintain their clients' bodily health irrespective of the reason for failing to thrive.

...there are other therapists that address what their [clients] feeding issues are, and trying to figure out ways that keep them gaining weight or of an adequate weight so that they're not...more ill. So, I think, OTs definitely have a very strong position on that, especially around feeding issues. On a feeding team. So that would be bodily health on a very basic level. (pp. 3-4)

Participant 12 claimed that having an interdisciplinary approach enables OTs to practice in various areas including working with clients who have feeding problems.

There's some specific roles that the OTs have and some of that currently, so for example to be "adequately nourished", the OTs do work with speech language pathologists and nutritionists to see that the person is able to eat and swallow safely. The feeding, so that's a big one. ...so we have to have an interdisciplinary approach which is really consistent with the way we try to practice in any way in my settings, the community setting. (p. 3)

Participant 9 also pointed out that OTs have a more consultative role to help clients with feeding difficulties. She noted that OTs try to ensure appropriate feeding for their clients through healthy eating recommendations.

It is in terms of like, say for example, to be adequately nourished, in terms of swallowing, so ensuring that people are able to eat a diet that's appropriate to their needs, and ensuring that, take for example, they have appropriate nourishment to help them from developing pressure ulcers or helping with healing, that would be through eating a better diet or what not. (p. 3)

iii) Addressing physical health for those with mental illness

Many participants perceived that OTs address Bodily Health Capability in mental health practice.

Certainly I know, within mental health, we talked a lot about nutrition, exercise, and sleep as just the basics of good health. And so, I think that there's a connect between this and OT...(Participant 5, p. 3)

A few participants mentioned that maintaining good bodily health of people with mental health issues is one of OTs main concern in mental health occupational therapy practice.

Wellness, so people are eating, sleeping, These are very important eating, sleeping and getting good exercise. My patients [people with mental health issues] will always talk about things like that...as things that they want to do, need to do, they desire doing. They want to be in good physical health. And I think that programs who are focus on mental health are increasingly addressing these issues as well. Helping people to maintain good bodily health and it maybe particularly important because there are side effects of medications like people who have mental health issues, taking medications and

those medications may cause people to gain weight and things like that...so it is a priority concern for the patients themselves and as a result I think it becomes concern also for the therapists for working with them. (Participant 1, p. 2)

One participant noted that people with disabilities, specifically people with mental health issues, are much less likely to have good physical health.

So, people generally may have more poor health as result of living with mental health issues. (Participant 2, p. 3)

iv) Advocating for adequate shelter and basic nutrition

According to some participants, OTs advocate for basic resources to help clients take care of themselves more independently. Occupational therapists advocate for promoting the health of their clients including adequate shelter and adequate nutrition.

...we spend a lot of time around adequate shelter, mental health and physical dysfunction, around adequately nourished, I mean we do have a role in that as well and being able to have good health. (Participant 13, p. 2)

Participant 5 noted that OTs have advocacy roles in addressing shelter issues for people with disabilities.

Yeah, adequate shelter. Yes, OTs are involved, in mental health, with keeping people in housing and so in practice, I can see that this is an important construct. You know, that they would be adequately housed....[OTs] help to assess people with mental health issues to the appropriate level of housing that they may require. What kind of care needs they might need, whether they need assistants or you know the different kinds of housing – there's supported or independent living. There's totally independent living, but financially supported. So they would assist in that process of helping to find people housing. (p. 3)

Participant 2 mentioned that the supported housing program enables people with mental illness to establish independent housing in the community.

Some people who work in housing and provide functional assessments to ascertain the kind of support people would need. Some OTs advocate for housing first model which is a best practice within mental health and to ensure that people have access to housing because we know that's one of the determinants that makes a profound difference to people's life, both in longevity and quality of life and one of my roles is being health coordinator for our system so that means developing services and supports around wellness issues for people with mental health issues. ...So the OTs may not be delivering the service but as an OT, I'm helping to develop those services for people within our systems. (p. 4)

Participant 7 noted that access to safe shelter has a direct impact on pediatric nourishment and development.

So one example is, I go into a school that's on a First Nations reserve and there's a little boy there who unfortunately was apprehended away from his mother and placed with his grandparents, and since he has been with his grandparents, he has been getting more sleep, more food and coming to school on a regular basis and those basics we're seeing a huge impact on his developmental progress. He's talking more, he's more attentive and he's definitely learning more easily than he was before. (p. 4)

Participant 12 indicated that OTs work to ensure ready access to adequate shelter for those in need.

In order "to have adequate shelter", yes, in our community setting, we do have. We have case managers who work a lot with clients who have OTs of needs around their personal care and their living arrangements...OT would be working with the person wherever they live and try to enable them to do the best they can with that. (p. 3)

v) *Uncertainty about managing reproductive health*

Although the majority of participants mentioned OTs' roles in addressing feeding challenges and advocating for shelter, some were unsure about their roles in addressing reproductive health, as noted by Participant 12:

I am not aware of OTs who are involved with reproductive health. (p. 4)

Some suggested that OTs do not address reproductive health issues in their practices.

...but reproductive health, I thought, you know what? We just don't address that in OT practice and I question whether we are the best people to be addressing it. (Participant 5, p. 2)

In contrast, some stated that OTs work with sexual health teams. Participant 6 indicated OTs have a role in reproductive health when working with adults and teenagers.

Yeah, and then reproductive health, again not an area I'm familiar with, but I do know there are therapists that work on sexual health teams, or sexual health resources. Especially for, not just adults, you know teen, or kids that I work with; they have a lot of questions, their bodies look different, they may be perceived as being very different. And they may or may not be of the understanding of other people around sexual health, and sexual development... So making the necessary connections for the family and for the health professionals to understand this family's particular situation. (p. 4)

Participant 13 also noted that reproductive health is relevant to occupational therapy practice as OTs are committed in principle to advancing the health and lives of their clients across occupational domains.

I mean if someone is living with a chronic disease, for example making sure that managing their life style, so balancing productivity, self-care, and leisure. There are lots of OT's who work in sexual health, so managing a nice healthy sex life following an injury or illness. (p. 3)

3.4.3 Bodily Integrity Capability

This part aims to explain the OTs' views on the Bodily Integrity Capability with respect to the two research questions:

Question 1) What are occupational Therapists' understandings of Bodily Integrity Capability?

Analysis revealed an overarching theme of Basic human rights. The following describes the quotes that support this theme.

i) Basic human rights

Almost all participants acknowledged that the Bodily Integrity Capability in many ways is consistent with people's rights as citizens and includes both moving freely from place to place, and protecting one's body against violations, abuses, and harms. Some participants emphasized this opinion:

I see it as a human right. I mean that is, something that everybody has a right to not have, you know, sexual or physical abuse against their body. So, in terms of this, I saw it as a basic human right...(Participant 5, p. 4)

Some people with disabilities are more *vulnerable and less able to* protect their bodies against physical violence and sexual abuse. A few participants who work with children with disabilities described that these clients are at risk of violation of body integrity.

...many of the kids that I'm working with have physical disabilities and are probably quite vulnerable in a lot of ways. (Participant 3, p. 5)

Some participants who work with clients with mental illness suggested that these clients have distinct needs. Participant 2 stated that in contrast to common views that people who live with mental health issues are violent, they are several times more prone to violence against them. She mentioned that many women and children with mental health issues have histories of sexual assault, child abuse, and domestic violence in their backgrounds. She perceived that people with mental illness have less capability of maintaining bodily integrity and cannot move freely from place to place, and thus lose their rights as citizens.

Moving freely from place to place around, I think it's citizenship. So, citizenship is a huge issues for people who live with mental health issues because stigma and discrimination, people may not feel welcome or may not participate in things like

libraries, community centers. So they may feel like they're not able to move about as freely as they would like. Also, when people are not well. They may be certified to hospitals, so that's a time when they really don't have freedom to make choices, so they are medicated against their will, they are isolated against their will in hospitals, so that's a time when lose their rights as a citizen. (p. 4)

Participant 7 noted that Bodily Integrity Capability is an important issue to consider when working with certain people. She mentioned that a *traumatic* life is definitely part of the aboriginal people's background as they lost their freedom to live in their place and to freely move from place to place.

So the context that I work in with Aboriginal people is that there is intergenerational trauma from colonization especially in the residential school system and so there are high rates of family trauma involving children, and women in particular and so when I look at this, it reminds me that many of us would take for granted that we live in a place that's free of these things but there are many people in Canada and also internationally where these are enormous issues for them. (p. 3)

For some participants, the Bodily Integrity Capability is a form of the principle of non-maleficence that everyone should be protected from unnecessary treatment. But many persons with disabilities, specifically people with mental health issues, may be less capable of making decisions for themselves such as avoiding unnecessary tests and treatments.

In my environment, babies are provided with treatment that is necessary but one could actually say is violent in relation to OTs' practices. It involves painful procedures; it involves sticking tubes in various places; that's not assault, it is part of care to save a baby's life, so it's provided in the greater good of the life support, nevertheless, all of that has, and there is a consent provided by the family to do that kind of medical intervention but the baby itself doesn't have a sovereign right, in effect they're spoken for by the parent and the family,...so they don't really have a choice if the parent consents to treatment...(Participant 10, p. 4)

Participant 9 referred to informed consent as a process to respect bodily boundaries and to ensure client safety.

...this talks a lot about sort of bodily boundaries, and we often don't know a person's history or whether or not they've had abuse in the past or what not, and so I think that's why it's always really important for us to try carefully and always ask consent or permission to like enter someone's house or being able to sort of touch someone or if we need to do some range movement exercise or what not, so trying to respect those boundaries, and if they say no, being able to respect that. (p.3)

Question II) How may Bodily Integrity Capability be relevant to occupational therapy practice?

The participants were asked how Bodily Integrity Capability is relevant to your practice and to the profession as a whole? Five themes emerged including: a client-centered approach; A social justice perspective; An advocacy perspective; Providing (emotional) trauma-informed care; Addressing mobility issues; and referring clients to resources. The following describes the quotes that support these themes.

i) A client-centered approach

Some participants mentioned that OTs respect the *Bodily Integrity* of clients. *Participant 9* described it as relevant to occupational therapy practice consistent with a client-centered approach.

I think that Bodily Integrity is extremely important and particularly in from our client-centered approach...(p. 3)

Participant 1 asserted that Bodily integrity is important to occupational therapy practice not only as a part of occupational therapy evaluation and interventions of body functions, but as a process to establish what clients are able and want to do.

We are concerned about the body, the bodily capacities..., I mean we take a one step further I would say, we're looking at not just what the capacities are, but how those capacities are supporting or limiting a person's ability to do the things they want to do or need to do. (p. 2)

ii) A social justice and an advocacy perspective

Some participants asserted that the Bodily Integrity Capability is related to occupational therapy practice from a social justice and equality approach to health.

So again from a social justice perspective, the language-ing is very pertinent when working with Aboriginal communities. (Participant 7, p. 4)

For some participants, social justice here means advocate equal opportunities for people with disabilities. For them, OTs not only educate people to advocate for themselves in terms of empowerment, but OTs do a lot of advocacy for their clients to retain or acquire jobs, or to improve relationships in their community.

So I think that some of this [Bodily Integrity Capability] is a little bit more in the advocacy area. (Participant 1, p. 2)

A few participants mentioned that there is a link between empowerment and advocacy.

According to them, OTs empower their clients to advocate for their rights including those related to bodily integrity.

This one speaks to me as a bit of empowerment; so how are we working to advocate and empower our clients, to know that they have the right to be respected and to be treated regardless of their disability, to be treated like an active member of society, so that one I do, I like that one in my practice. (Participant 14, p. 3)

Participant 14 provided an example of The Canadian Model of Client-Centered Enablement [CMCE] as a practical model for empowering people with disabilities to advocate for themselves.

CMCE has all those ten different blocks that we work with and I'm very, very, very much on the advocacy piece because I feel like sometimes people, when we're working with people with mental illness or with some sort of cognitive deficit, it might not necessarily be the cognition that's the barrier or it's the confidence in the organization, so we're just advocating for them to fulfill their dreams and setup some of their goals, so I think this piece really resonates with me so they know that to advocate...(p. 3)

To influence public policy and make request for change, Participant 8 noted that OTs advocate for reasonable accommodation and accessibility for people with disabilities.

Advocacy in terms of accessibility, to a point, yes. And when I say to a point I don't think Mt Everest should have an elevator put in, that's obviously an extreme example, but do I feel that Chemainus Chief should have a paved path through the top at taxpayer's expense so wheelchair people can go up? No, not necessarily. Do I think that City Hall, every office at City Hall should be accessible to the people who need to go in whether in a wheelchair, crutches or walking? Yes, so we do have a role for reasonable access...(p. 4)

iii) Providing (emotional) trauma-informed care

Some participants stated that OTs provide *trauma-informed care* to help people with mental health issues who have experienced violence and sexual assaults.

[Occupational therapists] provide trauma informed care for people feel disenfranchise, disempowered, and fearful of a system that have power to incarcerate them. (Participant 2, p. 4)

Participant 7 also noted that OTs can provide trauma-informed care to help traumatized people such as aboriginal children who have the experience of "intergenerational trauma from colonization".

So the context that I work in with Aboriginal people is that there is intergenerational trauma from colonization especially in the residential school system and so there are high rates of family trauma involving children, and women in particular...(p. 3)

Participant 10 asserted that OTs provide trauma-informed care to help their clients rebuild a sense of personal safety through implementation of strategies to minimize emotional distress.

... and we may be involved in mental health where practice, where people have experienced domestic violence, sexual abuse, child abuse, things like that, and so we would be in place to mitigate some of the negative aspects of that. (p. 3)

iv) Addressing mobility issues

Almost all participants described Bodily Integrity Capability in terms of the right to move freely from place to place. They agreed that OTs address mobility issues that enable this right to be taken advantage of.

...in terms of being able to move freely from place to place, I think that's a definite one that OTs work on. (Participant 1, p. 2)

Well, certainly with mobility, OTs are involved with being able to provide information and equipment and resources for people to be able to move about as freely as they possibly can, if they got physical limitations. And with mental health, certainly if people have anxiety or problems socializing and they can't move about freely because of that, OTs might address that, by a group or by some of their treatments. (Participant 5, p. 3)

A number of participants indicated that OTs enhance the Bodily Integrity Capability of their clients through increasing mobility and function, and enable their clients to interact with their environments and move freely by providing them the necessary tools and skills.

Well, I think we help these children through variety of different walking aids, wheelchairs, devices to be able to move freely from place to place. (Participant 4, p. 3)

Well certainly being able to move freely from one place to another, a big part of what I do is working with people who are not able to move themselves easily from one place to another. So either walking, limited walking or no walking. And what are the options, right? So a big part of what I do, I see is falling under bodily integrity. And then giving them the tools and the skills so that they, hopefully, can prevent or deal with situations that's listed here "against assault" or whatever. (Participant 6, pp. 3-4)

Participant 10 cited that OTs increase mobility by providing a way to move their babies to do various activities and interact with their families albeit they are living in critical conditions or chronic diseases, or they have parents with disabilities.

The role of OT would be to provide a way to move the baby into different positions for different types of activities... It might be that you have a parent who has a physical

disability and the occupational therapist might be involved in making sure that the access to the baby is managed given the parents limitations. We've had parents who've had Multiple Sclerosis or who are paraplegic and OT's have been involved in helping figure out how Moms are going to manage that. (p. 4)

v) *Referring clients to resources*

Some participants mentioned that OTs provide supportive service to assist their clients and refer them to available resources if needed.

[If someone being assaulted] and not having a way of being able to express that, right? So that's not typically something that we actively pursue, but at the same time, because those resources are there, it's certainly something that we can facilitate and let people know that they're there, and where to go if they need that kind of support. And then also, having someone who's able to communicate in any way is allowing them to be able to express what they're thinking, what they're feeling, what their concerns are. So yeah, definitely, in a lot of ways, I think the work that I do addresses that. (Participant 6, p. 5)

I think being able to say for example refer on, to counselling services if needed, and connect people up with social workers or whatnot, and if we notice any risk of self abuse or neglect or what not being able to report those ...I've seen quite a few clients in domestic violence situations and so being able to talk with them through it, ... and being able to liaise with the family support practitioner and counseling services, and getting them connected there and to try to support them in the home and give them information about resources. (Participant 9, p. 4)

Participant 12 indicated that those who are incapable of protecting themselves from abuse, and find themselves in situations of assault and violence, OTs have to refer them to legal system or report abuse to the police. But for those who are capable, OTs do have an educational role:

We have adult guardianship regulations in this province that are similar across the country, so as an OT or as an employee in this organization, if I suspect that any of those things are happening, I have an obligation to report it and to come back and to work with the team to see if there's anything we can do to lessen those risks, mostly that's with adult's who are incapable themselves of asking for help. For people who are capable or considered capable, then we may have an education role, but with adults who are incapable or maybe deemed incapable then, for sure we've got a role. (p. 5)

Participant 12 also mentioned that OTs not only provide supportive services to reduce risks to clients, but consider they are part of the team responsible for assessing an individual's capability. Occupational therapists work in teams who assess capability and are involved in making decision about whether or not their clients are capable of deciding where to live or with whom. Therefore, OTs have a responsibility to detect or prevent abuse and violence by informing authorities or establishing a support system for their clients.

Well right now, that's really interesting because the, up until now there's just been a few, like the doctor and a few other people in the legislation but they've changed the legislation around adult guardianship that there's a number of individual professionals and OT's are included in that, that could make a capability assessment...(p. 4)

3.4.4 Sense, Imagination, and Thought Capability

This part describes the analysis of the semi-structured interviews with respect to the two questions regarding OTs' views about the Senses, Imagination, and Thought Capability with respect to their understandings and perceived relevance of this capability to their professional practice.

Question 1) What are occupational therapists' understandings of Senses, Imagination, and Thought Capability?

In response to this question, the researcher's analysis revealed one theme: Expressing oneself in various ways. The following describes the quotes that support this theme.

i) Expressing yourself in different ways

According to some participants, Sense, Imagination and Thought Capability means having the freedom to be able to express yourself in various ways.

...so I just see it as a person's ability to use their resources as well as they can in order to express themselves. (Participant 13, p. 3)

Participant 10 noted that freedom of expression involving all types of expression, including freedom to determine one's meaning of life:

What it seems to me is that you should be able to see, think, imagine, create, independent, independently in a variety forms of expression. These may be as it says here religious, literary, musical, political or artistic, freedom of religion, being able to determine how your own life evolves and what the meaning of that life is. (p. 4)

Or, as participant 11 stated, a person's ability to express his or her political thoughts:

...it has to do with freedom to express yourself in different ways, to be educated, to be creative, to use your mind, to be able to express your political views. (p. 2)

Participant 7 described this capability as justice with respect to expressing one's thoughts. In social justice circumstances, people have freedom of opinion, expression, religion, and political thought.

I think this relates to issues around social justice, and ...freedom of expression, to participate, and to express their thoughts and in some ways. (pp. 4-5)

Question II) How may Senses, Imagination, and Thought Capability be relevant to occupational therapy practice?

Three themes emerged related to the OTs' perspectives on the relevance of Sense, Imagination, and Thought Capability to occupational therapy practice. These were: Self-expression; People with mental health issues; and Children with disabilities. The following describes the quotes that support these themes.

i) Self-expression

Participant 13 declared self-expression as a key component for occupational therapy practice to facilitate engagement in meaningful occupation.

I think it's [self-expression] a cornerstone for our practice, if we want to get people engaged, if we want to get people interested in participating... This is key. (p. 3)

Almost all participants agreed that this capability is an essential part in occupational therapy practice, and it is important for all to be able to express themselves.

I really like it first of all. I like the way that it's framed and it's an area of self-expression. It's an area that OTs have worked on also for quite a while. I used to do self-expressive groups with my client and I think, I agree that this is important, for a lot of people this is very important, being able to express themselves, and having the freedom to express themselves and this is relevant for OT. (Participant 1, p. 3)

Similar to the part of Nussbaum's definition of Sense, imagination, and thought as "Being able to have pleasurable experiences, and to avoid non-necessary pain." Some participants acknowledged that experiencing pleasure activities and avoiding pain is relevant to occupational therapy practice. They stated OTs help people build their abilities to express themselves freely and explore what they want to do.

Well, again, it's just allowing the individual to do the activities that they want to be able to do, and what's important to them. So you're looking at the ultimate meaning of life in one's own way. You're allowing them to share with you what is important to them and then you're, with them, working towards helping them achieve those goals. But you're doing it in a way that allows...if they do have limitations in those areas of sensory or cognitive mental capacity, you're allowing them to be able to function at the level that they have. And you're trying to help them make the most of it, right? (Participant 6, p. 5)

Participant 9 mentioned that OTs have an important role in enhancing the Sense, Imagination, and Thought Capability through learning processes and copying strategies, and resuming some of their previous activities where applicable.

I think that's actually quite a huge area of OT in terms of, being able to use your own mind say for example and your own senses to be able to do something, so, we often see people where that's impaired whether it's like after a brain injury or after a stroke, so being able to help them to process and reason, problem solve and being able to sequence things and having greater insight into situations or whatnot, so I think that is a big role for OT. (p. 4)

A few participants indicated that OTs support their clients in coping with new situations and their disabilities through engaging in self-expression activities. For example, Participant 9 noted that OTs may help clients use artistic expression as an indirect means of communicating and expressing their imagination and thoughts.

...being able to use the alternate meaning of life in one's own ways, so helping people process through like, whether it is their sorting out, their learning how to deal with their new disability and so they use like an artistic expression of that to try cope with that or whatnot and using their own through imagination meaningful to them, or be able to say use their imagination to try give them hope in life and try resume some of those activities that they might have stopped doing after their disability, injury or whatnot. (p. 4)

Participant 14 asserted that OTs not only assess limitations of the Sense, Imagination and Thought Capability through self-expression activities, but also evaluate their limitation of executive functions such as problem solving and planning, and decision making.

We do a lot of cognitive assessment and intervention and external and internal compensatory mechanisms to help mediate any deficit, so I do think it is. ...Like assess for the limitation, like executive functions like problem solving and planning and pacing, and moderating themselves and being able to assess for that and speak to their abilities; what deficits they have because of their illness or what they've still have retained through their illness; like decision making is often a really tough one with our population. (p. 4)

Participant 6 noted that assistive technologies provide opportunities for promoting self-expression and enable clients to do what they choose to do.

Well again, that's another area that I think I address a fair bit with the technology, because you're really just giving them tools to allow them to develop their own unique expressions. But you're figuring out "OK, for a lot of them, they may have sensory impairments, vision, hearing, cognitive impairments" so figuring out what are the best tools to allow them to do the things they want to do. So physically, they might not be able to...if art is something they want to be able to use to express themselves, they may not be able to physically do what everybody else does, but if you hook them up to a computer, and you have the right software, and you do the right access method, with the right level of instructional support, they're able to produce incredible pieces and it's their own self-expression. The technology is just facilitating that... (p. 4)

Participant 6 also stated that this capability would apply to both clients and their families with respect to their expressing themselves in meaningful ways.

...with respect to my area specifically, this would certainly apply to the families, the adult and the children of the families...Well, there are aspects of how the family might want to relate to the child that would inform, that might involve using art, it might involve using music, it might involve using therapeutic massage, it might involve speaking freely to the medical staff, things like that, and the occupational therapist, I have been involved in situations where parents may have wanted to do particular artwork related to the baby, have their siblings involved in that, how would we display that art, things about that art that would be particularly meaningful for the child and particularly the family. If the family wants to read to children, it's not going to over stimulate the baby, that kind of thing. So it's a matter of allowing the family to express themselves freely within a context of what the infant can manage, and OT is definitely involved in that kind of thing. (p. 4)

Participant 10 highlighted OTs have an ethical responsibility to avoid unnecessary pain in their clients, advocating pain relief to minimize their clients' pain, acknowledge and mitigate the impact on their families, and to promote more pleasurable experiences.

And the issue about avoiding unnecessary pain, one of the big things about my own job is reminding people not to do tests if they don't need them because they're painful, and then figuring out how to manage that, teaching the family how to help the baby manage that, teaching the staff how to manage it, so that's what we do every day. And with respect to having pleasurable experiences, there are OTs of things that you can do for a very sick baby that are pleasurable. There are also a lot of things you can do for a very sick baby which you would think would be pleasurable which are not because their brains are not ready, and so an OT would know, and be able to evaluate how a baby is responding to various things that the family might want to do and can help manage that interaction so that it actually ends up being pleasurable as opposed to being stressful. (p. 5)

Participant 10 also mentioned that OTs advocate for their clients and their families by providing feedback to service providers and organizations involved with their clients' care.

OTs may be an advocate for the family to speak to the medical staff about how the system works or doesn't work and OT's may be that person who the family connects with and talks to about that, and so the OT would facilitate, providing feedback to the larger system and so that would be a political way that OT's could be involved, for sure. (p. 4)

ii) People with mental health issues

Some participants mentioned that Sense, Imagination, and Thought Capability is more related to the mental health practice area in occupational therapy and suggested that people with mental

illness lack or partially lack this capability. Thus, improving this capability can be a focus of occupational therapy intervention.

...in mental health, this is very much a big part of what we're doing. (Participant 1, p. 3)

I think this one that's in my area with mental health, a lot of people struggle with their imagination and thought process, so this is definitely an area of intervention, is trying to see what someone's thought patterns are and whether they have a sense of imagination and they have the insight to know if their senses are compromised... (Participant 14, p. 3)

Sense, Imagination, and Thought connection is often a key component of mental health issues. Participant 2 noted that people who live with mental health issues do not have opportunities to express themselves as others do. According to her, they often become ill early in their lives, so finishing school and education is often challenging for them. She asserted that OTs help those individuals express themselves through restoring their lives and developing skills to experience worthwhile living.

[Occupational therapy practice] covers a whole lot of things. I think part of the role of an OT through a recovery framework is to help people often re-story their lives to help people to express that purposes and meaning as a result of living with mental health issues such that they're able to see themselves outside the illness so it is helping people develop self-efficacy though activities such that they're able to see a better future for themselves. So two things, restoring all life and also re-skilling people such that they are able to be more self-determined, more involved in their own care and more committed to their own recovery. Really coming to that place that they perceive that life is worth living, because that is an act of choice for many people who live with mental health issues. (p. 6)

Some participants noted that OTs often improve the Sense, Imagination, and Thought Capability for people with mental health problems and cognitive dysfunction. Occupational therapists are involved with cognitive retraining using relaxation training, helping clients decision making, learn compensatory strategies to cope with their new situations, and teaching them basic skills.

OTs work with the development, mentally delayed with cognitively impaired, with those with mental illness to help them use, to help them maximize their own ability to function in the area of thought, cognitive process, reasoning, planning. (Participant 8, p. 5)

Participant 13 said that improving the Sense, Imagination, and Thought Capability is important for people who live in residential care:

Well, I'm thinking of particularly in mental health for example, for somebody who is very depressed, maybe tapping into music or drawing and drawing them out that way and allowing people to express that part of them and then I think is residential care where

people are usually quite disabled by that time and, that making sure they have an ability to experience and to express themselves even if they have limited cognitive capabilities, that they have those outlets. (p. 3)

iii) Children with disabilities

A number of participants asserted that having this capability is a basic skill for children when learning to express themselves. They mentioned that this capability is relevant to occupational therapy practice as it is critical for child development and learning. They also noted that OTs consider this capability in their practices from educational and multisensory point of views.

I think it is relevant. I think, you know, even for example, we're trying to teach kids motor skills. And they need to be able to use all of their senses, their imagination their thinking process... You know, that sense of, just imagination and thinking and everything, I think it's fundamental to development. Yeah, so I think it actually has a strong sense in OT, in education and sort of the combination that I see with both, sort of health and education merging in the practice area that I'm working in. (Participant 3, p. 5)

Participant 4 indicated that OTs work closely with children with autism who lack this capability. She also mentioned that OTs help such children promote this capability by helping them connect with the world in a range of ways.

Oh well the population of kids that I work with, do have disordered senses and they do have disordered thoughts which is part of their diagnosis, children with autism have processing issues related to how they make sense of the world, and what we see are kids who are very isolated and don't make those human meaningful connections with family or friends, peers, and that's the most important piece of my job, cause I don't work with many children with physical disabilities, I work mostly with kids with autism, being able to improve how they make sense of the world and to be able to connect and communicate in meaningful ways, is what I do in a nutshell, that is my job, sort of in a very short way of saying it. (pp. 4-5)

Participant 7 noted that OTs enhance the Sense, Imagination, and Thought Capability with interventions to strengthen communication skills and promoting literacy as well.

I think, one of the things around literacy is that I think we need to really think about, for me that comes around the way that we communicate both in writing and verbally with clients. I mean, in pediatrics, a lot of what I do is promoting literacy in children around visual motor, fine motor functioning, so there's kind of a direct coloration, I guess, there (p. 5)

3.4.5 Emotions Capability

This part is intended to explain the OTs' views about the Emotions Capability with respect to their understandings and perceived relevance of this capability to their professional practice.

Question I) What are OTs' understandings of Emotions Capability?

In response to this question, the researcher's analysis revealed the main theme pertains of this research question was: Basic needs and rights. The following describes the quotes that support this theme.

i) Basic needs and rights

A number of participants state that Emotions Capability is a basic human right that is critical for well-being. It means the right to be loved and to belong.

So for me that would be a basic. It comes across to me as a very basic human right. Again, that all children and people have the right to have a sense of safety, love and belonging. (Participant 7, p. 5)

So I guess this is about the right to love and be loved and I think it's a very basic, basic need and basic right. (Participant 11, p. 3)

Some participants indicated that the Emotions Capability reflects baseline and fundamental needs connected this to other capabilities.

I think it's in a way it's sort of like Bodily Health. Like, you need the basics in order to be able to move on to other goals. (Participant 3, p. 5)

Well, I think it's a basic human need. For a person to be able to express emotions and also to have their emotions acknowledged by other, right? (Participant 6, p. 5)

I guess just that people have an innate right I guess, to be able to express the feelings that they have. (Participant 10, p. 5)

Question II) How may the Emotions Capability be relevant to occupational therapy practice?

Six themes emerged across the OTs' perspectives on the relevance of the Emotions Capability to occupational therapy practice. These were: People with mental health issues; Children with disabilities; All those seen by OTs; Finding support systems; Helping people manage their emotions; and Teaching anxiety management skills. The following describes the quotes that support these themes.

i) People with mental health issues

Some participants reported that the Emotions Capability is more relevant in the mental health area of occupational therapy, as many people with mental health issues are emotionally vulnerable.

...sometimes people lose family as a result of their mental health issues and studies seem to change a little bit these days, but perhaps 50% of people may lose their families as a result of their mental health issues. So because of the illness, they remain isolated without contact and without the chance to experience those emotions... Definitely, when people become ill, 16, 17, that emotional development is blighted. (Participant 2, p. 6)

Definitely, certainly in mental health. I think a lot of what the mental health part of OT is really looking at helping people deal with their emotions, effectively. So whether that's, recognizing what their emotions are, and then being able to express them. (Participant 6, p. 5)

... so, it's something that I think is really important if you work in mental health (Participant 5, p. 5)

A number of participants noted that OTs help people with mental health issues to manage their emotional health and overcome their emotional problems, and help to improve individuals' daily activities through enhancing the clients' capabilities to overcome their emotional problems associated with the activities.

Right, in the emotional side of things, I think a lot of this is worked on in group work in mental health. In engaging people into activities with others who, perhaps, can support them, in educating the people who are in the individual's life who is working with somebody in mental health. And I think it's in teaching about how these kinds of emotional things. (Participant 5, p. 5)

This is certainly relevant to occupational therapy in general and an example would be mental health, because you're helping people manage their emotions and how that may or may not facilitate or not facilitate their goals and how they view life and things like that. (Participant 10, p. 5)

ii) Children with disabilities

Some participants reported that the Emotions Capability is particularly important in early childhood development and contributes to the development of a healthy personality. They noted it is a fundamental component of children's well-being.

I sort of saw this as like, looking at attachment and appropriate behavior and sensory processing, just having a good, solid, early childhood development. I think it is relevant

to OT. I think it's in a way it's sort of like Bodily Health. Like, you need the basics in order to be able to move on to other goals. (Participant 3, p. 5)

Participant 3 also mentioned that children with behavioral issues often have problems with emotional development. In these cases, OTs focus their attention at basic emotional developmental to help minimize its impact and enable the child to develop healthier emotional strategies.

...because when they don't have the basics in that area, they don't participate in things appropriately and so, they're delayed in everything anyway. So, environmental modification, just around even positioning, or sensory distractions, or sensory strategies that will help them attend or focus. Still putting things in place for gross motor and fine motor practice, because they have had so many things going on. They haven't had a typical childhood to get out and explore and trying things. (p. 6)

Some participants stated that OTs work on Emotions Capability in early childhood development; such as attachment, appropriate behavior, and sensory processing. For example, participant 4 mentioned that children with autism lack the capacity to develop meaningful relationships and attachments. According to her, OTs facilitate the development of meaningful relationships by finding new ways of connecting with others, such as involving them in playful interactions.

a lot of these kids are unable to really form meaningful attachments, they become much more interested in things like spinning objects or something non-human, but it's not a particularly meaningful relationship or connection. A lot of it is facilitating a dynamic or a relationship with the child and being able to make that bridge with the child and the parent, so it's helping that parent find a new way to connect by starting at a very, very basic level with being able to develop that flow to be available, to be there. (p. 6)

A few participants stated that everyone including children has the right to feel safe emotionally as well as physically, to feel loved and that they belong. For example, Participant 7 asserted that confidentiality issues related to care would be included in this capability. She mentioned that OTs ensure the emotional safety of their clients during care.

Again, that all children and people have the right to have a sense of safety, love and belonging. And I think in occupational therapy, I think we do indirectly think about the, maybe the emotional safety. (p. 6)

Participant 10 noted that by considering the level of illness, OTs facilitate appropriate interaction as necessary for infant's emotional development while they are in acute care hospitals.

Another thing about that's listed here is that supporting the "forms of human association that can be crucial for development". One of the issues in the nursery is that parents are separated from the baby; I mean that's just a fundamental problem. It's not such a

problem in other countries but certainly in North America, it is a problem and the OT is definitely involved in providing parents ways of having, if they can't be there all the time, when they are there having high quality interaction with the baby, knowing what that baby's saying, what their movements mean, how much the baby can interact, what can they see, what can they hear, when is their seeing and hearing improved, all of those things that facilitate a relationship between the baby and the parents and that's appropriate for their development and it changes over time depending on their development and their level of illness. (p. 5)

iii) All those seen by OTs

Some participants suggested that the Emotions Capability is relevant across areas of occupational therapy practice as it impacts all areas of a client's capacity for occupation.

I think Emotions is huge, because we often see people at their lowest, when their emotions are very vulnerable and there is a lot of grieving, whether it's grieving from a loss of function, or loss of independence, or whatever it might be and so being able to sort of work around that and sort of work at the persons own pace is really important. So I think, emotion is quite important because your emotions impact everything. You can't separate emotion from body. (Participant 9. p.4)

A number of participants stated that The Emotions Capability is relevant across occupational therapy settings from hospitals, institutional, schools, and private clinic settings. For example, a few participants who worked in the acute care hospital setting noted,

Yes, it's relevant to my practice, in that my patients have undergone massive emotional trauma. On Tuesday, they're at work and they're not feeling quite well so they go to the doctor to get a sick note, the doctor does a blood test, and two days later they're facing life and death decisions about their leukaemia, so they're emotionally very traumatized. (Participant 8, p. 6)

In my practice, the whole experience is traumatic, just the nature of it is traumatic for families and for the baby. It is filled with fear and anxiety. It isn't something that can be avoided because of the nature of the experience. This is the person's offspring who could die at any minute. (Participant 10, p. 5)

A few participants indicated that in different practice settings, OTs acknowledged the effectiveness of culture when working with a range of clients from culturally diverse backgrounds. They explained the impact of cultural factors in development of emotions. For example, participant 7 asserted that OTs need to create an environment that is emotionally safe when working with ethnic minority population.

I know that in my practice with Aboriginal families, there are risks involved in accessing occupational therapy because of the historical relationship between indigenous people

and institutions including health care, and so, I'm very conscious of people's emotional safety within our relationship and the need to give time to allow that to develop because unless somebody is feeling emotionally safe with you, then it's very hard to go anywhere else with them in terms of therapeutic value. ...in community context when you're having potentially some long term relationships with people, gaining emotional safety on both sides is really important. (p. 4)

Participant 14 noted that the Emotions Capability is relevant to occupational therapy practice from both the client's point of view and that of the clinician. She stated that the Emotions Capability impacts both clients and therapists.

So emotions, regardless of where you're working, you're always working with people in a traumatic. The reason why you're an OT is to work with people to get them back to finding meaning and purpose in their life; and when you lose that meaning and purpose and role, you're going to be emotional about it. There's going to be anxiety and grief; and even if you're working with a child, it's their parents, so you've got that secondary emotion that you need to be dealing with, and with mental health outpatients, it's often the family. So, it's emotions on all levels, and also for yourself, because I find that sometimes I often just wish I worked at a coffee shop and didn't have to deal with anyone who's going through anything traumatic because it really wears on you, as much as you don't think it does, I think emotion is really relevant to OT, both for the clinician and the client. (p. 5)

Occupational therapists need to be aware of his or her emotions and feeling to prevent them interrupt the therapy process, as participant 8 noted,

Sometimes you have to get off the emotions to help the emotions heal. (p. 5)

iv) Finding support systems

Some participants indicated that OTs improve the Emotions Capability by identifying social, emotional, educational supports for clients, and help to incorporate family members and make use of the client's support networks and develop new ones.

Thankfully, we're doing a better job these days, where one of the roles that OTs play are developing family education sessions with their loved ones and we have literature to say that that's making a huge difference in recovery for people, so hopefully keeping families together, keeping support systems, as we know when people lose their family support, often homelessness is one of the first issues and homelessness becomes a cycle where people remain isolated without contact and without the chance to experience those emotions. ..So yes, for some it's really, it's really, once again trusting people, once again finding support systems, once again learning how to broaden their social support system, natural supports that people might have and OT's very much do that. (Participant 2, pp. 6-7)

Yah, I think it make sense. It's applicable. The idea of having attachments to things and people we know from research as well that people who have good family support, who have been adolescents, who have been able to develop strong attachments to one person that they feel they fit with, and can promote better outcomes, so the way services are organize also, we're trying to sort of incorporate family members and support networks into the work that we do. (Participant 1, pp. 3-4)

Participant 12 noted that OTs try to be aware of their clients' situations to maximally augment this capability and avoid inadvertent decisions that impact the client negatively.

What I would think that the role of the OT there would be to identify for sure what's going wrong...could help that person grow and develop in a proper way. I wouldn't as an OT want to do anything that would impair that ability. I would want to be very sensitive to it. For example, I'm suggesting some help that they would get from a loved one or a family member. ..They have a different relationship with that person, so I need at the very least to be aware of that and to look at consequences for involving and finding ways of checking in, because maybe my client doesn't know how to express that to me and they see me, who knows, they see me coming in and telling them this is what they're supposed to do and that's not on. I mean I've had, so, I think, at the very least, do no harm with that, don't make it worse, the next step up would be identifying what the issues are, finding some appropriate resources; the third would be OTs who are trained to help people move through different emotional stages, and transitions. (p. 6)

v) Helping people manage their emotions

Some participants asserted that OTs help people manage their emotions through developing communication skills to allow their clients to express themselves including their emotions.

I think it has to do with helping them through communication skills, expressing their, I think a lot of it has to do with communication skills and sometimes it has to do with communication skills and also, I guess, depending where problem solving, where it's being and looking it how it's affecting other parts of the person's life. (p. 4)

A few participants stated that OTs provide communication strategies to improve the Emotions Capability. For example, Participant 6 reported that OTs develop healthy emotional expression in their clients consistent with their wishes, engaging them in activities, and educating them. She 6 noted that communication devices allow clients to be able to make choices, communicate, and express their emotions.

OT is really looking at helping people deal with their emotions, effectively. So whether that's recognizing what their emotions are, and then being able to express them. And certainly from my point of view, more directly, for the people that have communication issues, providing them with strategies that will allow them to share...First of all, recognise those emotions, so some of the work we do is really talking about, helping them recognise when they're angry, what their behaviours is like, and what do they do

when they're angry or when they're upset or whatever. And sometimes, they're not making those connections, so helping them identify that, and then allowing them to be able to say about it. So when I'm having a page on their communication device that says "I am happy/sad/anxious/worried" and allowing them to be able to make those choices and to be able to say to somebody "you're pissing me off, get out of my face!" where physically they may not be able to express those; they may be expressing them but other people aren't recognising them. A lot of why we get people, a lot of reasons people come to us for communication devices is because there's a behavioural issue. ...So I think a lot of what we do, we're trying to allow healthy emotional expression. Right? In a way that is both respectful for the individual and for the people that are around them. (pp. 5-6)

vi) Teaching anxiety management skills

Participant 14 noted that OTs work with people experiencing emotional trauma, and help them reintegrate into their lives after a traumatic event.

I think this one really ties into the psycho-social Module that the psycho-social element that we deal with, obviously working in mental health right now. I can see very concrete evidence of someone's emotional development hindering them to meet their full potential and the fear and anxiety and a lot of what we do is helping people reintegrate into their lives after a traumatic event, which is usually a psychotic break so, I really like this one a lot, and to me although it's generalist, it really is concrete enough to tie into OT. (p. 5)

Participant 10 reported that OTs along with the other professionals provide knowledge, and sympathy and support to help their clients and their families to manage their fears and anxiety.

In my practice, the whole experience is traumatic, just the nature of it is traumatic for families and for the baby. It is filled with fear and anxiety. It isn't something that can be avoided because of the nature of the experience. This is the person's offspring who could die at any minute. It is filled with fear and anxiety, that being said, the occupational therapist is there to provide knowledge and compassion and support along with the rest of the team, about how that baby is doing or will do, and help the parents manage as best they can the fear and anxiety. We don't try to have it go away. It's not realistic not to have fear and anxiety so I guess one of the problems I had with this definition is sometimes overwhelming fear and anxiety is a normal response to a situation and it isn't something that is a negative; it's what you'd expect, so how do you then kind of manage it. (p. 5)

Participant 1 asserted that OTs help clients to manage stress and anxiety with activities such as yoga, meditation, and breathing.

I think that OTs do work on anxiety and helping clients find ways in which they can cope and manage with stress, maybe through various activities, like yoga, meditation, breathing. (p. 4)

According to Participants 2, OTs rebuild the Emotions Capability as a basic skill to overcome anxiety and fear through teaching clients about *anxiety* management skills and how to control their emotions when re-engaging in previous activities or engaging in new activities.

...we didn't encourage people to go get a job or to go get volunteer work and it caused stress vulnerability model, which is how we developed a lot of our service in the early days. Thankfully, these days we look at things much more through a strength, strength based approach. ...an occupational therapist, has developed a wonderful, ah and their team, a wonderful thing called "action over inertia" that teaches people about anxiety when they're about to take new activities, and teaches people that, that is to be expected. So, I think that is one of the first places that we've seen a focus from occupational therapy on the emotional impact of reengaging in activities, in my opinion. So, it's a very fairly systematic way to look at emotions as people look at activities. (p. 7)

3.4.6 Practical Reason Capability

This part describes the analysis of the semi-structured interviews with respect to the two questions:

Question 1) What are OTs' understandings of Practical Reason Capability?

In response to this question, the researcher's analysis revealed one theme: Making personal decisions. The following describes the quotes that support this theme.

i) Making personal decisions

Some participants defined the Practical Reason Capability to be the ability to make decisions and to make good choices.

I guess my understanding is just sort of making good choices and using the idea of reflection to impact future choices that you'll make. (Participant 3, p. 7)

...so I guess it's around choice and I guess it's around being given enough, being given the information that you need to make good decisions that fit for you...(Participant 13, p. 4)

A few participants described the Practical Reason Capability as a kind of reasoning and autonomy to control one's environment.

I guess for Practical Reason in terms of planning one's life, being able to have control over your own environment is huge I think and engaging in critical reflection so just the individual choice and autonomy is really big in that one. (Participant 9, p. 4)

Question II) How may the Practical Reason Capability be relevant to OT practice?

Three themes emerged from the analysis of the OTs' perspectives on the relevance of the Practical Reason Capability to occupational therapy practice. These were: A client-centered perspective; Helping clients to make personal decisions; and Providing educational and supportive strategies for caregivers. The following describes the quotes that support these themes.

i) A client-centered perspective

Some participants asserted that because occupational therapy is a client-centered practice, the Practical Reason Capability is highly applicable to occupational therapy practice.

...as a concept, it's something that maybe underlines client-centered care. That the individual themselves is able to have insight into them as a separate being and having meaning in their life by doing certain things. (Participant 6, p. 7)

Some participants reported that in client-centered practice, clients are considered as knowing what they want from therapy, and OTs respect their clients' values, beliefs, and reasoning related to this position.

It is in terms of allowing people to live how they want to live, even if it goes against something you might personally believe in, or it might be going against something that you think is ok... (Participant 9, p. 5)

... I think that OTs are and should be interested in what peoples values are, I am definitely have always been interested in what people's values are and I try not to impose my own values on somebody. (Participant 1, p. 4)

Participant 1 noted that in client-centered practice, the goals of the clients and OTs are aligned.

And I think planning is an area that OTs are also do help. ...well I mean the therapist's goals need to match the patient's goals. You shouldn't have different goals. Your goals shouldn't be that different from what the patient, ... whatever, formulate your goals that support get helping the patient gets his goals... your goals may be a little bit different because your strategies or interventions maybe something specific but I mean, so it is relevant. (p. 5)

Some participants stated that OTs respect the client's autonomy and their independency, and assist them with both what they want to do and are able to do.

Well to some extent, it's a matter of engaging in critical reflection of planning one's life. So having some autonomy and some recognition of them as an independent person with the unique set of circumstances and recognising that they have ideas around what they want to do and where they want to go, and what they want to be. And being able to, if

they so choose, having us assist them in reaching some of those goals... (Participant 6, p. 7)

OT is highly involved in that. We have a client-centered practice and so our whole operation is about how that client is going to achieve the goals they want, have the spiritual development they want, engage with occupation that they want, and having a meaningful life and that's kind of our bottom line. (Participant 10, p. 5)

Participant 13 mentioned that *in client-centered practice, the references* of the client have priority in determining *goals*. She stated that OTs provide clients with necessary information to enable them to make their decision and choices.

Well I mean that's, well I'm reading it here "engage in critical reflection and planning of one's life" and so I guess it's around choice and I guess it's around being given enough, being given the information that you need to make good decisions that fit for you, versus what may fit for me as a therapist... and I think that's an important component of OT. (p. 5)

Participant 14 noted that in client-centered practice, OTs are regarded as facilitators who only assist their clients to make decisions and give them opportunities to control their environment as much as possible to achieve their goals and independence.

... I think often people don't know where to go next, and even if they have an idea to, they're so petrified of doing it, that the OT is a "facilitary" role. (p. 5)

Participant 7 reported that despite client-centered practice being valued as the preferred approach in occupational therapy, ambiguity remains regarding the extent to which the therapist's power and assumptions guide client-centered process.

Well, certainly, I mean, the client-centered focus, the client-centered philosophy is aligned with that, but that philosophy comes with some assumptions around who decides, again, who in the end has that power to decide for that client and how much is the therapist guiding it. So, you know I'm kind of, I wonder when it comes to client-centered practice, which is I think what this possibly could relate to in OT, is, again the preconceptions from the therapists about that process, and how that's undertaken. It is about the assumptions and the ideas that the therapist has on what client-centered practice looks like. Is that what it looks like from the perspective of the client, or is it from the perspective of the therapist? I don't think sitting down doing a COPM is a way of necessarily understanding a client's life and of helping them to plan, but I think it's very relevant, but I think we just need to be really critical about that, more so. (p. 6)

Participant 7 also mentioned that there are barriers affecting individuals' ability to plan for themselves including social, political, and economic problems, and factors related to disability, gender, culture, and age.

Again, if you're living in chronic poverty or you're living in vulnerable conditions, reflecting on planning one's life, it gives a sense that you that you actually have the ability to plan your life and yet I think for some people, there are many forces and structures that impact their ability to plan their life that it's not something that is just under one person, an individual's control... that actually, can act as barriers to some people who are vulnerable, to be able to have a sense of autonomy in their life. (p. 5)

Some participants stated that the Practical Reason Capability is relevant to occupational therapy practice from an outpatient perspective.

...but in general, when somebody's more coming in from an outpatient point of view, yes I think it's relevant. (Participant 1, p. 5)

A few participants asserted that the ability to exercise autonomy and planning of one's life depend on a person's health condition. For example, participant 12 noted that persons with physical disabilities are capable of making decisions about their lives.

Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. That to me is to be able to help self-direct and even if a person can't enact everything they want about their life, at least they have a way of managing that. So for example, if you have a person who is very physically disabled but they have a clear idea of what they want to do, then they can be capable of making those choices about their life. (p. 8)

Participant 5 also reported that individuals who are living with a chronic long-term health issue, they have serious problems that affect their ability to plan for themselves. Or, people with severe mental health issues, and cognitive impairments are less capable of reflecting on their lives and making effective decisions.

Wow, there's a lot of people who don't have this. [laughing] A lot of people aren't planning one's life. It's something I might have to work on. So I just thought, yeah, that's a nice thought, but I didn't see it as being something that applies to everyone. I really don't think that that's something we could expect of everyone. And in particular, someone who has had a brain injury, or a mental health problem. You know any kind of difficult life transition or change, expecting this of everyone is... (p. 6)

ii) Providing educational and supportive strategies

A few participants noted that the Practical Reason Capability is relevant to occupational therapy practice from an educational perspective.

Um, yeah, I suppose it's relevant in thinking about it from an educational standpoint, so understanding this as a capability is something that would be important. (Participant 5, p. 6)

more I saw it as relevant to education and that part of my job...So more from an education point of view. (Participant 3, p. 8)

Participant 12 asserted that OTs need to be able offer options to the clients at their level of ability, and need to be aware of clients' problems and have realistic expectations.

About the planning; I think we need to be able offer options to clients so that they can see beyond make choices. It really depends on the person's, what is it? OTs of control, if they are really someone who has an internal sense of control, then we need to work with them and how they can enable it and what choices might be possible... we have to just offer options and choices and work with someone at that level. We can do that it very mundane ways. We do that in very mundane ways everyday just around practical things, just every day ADL. (p. 7)

For example, Participant 6 mentioned that people with mental illnesses may be less able to make critical decisions and their capacity for practical reasoning may be deficit. Nonetheless, they may be capable of making simple decisions in daily life. She noted that OTs can work at a basic level to improve the Practical Reason Capability of a client by providing opportunities and strategies.

And then there's also people that physically or cognitively can't understand; then being able to understand, to help them figure out what is important, what isn't. They're not maybe able to make those big life decisions, but they're able to make decisions around a very concrete activity. Or being able to say "I like it this way, not this way."... So I'm going to give them the opportunity to decide. We give them the strategies; the tools to use, their partner's still aren't giving them those choices. Even though they're capable of making them. I think you can, that's very relevant in a lot of ways. (p. 9)

Participant 12 reported that OTs enable their clients to develop the Practical Reason Capability to identify barriers and to achieve what they want to do.

I think OT could do a lot more with enabling people to reach their own goals by helping them figure out what those goals are and helping them shape it, and helping them, enabling, and finding out what the barriers are now...(p. 8)

Participant 4 asserted that OTs provide educational and supportive strategies not only for their clients, but for their caregivers as well.

Well again I think that this would maybe be more appropriate to the mother, the parents, being able to have an understanding of how to make sense of their child's diagnosis and then how they can engage in a new process through information and education from an OT and that way they're able to promote more independence for their kid. (pp. 7-8)

Participant 10 mentioned that OTs develop some strategies to better ensure the families have the opportunity to plan their care.

...in my area of practice, I would say it's about supporting the family and the baby to have the opportunity to plan their life and that maybe, the life might be 5 five minutes, the life might be a month, the life might 89 years. It's still what it is for the time that it is and again what we would be involved in is how they engage with the baby, how that baby is brought into the family, who the family structure is and how the life that they have will be as good as quality as they can have it for the time that they do have it. (pp. 6-7)

3.4.7 Affiliation Capability

This part is aimed at describing the OTs' views about the Affiliation Capability with respect to the two questions:

Question 1) What are OTs' understandings of Affiliation Capability?

In response to this question, the researcher's analysis revealed two overarching themes: Basic needs and rights, and Social relations. The following describes the quotes that support these themes.

i) Basic needs and rights

One of the perspectives from which a number of participants described the Affiliation Capability was to see it as "basic needs and rights". Here, basic rights and needs means being treated with dignity, being considered equal to others, being able to have compassion for situations, having friendships, being able to meet freely and speak freely with respect to politics, and being able to work with people in a mutually respectful way.

[It is] talking about self-worth and dignity to some extent that individuals of all different variations have the basic, same basic needs and rights. (Participant 6, p. 9)

According to some participants, there were two types of comments about basic human rights and needs: those referring to basic rights, such as being treated with dignity, and those referring to basic needs, such as the sense of belonging. For example, participant 10 described the Affiliation Capability as an important aspect of being treated with dignity. She explained it in terms of equality and rights.

So, again, this is about being treated with dignity, being considered equal to others...we are very much involved in our clients and their relationships with other people and seeing them as having their own rights to engage the life they want to have and being treated with respect and with equality. That's right, and we're super involved politically with equal rights for those who are disabled...(p. 7)

Participant 7 defined the Affiliation Capability as a sense of belonging in terms of being a basic need.

Again it goes back to that sense of belonging, possibly as a basic kind of human need. (p. 7)

ii) Social relation

The second perspective from which some participants described the Affiliation Capability was to see it as “social relation”.

I mean this is key to living, I think and so being able to engage and being involved in, being in a social group really, and being able to live with others in a way that’s effective, that the people you are living with are benefiting and that you, yourself benefit as well, so it’s “you give and you get”. (Participant 13, pp. 4-5)

In other words, it means seeking out positive social support that is a key component of healthy living as described by participant 5:

...That social relations are important for general health and function. (p. 6)

Participant 7 stated that the Affiliation Capability is critical for maintaining relationships and achieving their needs as human beings are social beings.

Ok, so the first one, Affiliation, it’s really talking about being part of a social group. So I think the first part for me is looking at the importance of the social connectedness, within society as well as for individuals, and that feeling like that you’re a part of some sort of group, in which you’ve got a shared identity, or there’s something that you have in common with the people in that group, I think that’s a really important part. (p. 7)

Participant 9 also asserted that this capability it is about one’s social network and having relationships that are mutually respectful.

I think having a social network is huge and the social interaction, being able to nourish friendships and what OTs and where it’s an equal friendship and where one person doesn’t have power over the other one, but its having that social network and people who care for them or whatnot, I think is what the Affiliation is talking about. (p. 6)

Some participants mentioned that the Affiliation Capability is about belonging and how people belong. It was noted as being about seeking social support through healthy attachments and pursuing social support through others.

... so it’s about belonging, so that’s friendship, social interactions. It gives us some ideas I think about how we can be, how people belong, so belonging maybe in relation to having compassion for others or for a situation. (Participant 1, p. 5)

Participant 14 explained the Affiliation Capability from the empathy perspective. She mentioned that OTs try to understand the clients' situations and problems in order to better contribute to their well-being.

This speaks to like, perspective taking; so can someone show concern for other human beings, can someone interact with others. This is like the empathy perspective taking part...I think is really big in people with both personality disorders and I mean this is why we are so good at our job, is we try so hard to have that empathy and imagine the situation of another, compassion for that situation. (p. 6)

Question II) How may Affiliation Capability be relevant to occupational therapy practice?

The results describe the four themes that emerged from the analysis of the OTs' perspectives about the relevance of the Affiliation Capability to occupational therapy practice. These were: Helping clients to identify their interests; Developing friendships; social network and social skills; Advocating for their clients; and Working with clients with mental illness. The following describes the quotes that support these themes.

i) Helping clients to identify their interests

Some participants noted that the Affiliation Capability is relevant to occupational therapy from a client-centered perspective. They asserted again that occupational therapy is client-centered practice, so OTs need to identify their clients' values and interests, and respect what their clients want to do.

And the intervention with those individuals who have some interest is really helping people to identify interest, to participate in experiences that may, that may nurture them, that may give them possibility for future, so OT's are heavily involved in that... (Participant 2, p. 9)

And they should be in the driver's seat; not us. They determine what they're ready for, what would be useful for them...(Participant 5, p. 7)

Participant 12 noted that OTs help people with what they want to do by identifying goals and the barriers.

...I could do a whole lot of different things, depending on what this person wants to do; ...as an OT, I'm trained to help identify what goals are, what are barriers, what are facilitators, and I don't have to know a lot of content in area to start, I just need to get going on that. (pp. 9-10)

Participant 13 asserted that OTs are responsible for reintegrating their clients back into society after an event or an illness. She stated that OTs help their clients to identify their interests, and help them redefine what is his or her new role is after trauma or disability.

I think with someone who's living with a physical disability, you're talking to say a father who has lost his ability to work maybe and provide for his family, helping him redefine what is his new role. He's still a father, but he may be not the bread winner anymore, so then helping him sort through, you know, what is a father and how can he maintain that role even though maybe one of his primary jobs or duties was to make sure everyone, to make the money so that the family could live. (pp. 5-6)

ii) Developing friendships, social network, and social skills

Some participants noted that OTs promote the Affiliation Capability through supporting the notion of social networks and friendships. They mentioned that social relationships and friendships have effects on both mental and physical health.

So I thought that this affiliation is important and how it might relate to OT would be...really looking at how do we help people to think about their social relationships. How do they protect some of their social network and friendships; how do they expand it if it's shrunk down to such a size that it's just not working for them. That social relations are important for general health and function and so, looking at that, is something that I think is really important for occupational therapy. (Participant 5, pp. 5-6)

Participant 4 asserted that many people with disabilities lack the opportunity to interact with others to develop social relationships.

Yeah, so a lot of these kids have no friends, they don't know how to socially interact. And it's heartbreaking for a mom that their child never gets invited to a birthday party, you know, they're not included in social gatherings, because they're just difficult kids to take out. (p. 8)

Participant 3 noted that OTs are responsible for promoting social support systems for their clients which include friendships and fostering social skills.

And then, I guess, just even, for our students [clients] being able to live with others and manage well and have friendships and things, just that social interaction piece with children, which sometimes comes into our role, and I think some of our kids who really need a lot of practice with social interaction that are not developing naturally, they have referred to other OTs for more private work for group type intervention where they might build skills as well as social skills. (p. 9)

Participant 4 reported that one occupational therapy intervention for fostering social skills and friendship is educating the client's family members as well as the client.

So promoting friendship and affiliation among, among other families and among children is a big part of my job. I might ask them to bring one of the siblings into an appointment, and then I might help that sibling and the autistic child that I was working with, develop maybe a very simple skill, like, you know, maybe, being able to take turns...you would help that sibling and that child work on winning and losing, or waiting and turn-taking, how to co-operate with working on maybe building a puzzle together so we would facilitate that friendship through the activity, so the child with the, um, who had difficulties, you know, very impulsive, very easily anxious and frustrated, starts to develop the skills. (p. 8)

Participant 4 stated that OTs promote the Affiliation Capability by providing support for caregivers, e.g., shared information and education.

I think affiliation is a huge part... a lot of the families I saw, particularly, the poorly educated, to have a severely disabled child, to have a child with a mental health or cognitive challenges; they were so sheltered from the community. And there was a lot of blame of the mother,...and the mothers were very much isolated from the community and their families...I find that mothers and mothers with children with disabilities are an enormous support for each other...so it was promoting shared information, shared education for moms, yeah. (p. 8)

Participant 6 reported that OTs facilitate the Affiliation Capability by providing assistive technology and giving devices to their clients to provide opportunity to do things they want to do.

Certainly with the work that I do, a big part of what we're trying to do is allow or facilitate the skills and the tools to allow them to interact with others, as they wish. So whether it be providing a para-mobility device so they can get around and do the things they want to do, with the people they want to do it with or, from a communication point of view, giving them supports so that they are able to express what they're needing and wanting and feeling or not, refusing to participate in and to be able to do it both, ...as a therapist, I've facilitated an understanding of communication among those individuals. (p. 9)

Participant 6 also stressed that para-mobility devices empower the clients to do what everybody else does. Assistive technology gives them support to express their feelings, promote their mobility and the opportunity to communicate. Para-mobility can provide opportunities for freedom and independence, provide opportunities for making independent decisions, and provide opportunities for inclusion and social relationships. Para-mobility empowers individuals to be able to do what they want to do. She mentioned that OTs also educate others to treat them with respect.

And hopefully, when you talk about the social basis for self-respect and not humiliation, so a lot of what we do is educating others around this individual as an individual is worth putting energy towards. So giving them the information and strategies to help them see this person in a very different way. To gain respect, or to have consideration and appreciate diversity– those kinds of things. (p. 9)

A few participant stated that OTs help clients to learn skills to develop and maintain friendships through educational process for both client and their social networks. Participant 8 claimed that OTs not only help their clients to develop relationship with others, but also help others to interact with them in appropriate ways.

helping patients learn to live with others, show concern for other human beings, act in a way that is behaviourally appropriate, enables others to act in a way which is behaviourally appropriate to the patient...(p. 7)

Participant 8 also mentioned an example of how OTs helped others to interact with a child who was severely burned and was having difficulty forming friendships.

The other area where I know of OT's getting specifically involved is, it was the OT's and the social workers at the burn unit, have produced a video, for parents to take to a school so that a child who has been badly burnt, especially if they have facial scaring, they have a video to take to introduce a classroom, and the other students and the teachers and what to expect, to answer a lot of the questions so that the kids are not terrified when they see this Johnny coming back looking like an alien and that makes a huge difference to a child being able to function in that environment and being able to maintain friendships. (p. 8)

According to some participants, developing the Affiliation Capability needs to be based on meaningful relationships and mutual respect.

OT's really try to help people develop meaningful relationships and mutual recognition, So, I would say that that's a big area for OTs. But, for recovery, within the recovery framework helping people find meaningful relationships and mutual recognition is part of the journey of recovery, People may end up being very isolated and not feel worthy sometimes of friendships. (Participant 2, p. 9)

Participant 5 noted that OTs help their clients to rebuild their social networks during recovery. She stated that OTs try to provide opportunities to build social relationships and friendships in new ways.

But people recover from mental illness. Building that back up again, is where an OT might intervene. How do you go about doing that? How can you start to get new life? Back on track; build up that social network again. Maybe not, maybe in a different way, maybe in an altered way. But in a way that works. (p. 6)

iii) Advocating for their clients

Some participants asserted that improving Affiliation as “having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others” is relevant to occupational therapy as advocacy role piece.

To me this is the same as Bodily Integrity. This to me is that advocacy piece..; so knowing when someone needs to draw a boundary, what they’re entitled to as a human being and so to me. (Participant 14, p. 6)

Participant 9 reported that OTs advocate for their clients and refer them to available resources to make sure that their clients are not being discriminated against.

I think just being cognisant of discrimination that might be happening and encouraging them to support services if needed if there’s discrimination that is happening or there’s some sort of power imbalance somewhere in their life, connecting it with social work, and other...I think probably more referral if needed, and sort of advocating on behalf of the client. (p. 6)

According to some participants, self-respect and non-humiliation are important issues in people with disabilities. One participant highlighted that many people with disabilities do not feel that they are treated equally. She asserted that OTs can develop the Affiliation Capability by serving as advocates for their clients in various ways.

Some of it relates to advocacy like being part of organization and protecting organizations that support people’s ability to have freedom of assembly and political speech. ...as an OT, trying to help people go back to school, go back to work or engage to activities and things they need to do and things issues like self respect, humiliation, stigma, you can’t really help them without addressing those issues as well. And we could address them in different ways. We can address them by doing advocacy with employers, advocacy with educational system. The OTs can do that, or we can support broader movements that are like community awareness campaign, and things like that, we can support them. That’s really our role specifically...(Participant 1, p. 5)

Participant 10 noted that OTs are involved politically, for example to help ensure people with disabilities have equal rights. She mentioned that OTs advocate for treatment for their clients, and help caregivers advocate for their children to access services.

we are advocates and/or help the parents advocate for their own children with respect to receiving services that their children might need as a result of being born early or with a disability of some sort. (p. 7)

Participant 6 reported that some OTs are involved in advocating at a societal level, and an institutional policy level to advocate for their clients in a respectful, inclusive way.

And I know of other therapists that do that on a more of societal level, more on an institutional level, where they're going in and looking at policy changes. (p. 6)

iv) Working with clients with mental illness

The majority of participants agreed that the Affiliation Capability is relevant occupational therapy practice in mental health.

This would be something you would see a lot more in mental health and there's a lot of OT's who work strongly in mental health... in mental health I think this is very, very strong. (Participant 8, p. 7)

Participant 13 stated that OTs who work people with mental health issues work to reintegrate their clients into society through the development of social skills.

Well, mental health is the easy one right, because often those individuals may have some difficulties interacting, so the OT, with some populations might be working really on helping people develop social skills, so that they can interact in a reasonable way with individuals so that they'll be accepted by the social group that they would like to be belong to. (p. 5)

Participant 2 noted that people with mental health lack of having the Affiliation Capability.

... so OT's are heavily involved in that and if I'm to bring into affiliation, part of that would be developing friendships, or going to social groups or just sometimes being around other people. Sometimes it's hard for people who live with significant mental health issues to tolerate being around other people, to be able to negotiate, conflict at work, and that may be immensely stressful for people. So it's providing the right supports, possibilities for people within those environments and OT's do a lot of that. To engage in various forms of social interaction, to be able to imagine the situation of another and to have compassion for that situation. (p. 9)

She also mentioned that OTs provide services that help people engage in healthy social relationships and activities, e.g., embedded in self-respect and non-humiliation.

so people who live with mental health issues are not only stigmatized within the community, but also stigmatized themselves. Often people feel less than, feel ashamed and unable to connect with people in the community. So, OT's try to help people to take next steps around that to have the right support and structures to help people to take the next steps. So, to help people develop meaningful relationships and mutual recognition, So, I would say that that's a big area for OT's...(Participant 2, p. 9)

Participant 5 noted that although the Affiliation Capability is relevant to occupational therapy practice, its role in mental health services in particular, is not as visible as it might be.

This is one that I thought was most applicable to mental health and is one that I think is relevant to occupational therapy. One that we haven't always perhaps discussed enough in education of OTs. (pp. 6-7)

3.4.8 Other Species Capability

This part describes the OTs' views on the Other Species Capability with respect the following two questions:

Question 1) What are OTs' understandings of the Other Species Capability?

In response to this question, the researcher's analysis revealed one theme: The idea of environment. The following describes the quotes that support this theme.

i) The idea of environment

A number of participants noted that Other Species Capability is about the relationship a person has with the living environment.

My general understanding is that it seems like the idea of working in the environment, so to be relevant of your impact on another things, even if they're not people. I think it's very important. (Participant 3, p. 9)

I think just the fact that we are part of a bigger world than just ourselves, where creation matters where plants and animals in the world, it is important, and we don't just lure over these things we're all sort of in it together. (Participant 9, p. 7)

Some stated that it is about sense of belonging and attachment to other creations. In other words, it is about your relationship with animals, plants, and nature.

Is that kind of affiliation with the world other than people? That's my interpretation. (Participant 13, p. 6)

Well I guess it's being able to appreciate that we're not the only species on this Earth, and that there are, Being able to respect and maybe foster relationships with animals and plants and nature. (Participant 6, p. 10)

Participant 7 mentioned that the concept of health is deeply affected by human-environment interactions in some client populations.

I work with, Aboriginal people, connectivity and relationships with animals, plants, the land, nature, is an important part of I think how health is perceived and experienced. (p. 9)

Question II) How may Other Species Capability be relevant to occupational therapy practice?

Five themes emerged from the analysis of the OTs' perspectives on the relevance of Other Species Capability to occupational therapy practice. These were: Relationship with animals and nature affects health; A client-centered perspective; A spirituality perspective; An environmental perspective; and Not the main focus of occupational therapy practice. The following describes the quotes that support these themes.

i) Relationship with animals and nature affects health

For some participants, Other Species Capability is relevant to occupational therapy practice because human-animal interaction and relationship with nature affect health.

I think it's important because a lot of people talk about relationship with their animals, their relationship with nature as being important for their health and human being.
(Participant 1, p. 5)

According to some participants, there were two types of remarks about the impact of human-animal interactions on health: those referring to developing social skills, and those referring to animal-assisted therapy. Some participants noted that pets, specifically dogs, can make the first connections that is needed for a therapeutic relationship. For example, participant 4 said that a dog can help autistic children develop social skills and induce a sense of calm.

Well this big dog of mine is a therapy dog. So when the children come to see me, they come to see him. The children prefer animals to me sometimes, and the kids love my dog. They feel so safe and he usually lies down and they may lie down beside him, they may talk to him, they may read a book. (p. 10)

Participant 4 asserted that the effective relationship with pets depends on factors such as the cultural background of the family, the child's characters, and the training of the dog.

I have one family from Korea, and they don't like dogs. At all. In Korea, and so the mum and the dad are like "OOOH, get the dog away from me!" But the little girl is beginning now to...With the dog, and that's very interesting for her parents to see, because that's not what they grew up with in Korea. It really depends on the family, because you have to take really good care of the dog, and so many parents are so overwhelmed with looking after their children. It depends; it really just depends on the child, and the family and the dog. You have to have a really well-trained dog, and not just any dog. (p. 10)

She also mentioned that for autistic children having pets such as dogs not only improves their social relationships, but can help keep them safe.

I have one kid that's not safe in the house; he's like a Houdini, a magician. He'll figure out how to undo all types of locks on doors, and he runs, but he can't speak. He's very unsafe, but that dog is always with him. So where he goes, the dog follows. Like a guard, he keeps the child safe, so if they're out on the streets or in town. The dog and the boy...But that dog's job, with training, is to keep that child off the street; safe. (p. 11)

In addition, she mentioned the role of other animals such as horses in an individual's health. She noted that horseback riding therapy can be considered as an intervention to develop relationships for children with autism, and to assist children with cerebral palsy as well.

Horses are very big; a lot of my kids do riding therapy. And the riding is not just getting on the horse and riding; it's the grooming. Yeah, yeah so the children will become part, they'll go in, they'll put the bridle on, they'll do the brushing, they'll clean the hooves, and then they'll ride the horse, but eventually, and these kids with autism, a lot of them have posturing difficulties, and mild to moderate motor impairment, so riding on the horse is also a way to work on their trunk and stability and balance. And you know, holding the reins and being able to initiate the horse to move. Um, and it's also a social thing, because, you know, there're other kids who're on horses. And then they develop that rapport with their own horse over time, so the therapeutic riding is actually a big thing here. And, with the CP kids. And, with the CP kids, too. The riding is huge with our kids. (Participant 4, p. 11)

Participant 6 referred to the importance of animal-assisted therapy for physical disabilities.

Yeah, so these are people who are in wheelchairs themselves and they use a dog to assist them. And the dogs are much more efficient than any of the tools that I would maybe provide for them. The dog is just that much smarter, and that much more intuitive. And so for that individual, it's a really good match, right? (p. 11)

Participant 3 also mentioned the benefits of animal-assisted therapy for autistic children or people with visual impairments.

I don't generally work with animals, unless one of my clients, will have a dog due to a visual impairment, or I even have a student with autism who received a dog for safety in the community. It actually worked quite well, so far anyway. He actually has a visual impairment, as well as autism, but he was a bit of a bolter, so he would just run off and now that he has the dog, I think it's given him sort of something to lead him, that isn't an adult telling him what to do. So I think it actually worked out to be quite a nice relationship. (p. 6)

Some participants mentioned that not only the relationship with animals, but one's relationship with nature, affect physical and mental health.

And I also think that for, especially with mental health, just the value of being in nature and connecting with nature. So being able to walk outside, you can use it from a physical

disability's point of view – someone being able to walk over rough ground is a different skill than walking on a flat, indoor surface, right? (Participant 6, p. 11)

Participant 1 noted that the relationship with plants may be important for a client's health but it likely depends on a client's age and interests.

Community gardening can be important for people's well being...so I think it depends again like, your clientele. (p. 6)

She also addressed the impact of our connection with nature on our health.

Animals being very important to people and being in nature. Taking walks in nature, various good ways to reduce people's anxiety, calming, meditations and things like that. (Participant 1, p. 6)

A few participants mentioned that although the relationship with nature is important to health, accessing nature for people with disabilities can be challenging. For example, participant 2 mentioned the lack of community support and poverty as challenges for accessing natural environments.

So, I guess I'm saying that people certainly have the capacity but maybe not the opportunity to function in that area because of life circumstances, because of poverty and not having a little green space which they can call their own, and if people are living in smaller communities, sometimes mental health supports are not as strong as they would be in the city. (Participant 2, p. 11)

ii) A client-centered perspective

Some participants noted that peoples' beliefs are related to their health and well-being. As client-centered practitioners, participant 5 stated that OTs are trained to identify their clients' beliefs, values and interests and respect them in management planning.

It's totally driven by the client and then you say "OK, that matters to them. How do we help support that?" (p. 7)

Some participants mentioned that the Other Species Capability is more relevant to occupational therapy practice from an individual point of view. They asserted that if the relationship with the living environment is something important to the client, OTs help the client to explore what they want to do, what activities are meaningful to them, and how to achieve these.

If that is something that is meaningful to the client, I will be doing that to help the patient do what is meaningful to them. (Participant 8, p. 8)

So if somebody feels it's really important to walk with nature, for whatever reasons they are experiencing some kind of a barrier and I think it is important for OT to kind of explore that with them. (Participant 1, p. 5)

Participant 6 also affirmed that the Other Species Capability has relevance to occupational therapy practice with respect to pet therapy and horticultural therapy, but improving this capability depends on the clients' interests.

...but I know of related to pets and pet therapy and horticultural therapy. If those are areas that an individual has identified as being something of interest for them, then maybe using those as a way to work with the individual on developing their interests or their skills. (p. 11)

Some noted that improving the relationship with animals is only of value with someone who likes animals and is capable of caring for them. They reported that OTs help clients to care for their pets if it is important to the client.

Sure, if that's what the client wants to do. If they want to have a pet, yes...(Participant 12, p. 11)

So again just helping people, I mean if they have pets, helping them care for their pets, if there's been a change in their ability to do that, and looking at different options, or if they were interested in, or if they can't have a pet because they're living some place that they can't have a pet, looking at what are some other solutions or options to do that. (Participant 13, p. 6)

Participant 12 mentioned that there are two considerations regarding the relevance of the Other Species Capability to occupational therapy practice. The first is to look at it from a client-centered perspective and what the clients want to do. The second is to look at it from animal-assisted therapy.

There's two ways of looking at that. One is if they are a person with a physical disability and they love their pet but they're finding it difficult to care for the pet, then yes, I would definitely see that as a role for OT and the reason being that it's really important to their client which I can understand because a lot of people are very very attached to their pets and they get emotional gratification from having a pet around, companionship, all of that, that stuff; So I would see that, if you're talking about an animal that's assisting a client, to me that's quite different; a person has a physical disability either visual loss, or physical loss and they need help to do regular ADL and managing in the community, and a pet is kind of like a, not a pet but a dog, an animal, is an intervention to help them do that. (p. 11)

iii) A spirituality perspective

For some participants, the Other Species Capability can be defined beyond the physical relationship with animals and plants, and nature. They asserted that it can be explained from the spirituality perspective. According to them, OTs are involved in enabling clients to live with other species to improve spirituality.

I think for some is part of their spirituality, and spirituality is the center of our model. (Participant 2, p. 11)

Some participants noted that the Other Species Capability is related to people's spiritual beliefs. For example, participant 7 asserted that aboriginal people connected it with spiritual beliefs, and the power they have in healing. According to her, this population believes in the substantial roles of animals and environment in healing. So, OTs need to understand their clients' beliefs and values and respect them.

Is it relevant to how I, only in, again, only in my understanding and appreciating the importance that that has for some of my clients, so connectivity to the land, and it also, for some of my clients it's connected with spiritual beliefs around inanimate objects and the power they have in healing, so for me, it's a matter of learning and respecting other peoples world views, how they see their beliefs... In terms of the environment that the persons and animals, people have used animals in therapy but I think it's going beyond that, I don't know. (p. 9)

iv) An environmental perspective

Some participants noted that the occupational therapy profession focuses on the idea of living and working within the environment. According to them, understanding the person-environment interaction is a fundamental premise in occupational therapy practice.

My general understanding is that it seems like the idea of working in the environment, so to be relevant of your impact on another things. I think it's very important. (Participant 3, p. 9)

Oh absolutely, I think you should be able to live happily with animals, plants and nature but what's interesting about that, and OTs in general have a very clear conception of what the environment is and it includes all of these aspects of the environment and we're not just talking about the physical depths and things like that. (Participant 10, pp. 7-8)

Participant 10 asserted the benefits of including aspects of the environment for improving human health, for example, including living environment in a nursery unit.

So my personal view is the babies would be healthier if they had plants and little animals crawling around and so maybe someday that will happen. But I would be an advocate for

the benefits of those aspects of the environment for the health of the neonate and for the family and it may be that there is a compromise that is made that the waiting area where the families wait would have some aspects of this which were allowed. I want the babies to have plants in their room. I really do, I think it would be fantastic, so we'll see what happens. (p. 7)

v) Not the main focus of occupational therapy practice

For some participants, the Other Species Capability is not consistent with mainstream occupational therapy practice.

...it's an important component of, it might not be the main thing we do, with as OTs. (Participant 13, p. 6)

Some participants noted that OTs are too busy to include this capability in their practices.

...it's not OT and we're so busy trying to redefine who we are that if we start bringing things in like helping people interact with other species and helping them end life with normal length I think it doesn't do our profession justice. (Participant 14, p. 7)

On the other hand, others noted that OTs do not pay sufficient attention to other species; perhaps, because we believe that human beings are more important than other species.

I think it's not such a huge of a role because I think that there's still a mindset that just generally in society that humans are important and plants and animals and things are not, and so I think that hasn't been an area historically that OT has been in it. (Participant 9, p. 7)

Some participants mentioned a number of barriers for including the Other Species Capability in occupational therapy practice. For example, participant 2 said that although there are advantages for some clients having animals such the opportunity to communicate with others and love another being, there are challenges such as cost, housing structure, and nature of a person's illness.

We've talked about that saying that because of poverty or because of housing structures within the large cities that for people to be around animals, to care and love for animals is prohibited because the landlords, but also the cost involved. (p. 10)

Some reported that sometimes the structure-nature of an illness does not allow people to develop their Other Species Capability. For example, Participant 1 mentioned that the clients who have unstable conditions have difficulty keeping animals.

when as they were becoming a bit unstable, then they did not know what to do with the pet... (p. 6)

3.4.9 Play Capability

This part describes the OTs' views on the Play Capability with respect to these questions:

Question 1) What are OTs' understandings of Play Capability?

In response to this question, the researcher's analysis revealed three themes: Human happiness; Quality of life; and Work/life balance. The following describes the quotes that support these themes.

i) Contributes to human happiness

One of the perspectives from which participants described the Play Capability was to see it as recreational activities. This perspective appeared often in interviewees' statements.

...I think it's important to look at play in terms of recreational activities. (Participant 9, p. 6)

So this is the ability to enjoy recreation. (Participant 11, p. 6)

A few participants reported that recreational activities and happiness are closely intertwined. Happiness means different things to different people. For them, happiness means the ability to pursue "your joy".

depending on what's important to you and what gives you joy and they can be recreational activities, they can be at home or out in the community. It could be things you do alone or it could be things that you do with other people in a social settings. (Participant 12, p. 10)

ii) Preserves quality of life

Some participants noted that improving quality of life means helping the client to identify activities that are meaningful and recreational.

...promoting sort of quality of life connected to play...helping people clarify their values and their interests and their goals and then helping them to achieve what they want to do and what they feel they need to do. (Participant 1, p. 1)

Participant 9 asserted that recreational activities can be considered meaningful if they enhance the individual's quality of life. She noted that the ability to engage in recreational activities support the individual's quality of life and its well-being.

Being able to engage in leisure activities and recreational activities is huge, in maintaining a sense of self and of quality of life, and so I think that is something that is quite important. (p. 6)

iii) Achieves a work/life balance

According to some participants, we play various roles in our lives and achieving a balance among our roles is difficult. There is often imbalance.

one thing we don't spend enough time on I think that's related to all of these things is the balance. So say for example: personal care, like daily routine of personal care is something that needs to be done. I could do it myself with a lot of time and energy and equipment, but I'm exhausted by the end of it and then I have no time or energy left to do other things in this area. (Participant 12, p. 10)

For participant 3, the Play Capability helps establish work/life balance.

...if you don't have play, so to speak, in your life, then I think there is a huge part of life that is missing. (p. 7)

Participant 13 noted that achieving work/life balance and bringing joy into your life, improves happiness and life satisfaction.

So I think, I mean not just focusing on self-care and productivity but make sure that you have a balance in your life and that you're doing things that you enjoy, that you're having fun, that might make you laugh, and that you get other good feelings of feeling able or feeling capable. (p. 6)

Participant 6 mentioned that the Play Capability not only can bring joy and balance in life, but can reduce stress and pressure. So, she stated, it can be described from therapeutic perspective as well.

It's a very important part of life. And I think looking at balance, from a therapy point of view, to be able to say OK. For individuals who may identify that as a problem that they don't have enough of that in their life, or that they don't have the skills or the abilities to develop the areas that they want; to be able to say "OK, alright, you can't walk now, but you can still go sailing, or go hiking, or there's other ways of doing that." And then with kids, just play-based therapy, right? (p. 11)

Question II) How may the Play Capability be relevant to occupational therapy practice?

Three themes emerged from the analysis of the OTs' views about the relevance of the Play Capability to occupational therapy practice. These were: Pediatric practice; Working with people with mental health issues; and Its important for everyone. The following describes the quotes that support these themes.

i) Serving as a primary therapeutic approach in pediatric practice

Many participants asserted that Play is key for children development and participation. They emphasized the importance of play-based therapy in pediatric occupational therapy.

Oh, that's one for kids, that's a key. With kids, just play-based therapy, right?
(Participant 6, p. 11).

Occupational therapy is a play-based functional model. Everything, I mean. People who don't know what I do just think "Oh well, you know, she just plays with kids all day!" And I do play with kids all day and it's the vehicle through which we help develop the new skills, right? (Participant 4, p. 9)

I think it's often emphasized in the pediatrics practice where play is so important as part of the life development stages. (Participant 9, p. 6).

A number of participants reported that interactions with children are largely through play.

For children, as they mentioned, play is a way they learn about themselves and their world.

Play: big, very big. Children have to play, we play through learning. So absolutely, probably up there with Bodily Integrity, Bodily Health, Senses Imagination. I mean, play is how children interact, it's how they learn. (Participant 4, p. 9)

Oh I think OTs have a huge focus. I mean pediatric for sure, I mean it's probably one of their major focuses, making sure children can engage in play and do engage in play because they learn so much. (Participant 13, p. 6)

Participant 3 asserted that play is a way to connect body and mind, and it is necessary for childhood development and growth. From her perspective, it is also seen as a way to enable therapists to build therapeutic relationships.

Play, I think it's so important...I just think play is so key to the development of gross motor skills, fine motor skills, visual motor skills, social development, everything. Imagination, desire to learn, and everything. I think it's...And I think, really, that's why I enjoyed working with children so much. It's because all of our interventions, usually, as much as we can anyway, are play dates. And if the child is not enjoying it, then we are missing out on something. (p. 7)

Some mentioned the Play Capability also can be considered as a way of enabling parents to connect with their children. Participant 4 noted that in children with severe disabilities, such as autistic children, the Play Capability can be considered as the primary level of connection that affects the relationship between parents and child.

Well a lot of my work is helping a parent understand why their child does what they do, so it's being able to...for example a child that just flips, can't sustain any kind of eye contact...so these children are non verbal, they have no language skills, they have no eye contact, they're completely self absorbed, completely withdrawn, unable to really show any kind of interest in a parent figure, for example, and so then we have this play based activity where the mother is taking the child's lead and following the lead in something that they may be interested in, the practical application is that she's beginning to have a

different way of understanding how her child is being in the world and she can start to take some steps to understand that differently, and know how to engage with her child to have maybe for the first time in her life, some sort of nurturing mother role, ... (Participant 4, p. 5)

Some participants reported that OTs provide a range of activities to engage clients of all ages and abilities. Participant 4 noted that OTs modify activities in various ways to be appropriate and accessible for their clients by breaking down activities, adapting the environment, and using the simple and clear instructions.

A lot of my kids don't know how to play. You know, if you've got a kid who's got a severe motor impairment, he doesn't know how to interact with objects or people, because of his physical challenges, right? So, it's about adapting play. To being able to produce that higher level of learning, and with my children with autism, they don't have a meaningful relationship to objects. They don't know how, it doesn't mean anything to them. So it's being able to develop those concepts, through umm, I use movement a lot because those kids really like to move, so I use swings, and different types of suspended pieces of equipment, because they like to move, and then we would start to add onto that with something simple like throwing a beanbag and knocking over a tower, while they're moving. And um, starting to develop some meaningful relationship to play. (p. 9)

Participant 10 indicated that play not only affects children's developmental growth and improves social skills, but it was thought to contribute to family happiness.

Play, pretty obvious, I'm a pediatric person, being able to laugh and play and have lots of fun, I think is super important for families. And for the neonates, we don't have play until they're a little older, but if they happen to stay in the nursery, we provide access to toys, we educate parents about what toys would be appropriate to promote development, that kind of thing... (p. 7)

ii) Serving as a therapeutic approach when working with persons with mental health

Some participants mentioned that the Play Capability in terms of recreational and meaningful activities is important for improving mental health. Participant 5 stated that the Play Capability can support individual's well-being.

Again, I think it's very important. And so, it's part of what I think in mental health, we try to integrate into some of our treatments by making some of the learning part of what we did fun. Like I can remember in our group about stress management, we always connected it to an activity, a game or something we could play. To help people remember the actual activity and the learning of what we were doing. So an example might be, when we talked about stress and having all these balls to juggle of family, home, finances, all the things that can be very stressful. We did this juggling activity and it was interesting because people remembered the learning of that group, based on the juggling, based on the play. So it was very interesting. So it is relevant, I would think. (p. 7)

Participant 8 noted that improving the Play Capability is an important part of mental health occupational therapy practice.

In mental health, in extended cares, in other places, it is done a lot more, but it is supposed to be a very significant part of OT. It's a very significant part of life. (p. 8)

Participant 14 also asserted that recreation or leisure activities are important in mental health practice for establishing effective therapeutic relationships between the clients and the therapists, and other effects.

I think this one is definitely important for occupational therapy, mostly for building a therapeutic relationship. I don't actually enjoy the recreation or leisure component of my work, but obviously working in mental health is very important as well as other, it expands other areas as well. I just think that's a way you get in with a client, you go through the route of what's meaningful to you, what do you enjoy and then you can actually work, and it's different because other professions want to be seen as very goal focused and they talk about medications and they're talking about housing, and we're talking about what's important to you, so we cannot avoid the recreational activities, but I look at it like in the CMOP. Obviously leisure is there, I don't like leisure but I use it as a means to an end. (pp. 6-7)

iii) Its important for everyone

The majority of participants stated that the Play Capability is not only important for pediatric and mental health occupational therapy practices, but it is important across occupational therapy settings and clients.

...I think it's important for everyone to be able to laugh, enjoy life and to do something that is joyful just for the sake of doing, not because it's expected, or they have to do this before they can do that. (Participant 6, p. 11)

Some participants asserted OTs familiar with the Play Capability and they use it in a range of practice settings.

... OT always, I think, been very much interested in trying to understand people's interest and try to facilitate, their ability to engage in the things they want to do in recreation, in pleasure, and in enjoyment, things like that. So that's one that I think that we're pretty familiar with it. (Participant 1, p. 1)

...[Play Capability] is about social connection, it's about engagement, it's about helping somebody to develop their own identity again, and these are all areas OTs are involved in. So, recreation, participating in recreational activities is definitely a focus for OT and the notion of enjoyment and developing awareness and language around enjoyment I think. (Participant 2, p. 12)

Participant 13 mentioned that play is not only a focus of pediatric occupational therapy, but it is important for older adults to augment happiness. According to her, OTs can adapt activities for people with cognitive and physical disabilities to promote fun.

Oh I think OTs have a huge focus. I mean pediatric for sure, I mean it's probably one of their major focuses, making sure children can engage in play and do engage in play because they learn so much, and then I think for the older adult, again, what kinds of activities or leisure activities are of interest to you and that you can participate in and that you feel good about it and then in what role. ...So again, I think we have a huge role to play. We can talk about physical capability and cognitive capability and kind of match that with interests and help people kind of explore and come up with their ideas of how they're going to have fun and what are they going to do with the rest of their life, kind of thing. (p. 6)

Some participants mentioned that OTs have a role in enhancing the Play Capability. They stated that OTs need to consider play across ages as it has an important role in promoting health.

It's a really interesting one, to have it in this list, in terms of looking at this list as basic human rights, the right to play, the right to laugh, the right to enjoy recreational activities for all ages, not just for children, I think it's a really interesting concept, and I definitely think it's something that we need to look at beyond pediatric populations, especially that we're going to have more aging people who are maybe not working full time or not working, the role of recreation in promoting health. I think OT's have a big role to play in that, so I think play across the ages is a really important concept. (Participant 7, p. 8)

And I think it is also very important through all aspects of occupational therapy, even with the adult population, I think the whole idea of play or leisure kind of gets missed sometimes because we are so focused on work and activities of daily living ... self care, and all those things that are important, but if you don't have play, so to speak, in your life, then I think there is a huge part of life that is missing. (Participant 3, p. 7)

Participant 10 noted that play activities can be used in various occupational therapy settings including acute care.

We're one of the few areas of the hospital that still does a lot of leisurely activities in acute care, but then our patients can be in there for months but in most OT areas of acute care unfortunately this has been lost because it comes well after survival and all that, most OT's are allowed to do now is survival. The patient has had their surgery, now get them out. Now, you worried about is that they can get home, get on the toilet, get them food, in and out of bed and not fall over or hurt themselves or starve, so leisure, someone else has to deal with. (p. 7)

A few participants asserted that despite advantages of developing the Play Capability in occupational therapy practice, it may be precluded in some settings. For example, participant 2

cited that a therapist-consumer relationship makes consumer expectations high, so it may be difficult for clients to take play seriously.

I think we don't pay enough attention to play, to be perfectly honest. And I thought this were a long, long time and I think in that interaction with people often we are a little bit restricted by, historically by our relationships. Being in a therapist-consumer relationship, I see that changing with the recovery model that we can become more authentic with people and have an opportunity to but I think that is a very powerful therapeutic tool that we don't maybe pay enough attention to. (p. 12)

Participant 9 also mentioned workload issues may contribute to OTs paying less attention to the Play Capability.

In adults, we often don't have time for it, just that things are so busy and there are so many people to see. (p. 7)

Some noted that it is important to have some guidelines to include the Play Capability in occupational therapy practice.

So this is a good thought that play should be part of what we do. How do people then put that into their practice? It either doesn't happen. They say "we don't have time; it's nice in theory, but we don't have time." So it's getting beyond some of these roadblocks that tend to put into practice. (Participant 5, p. 7)

3.4.10 Control over One's Environment Capability

This part describes the analysis of the semi-structured interviews with respect to the two questions:

Question 1) What are OTs' understandings of Control over One's Environment Capability?

In response to this question, the researcher's analysis revealed three themes: Decision-making; A basic human right; and Political opinions. The following describes the quotes that support these themes.

i) Decision-making

One of the perspectives from which a number of participants described the Control over One's Environment Capability was the capacity for decision making.

Being able to recognize that the individual does, is empowered to make decisions over things and decide politically or decide about sort of their material environment, just being able to have the ability to make decisions for themselves, and not have someone make those decisions for them. (Participant 9, p. 7)

I would say that the idea that people are able to participate in their decisions making, in their treatment decision making...(Participant 1, p. 6)

Some participants mentioned that some people do not have control over their environments and are unable to make decisions.

My sense is that many people living in mental health issues feel that they don't have a lot of control over their environments...(Participant 2, p. 12)

...sometimes when people becomes patients, family makes the decision, people in authority make decisions for them. They start to lose the power in making decisions...(Participant 1, p. 6)

ii) A basic human right

For some participants, the Control over One's Environment Capability is about human rights. Here, basic human rights include both citizenship rights and basic needs. It means as citizens, everyone has a right to exercise control over his/her environment and meet his/her basic needs. This perspective appeared often in interviewees' statements. There were two types of statements about basic human rights: Those referring to basic rights, and those referring to basic needs.

...this reminded me the concept of citizenship. So "being able to participate effectively in political choices"- I mean, again, there are good human rights. (Participant 7, p. 10)

So this is being about being able to own property and participate in political events, having the right to seek employment on an equal basis so it means that you wouldn't be discriminated against, so again I think it's largely human rights. (Participant 11, p. 5)

It's the idea that you feel like you have that as part of your human right (Participant 3, p. 10)

Some participants mentioned that it is necessary to ensure that people of vulnerable populations can access to resources to address their basic needs.

but I'm not expecting my clients to do that when they're in a vulnerable position, when they're in a vulnerable position they have to get their immediate needs met. (Participant 12, p. 11)

So part of it, was making sure the individuals had the needed supplies and resources, food, shelter, meaningful occupation, that kind of thing... a lot of these individuals need diapers, they need feeding tubes, they need feeding supplies...Very basic needs! (Participant 6, p. 12)

iii) Political thought

Some participants mentioned that the Control over One's Environment Capability is about political thought and political choices.

So, and it has more of a political connotation to it. (Participant 13, p. 7)

So, being political or having influence politically around the policies and procedures that support participation. (Participant 6, p. 12)

Some participants indicated that the Control over One's Environment Capability implies the right to privacy and freedom of expression consistent with political thought about being able to govern, contribute, and participate in your environment.

So, all of us need to be able to feel like we can speak up and impact political choices. (Participant 3, p. 10)

So again, you should be able to choose who's governing you and be able to have free speech and participate in politics if you so choose and that you should also be able to hold property...that's important. (Participant 10, p. 8)

Participant 3 noted that political choices and costs affect the delivery of health care and the delivery of education as well.

...identify more with the political side of things I think in this capability, just because I think that you do need to feel like you have some sense of participation and choice in political outcomes and if you don't agree with things that you are able to speak up without feeling like that it's going to be detrimental to you and I think that political choices impact the delivery of health care and the delivery of education and both of those areas are so significant in my area of work. (p. 10)

Some participants noted that Control over One's Environment Capability is about political thought, but OTs do not tend to work from this perspective. They mentioned that OTs are not usually politically active in relation to their professional responsibilities.

That is, OTs should stay out of politics, professionally. (Participant 8, p. 9)

The political one, I really thought, was not very relevant to OT.... So, which again, I think is very theoretical, and it isn't very practical. (Participant 5, p. 10)

Question II) How may Control over One's Environment Capability be relevant to contemporary practices of occupational therapy?

Three themes emerged from the analysis of the OTs' perspectives on the relevance of the Control over One's Environment Capability to occupational therapy practice. These were:

Developing decision-making; Helping clients gain and retain employment; and Advocating for their clients. The following describes the quotes that support these themes.

i) Developing decision-making

Some participants claimed that OTs have a major role in enabling clients to exercise control over their environments and empower individuals in order to independently participate in their society and make their own decisions. Participant 1 noted that one of the OTs interventions for the Control over One's Environment Capability is to empower people with disabilities in decision-making process.

... and I think that I guess in my practice that was one of the things to try to ensure that people becoming empowered in the decision making process of their lives. (Participant 1, p. 6)

I think it comes up primarily when, when it comes to competency assessments, and is the person able to make those decisions and have control over their environment, when often they may not be due to cognitive impairment, or dementia or whatever it might be, so I think that's where often OT does come in. (Participant 9, p. 7)

Participant 2 stated that occupational therapy interventions include developing awareness, self-determination, and decision-making to help clients exercise control over their environments.

My sense is that many people living in mental health issues feel that they don't have a lot of control over their environments, and OT's often help people articulate what are they unhappy about, or what are they happy about within their current situation, developing an awareness and then developing the self-determination to effect change if needed. So it goes from developing an awareness to a place of shared decision-making, to a place of self-determination...(p. 12)

ii) Help clients gain and retain employment

Some participants noted that people with disabilities do not have equal opportunities to seek employment. They claimed that OTs play important roles in helping their clients seek employment.

That's a huge piece. We work, we help people return to work or to find productive activities, be it paid or unpaid, I guess this is kind of looking more probably at a paid, on a paid basis but, I think OTs work in that area for sure...(Participant 13, pp. 7-8)

Participant 2 also said that there is a shortage of employment opportunities for people with mental illnesses, and a shortage of OTs involved in this area.

Only approximately 15% of people who live in significant mental health issues actually work at this point, part-time for the most part. We know we can improve that to 46, even 60% with the right interventions, and OTs are involved in that. (p. 13)

Some participants also indicated that equal access to employment opportunities is important, people are not equal as they have varying abilities. So, it is important to be realistic about disability issues.

Employment on an equal basis with others is a contradiction in terms. A person, who is disabled needs or has a right to work but they need to be realistic in doing work that their disability doesn't affect. A person in a wheelchair does not have a right to be a fireman because a fireman has certain physical capabilities that they need to carry out. Access to work, OT's get involved in vocational rehab, in helping a person figure out what they can do and helping prove to employers they are able to do these things, and they also get involved when they know what the job needs in helping a disabled person get to that physical or mental ability but that's not about equal rights, that's about maximizing the persons function. (Participant 8, p. 10)

Yeah, I thought that was important and I thought, certainly, but we're not all equal, we're different and so people should be able to seek employment on wherever they want to. But it doesn't mean they necessarily should gain employment in every...(Participant 5, p. 10)

iii) Advocating for their clients

The majority of participants stated that OTs have a role in promoting their clients' capabilities to exercise control over their environments by advocating for them. They asserted that OTs advocate for the basic needs of their clients, and their access to the services and resources.

This one also speaks advocacy for me...(Participant 14, p. 7)

I think obviously that's a big role that OTs could play a role in promoting, but also in informing, in terms of advocacy...(Participant 7, p. 10)

...that I think it's a big thing for children and for adults and for OT in general that we need to be able to, if you feel like you 're going to be persecuted for speaking up and for fighting for something, or if you see that there's something in health care which isn't funded right now, then we should be able to advocate for that. (Participant 3, p. 10)

Participant 6 described that OTs advocate for their clients in two ways: first, by building their skills and by empowering them to advocate for themselves:

I think a big part of that was political and recognizing and a big part of it is the people themselves organizing and being able to speak up for themselves around "this isn't

acceptable, right? ... that for me, it's a matter of supporting the individuals to allow them, if that's their interest to be able to do that. And I have a couple of individuals that I support that have been part of government committees that are listening to them around how should we change things. So I had a very small role and I was able to set up the computer so that they could use the computer independently. And now they're using the computer for written output so that they can participate in these committees and schedule. So, it's a small little part, but I'm facilitating their capability to be political. (p. 12)

Second, as she mentioned, OTs advocate for their clients by accessing resources and identifying financial and other resources for them.

And then also, around the material, I think a big part of, now, I think a lot of the individuals I work with are supported through the CLBC (Community Living BC Program, which has so many issues) and a big part of that is that they just don't have the funding required to support these individuals and the lifestyles that they have been saying that they will support them in. So, my job is to advocate for my clients and to say "listen, the equipment they need, the supplies they need, the kind of housing situation they're in...So you know, from a material point of view, sometimes it's like jumping up and down and saying this is not OK! We need to keep working on a solution that's going to be better. And I can do it individually for my client or I could as an individual be involved in voting for the government, or raising those issues around – this is appalling! The decisions you're making around these major life issues for these individuals where they already have way too much on their plate already. So I definitely think that's very applicable. (Participant 6, p. 12)

Participant 3 noted that OTs have a major role to assist clients advocate for access to OT services, funding, and other resources.

I guess it's more with the kids that I work with. There is sometimes funding through our general medicals unicare, but there is a lot of things that aren't funded, and so we are looking at the advocacy side of things and putting in justifications for a piece of equipment that may not fit the typical description or maybe it needs to be customized or, I mean, even in there lies more of, like, medicines or other just funding, I guess. It's more of an issue, and the funding of programs and things too. So, all of us need to be able to feel like we can speak up and impact political choices. (p. 10)

Participant 10 mentioned that OTs support families to advocate for their children's needs.

Occupational therapists might provide guidance to the families to be politically active.

Politically, I think we can support clients to pursue political avenues if that's going to help them, and we can be political ourselves if we want to be. In the nursery, we're kind of down, "yes, you can have a blanket and a toy and a mirror". We do support families to talk to their members of parliament or their MLA's about advocating for their children's needs. They actually have more power than we. As OTs, we might provide

guidance, and typically it's to guide the families to be politically active, in my setting anyway. (Participant 10, p. 8)

Participant 4 mentioned that OTs advocate at various levels: individual, family, school board, provincially, and nationally.

Yeah, I think that's very much what we do. And again, for the kids that I see, it's being able to make sure they have access into writing programs, or being able to be included into typical school programs with peers. So it's enabling their independence to participate fully within their community. And we have all kinds of laws and umm, school policies that promote the inclusion of all kids within the school boards, on a provincial level, on a national level. Certainly with parents, a big thing that I do is help parents become more knowledgeable so they can go into the school and say "This is my child's disability and this is what we can do to help him manage more successfully in the classroom." So parents being able to understand how that disability impacts their child and to be able to know how to help the teacher, for example, work with their child. (p. 10)

Participant 12 asserted that OTs help advocate for changes in external sources. She mentioned that OTs advocate for their clients at an organizational level to identify efficient ways of accessing services and resources.

Now in the bigger picture, as an OT, I probably have a responsibility to advocate for better services or better processes, but I'm not expecting my clients to do that when they're in a vulnerable position. ... the way I think that we need to advocate is to say; this is making me inefficient and not very productive and I can't provide as much OT service to my clients because I'm tangled up in all this other stuff. So, also my clients in the meantime are living in risky situations without this or not very good situations while they're waiting for you to decide whether or not you are going to give them this particular thing, service, so let's get together and figure out how we can smooth it out for everybody so the clients get served better, our services, our public services are more efficient. Now, if it's something really big, then we have to work with our organizations and see what our organization's mandates are and see if they can help. (p. 12)

Finally, some participants noted that OTs can play a major role for enabling individuals to exercise control over their environments by identifying effective occupational therapy interventions and resources to fund them.

I think OTs have a much broader role and could contribute in a lot of areas, but because they haven't traditionally in those areas, it's difficult to make inroads, and unless there are models for them to consider...I think OTs could do a lot more and need to do a lot more, we just have to find a way to get it in the system...(Participant 12, pp. 12-13)

3.4.11 General Views

This section describes the OTs' general views about the CHFCs with respect to their general understandings and perceived relevance of these capabilities to occupational therapy philosophy, models, and approaches with respect to the two questions:

Question 1) What are OTs' general senses of the ten CHFCs?

Six themes emerged: Constitutes a novel approach; Encompasses a range of occupational therapy practices; More theoretical than practical; More related to mental health practice; The construct of function is common to the CHFCs as well as occupational therapy models; and They overlap. The following describes the quotes that support these themes.

i) A novel concept

Almost all participants mentioned that they were unaware of the Capabilities Approach or the ten CHFCs:

Yeah, I'd never heard of it. (Participant 5, p. 1)

Well, I've never heard of it before. (Participant 7, p. 1)

I think I don't know about it. (Participant 2, p. 1)

ii) A range of occupational therapy practices

The majority of participants mentioned that the ten CHFCs are applicable to occupational therapy practice. According to the participants, although the Capabilities Approach was described as a new concept in occupational therapy, the principles embedded within the ten CHFCs were not seen as new ideas.

So What I am saying is that I see, I feel that it is applicable, yes, and at the same time I feel that some of I think that many of these things we kind of de-familiar, not familiar to OT... I think the concepts are not necessarily new. They're framed maybe differently, for sure, but I can see bits and pieces in them in the various models. (Participant 1, pp. 1-2)

I think some of the terminology is different but I think the ideas are related, definitely and to some extent...(Participant 10, p. 2)

Some participants affirmed that the CHFCs encompass many areas of occupational therapy practice. For them, it is a broad perspective that reflects many areas of occupational therapy practice.

When I had a glance over it, it seems to encompass all the different areas that we would be looking for. It seems like as far as our models that we use, it would be like a conceptual model that we kind of have but a little bit more detailed, so I think it's

something we would possibly use in practice but it's interesting to see it all written out. (Participant 14, p. 1)

Well, I guess what I would say is that all areas of practice have clients associated with them. (Participant 10, p. 8)

A number of participants mentioned that CHFCs are close conceptually to occupational therapy conceptual models, and reflect shared models and approaches.

It does fit in quite nicely with a lot of the models of OT, where you're looking at physical, emotional, spiritual, all the different arenas of OT that practice that we look at and the different approaches. (Participant 9, p. 2)

.. so I do see that there is a fit with occupational therapy...Probably philosophy and approaches, so you know I mean if you look at some of our models...(Participant 13, p. 1)

iii) More theoretical than practical

Some mentioned that although the majority of participants asserted that CHFCs are relevant to occupational therapy models and approaches, they described them as more theoretical than practical constructs.

So, which again, I think is very theoretical, and it isn't very practical. So in a practical sense of what an occupational therapist does, I didn't see. (Participant 5, p. 8)

So I'm looking at this more from an academic than as a clinician. (Participant 2, p. 1)

Some participants were also concerned about how the CHFCs could be applied in practice.

... but there is no real guide to action. How do we apply it in services? (Participant 1, p. 7)

I'm not sure how it would guide my practice. As a theoretical's perspective around social justice, I think one of the challenges is how do we enact social justice, so we have these ideas around social justice. (Participant 7, p. 2)

...it kind of delegates how we should approach working with our clients, but it doesn't necessarily guide practice as much as some of the other models do. (Participant 14, p. 1)

iv) More relate to mental health practice

Some participants who work in mental health practice agreed that CHFCs are related to occupational therapy in the mental health area more so than other areas. They mentioned that the CHFCs include important issues in mental health practice.

.. [CHFCs relates to] models in mental health. Now, when I look at some of the more psychological models and theories, I think this relates fairly closely to more of a psychological model, a large part of it. (Participant 5, p. 2)

... OTs are working on that already. In mental health a lot of these things I think are very, as I am saying, it might be important also to talk to people who are working in physical rehab, because in mental health, this is very much a big part of what we're doing. (Participant 1, p. 3)

That's the issue I think is very common, like we have the same thing with recovery philosophy in mental health. The recovery philosophy we know that people and a lot of these things are actually reflects recovery philosophy as well. (Participant 2, p. 7)

v) Function is common between CHFCs as well as occupational therapy models

A number of participants acknowledged that OTs enable clients to enhance occupational performance of daily activities. They mentioned that "function" is a shared goal between the CHFCs and occupational therapy approaches and models.

I do see a fit with occupational therapy... you know, that we're helping people develop, maintain or regain the capabilities to function effectively in society. (Participant13, p. 8)

According to some participants, OTs attempt to maximize the persons function and to compensate for loss of function.

I think in general, it fits quite well with occupational therapy because I think, our big thing is that we want to be client-centered and that we want to find things meaningful to an individual and that are function based. (Participant 3, pp. 1-2)

Participant 5 indicated that the CHFCs constitute a basic theory of human function.

...So what I thought was that this was a theory that could overarch our understanding of basic human function and interaction with others ...then obviously that might be much more of a functional issue that OT might address in practice. (p. 1)

Participant 2 noted that the CHFCs aim to restore function as much as possible.

To me it is very related to recovery, very much related to recovery,..., because it is about function and it is about best possible function that somebody can have, so that's the end point is where I see where they come together...(p. 2)

vi) CHFCs overlap

Some participants described that the CHFCs are closely interrelated, with many overlapping each other.

I think it sounds great, because they are all things that are quite important to look at in an individual's life and they all impact on a person. So if someone is having issues with bodily integrity then it will impact all the other areas. So, they're all very interlinked. (Participant 9, p. 1)

The only other thing that I was thinking of, they are all obviously interconnected. (Participant 7, p. 9)

For example they asserted that there is overlap between the first and the second capabilities (Life and Bodily Health), and between the fourth and the fifth (Sense, Imagination, and Thought, and Emotions) capabilities.

Question II) How CHFCs may be relevant to occupational therapy philosophy, models, and approaches?

Overall, the ten CHFCs were described as being highly relevant to contemporary occupational therapy practice. Thus, the participants were asked how the ten CHFCs may be related to current occupational therapy philosophy, models, or approaches. The results describe the ten themes that emerged from the analysis of the OTs' perspectives on the relevance of the ten CHFCs to occupational therapy practice. These were: The Canadian Model of Occupational Performance; The Human Occupational Model; The Person Environment Occupation Model; A client-centered approach; A recovery philosophy; A framework for health and wellness; A human rights model; Maslow's hierarchy of needs; A social justice model; and An advocacy approach. The following describes the quotes that support these themes.

i) Canadian Model of Occupational Performance

Many participants stated that there are similarities between the Canadian Model of Occupational Performance model and the CHFCs.

I can see various parts of what's being said here in the Canadian model of occupational performance...(Participant 1, p. 3)

Yes, absolutely. I think that, I haven't really looked at it closely to see how it maps but on the Model of Occupational Performance for example a number of these areas would definitely be huge environmental areas that would impact the person's occupation for sure. A number of them would be in the inner-circle or the inner-triangle related to the person's, probably cognitive and effective areas, maybe physical as well...(Participant 12, p. 1)

Some noted that the CHFCs focus on more areas than the Canadian Model of Occupational Performance areas (self-care, productivity, and leisure). They asserted that the CHFCs help OTs

to analyze a client's status in greater detail than the Canadian Model of Occupational Performance.

There are some that focus more on the areas that we look at like the self-care productivity and leisure. I think that this kind of expand those, like explodes each of those, you know like self-care being bodily health, bodily integrity, and then it does a little bit more of that spiritual component in the Canadian Model of Occupational Performance that people don't necessarily, they kind of shy away from, so it's got that kind of sense of interaction with other species and life. (Participant 14, p. 2)

In some ways, it's more applicable than looking at self-care, productivity and leisure, right? Because, for example, play is, for kids, their productivity, but it's also their leisure. So, in the other frameworks, they don't necessarily frame it as play and I see play as being much more complex maybe than productivity, leisure, focus. So that resonates more with me. (Participant 6, p. 1)

ii) Model of Human Occupation

In addition to the Canadian Model of Occupational Performance, some mentioned that the CHFCs reflect parts of the Model of Human Occupation.

...but I can see bits and pieces in them in the various models, like the models of human occupation...I can see various parts of what's being said here in the Canadian model of occupational performance. So, like bodily integrity, in both in the Canadian model of occupational performance and the model of, I'm getting mixed up – CMAP and MOHO, I prefer, it's easier that way. So in both of them, they have the section of performance capacity, performance capacity and even the ICF – there's all about bodily functions and all that, so most of the models I think that OTs are familiar with. We are concern about the body, the bodily capacities and how the bodies, I mean we take a one step further I would say, we're looking at not just what's the capacities are, but how those capacities are supporting or limiting a person's ability to do the things they want to do or need to do. (Participant 1, pp. 2-3)

...it's kind of that like, personal causation from the MOHO model where you have to have a sense that you're effective whether it's through your speech or through your participation in the community. (Participant 14, p. 7)

iii) Person-Environment-Occupation Model/Framework

A few participants reported that the CHFCs include aspects of the environment and person dimensions that impact a person's occupation. Participant 5 stated that the CHFCs are closely aligned with the Person-Environment-Occupation Model.

Well, the models that I'm most familiar with and the ones that I thought I could kind of compare this to, are the Person-Environment- Occupation Model, the Canadian Occupational Performance Model. (p. 2)

Participant 13 also mentioned that it is consistent with the Person-Environment-Occupation Model that aims to adapt the environment and to empower individuals in order to independently participate in their society.

when I first read it ..I said of course, that's pure OT, right, I mean if you look at a person, environment and occupation model it's kind of how can we adapt the environment so people can be as independent as possible in the things that are important, or participate as much as possible in the things that are important. (p. 7)

iv) A client-centered practice

Many participants stated that the CHFCs are related to occupational therapy practice from the perspective of the client-centered practice.

I think in general, it fits quite well with occupational therapy because I think, our big thing is that we want to be client-centered and that we want to find things meaningful to an individual and that are function based, so, having a reference of different things that you know, relate to an individual's human rights seems to mesh well with occupational therapy as opposed to things that are just strictly biomedical. (Participant 3, p. 2)

We have a client-centered practice and so our whole operation is about how that client is going to achieve the goals they want, have the spiritual development they want, engage with occupation that they want, and having a meaningful life and that's kind of our bottom line...(Participant 10, pp. 6-7)

Consistent with other responses, some participants stated that OTs try to understand the clients' interests and respect their autonomy and choices by engaging them in what they are able to do and want to do.

... Well, what I already mentioned, I think regardless or the different models that you may use or approaches that you may take, depending on what practice area you are working on within OT, we just want things to be more about the person and what is fulfilling for them and what do they actually want to participate in, and the goals they have for themselves. So, I can see that many of them I guess, when we talk about each one individually, that many of them would sort of fit into that idea of OT. (Participant 3, p. 2)

...helping people clarify their values and their interests and their goals and then helping them to achieve what they want to do and what they feel they need to do. (Participant 1, p. 1)

The majority of participants asserted that OTs can enhance all the ten CHFCs, but it depends on what clients want do and what they are able to do.

I could do a whole lot of different things, depending on what this person wants to do. (Participant 12, p. 9)

And they should be in the driver's seat; not us. They determine what they're ready for, what would be useful for them...Being able to, I think, being able to work at the persons own pace and being able to gauge where they are emotionally and being able to work on whatever they really want to work on, and really respect the clients choice in that and be able to sort of work with them as like. (Participant 5, p. 7)

v) A recovery approach

Some participants asserted that there are similarities between the CHFCs and recovery philosophy in occupational therapy practice related to mental health.

To me it is very related to recovery, very much related to recovery, so the outcome of psycho-social rehabilitation is recovery. OTs are one of those people who provide rehabilitation and recovery services to individuals, so their end goal is to recovery and if somebody is in recovery, you 're hoping that they're able to use the capabilities and freedoms, such that they're able to function and that two ties in the occupational therapy model, because it is about function and it is about best possible function that somebody can have, so that's the end point is where I see where they come together...(Participant 2, p. 2).

That's the issue I think is very common, like we have the same thing with recovery philosophy in mental health. The recovery philosophy we know that people and a lot of these things are actually reflects recovery philosophy as well, ...(Participant 1, p. 7).

vi) Framework for health and wellness

Some participants noted that the CHFCs could be described as a health or wellness framework.

but how does it [CHFCs] inform the model, I think much like the determinants of health would inform the model...so, my general sense is yes, it is probably has some applicability but if I am looking at it as a framework for wellness. (Participant 2, p. 2)

It kind of struck me as a World Health Organization type of theory. That's what it struck me. (Participant 5, p. 4)

As well, a few participants noted that the CHFCs could be explained as determinants of health that are important for OTs to consider in their practice.

I don't think we necessarily see ourselves addressing some of those determinants of health but I really think we need to think about them, a lot more. (Participant 7, p. 2)

vii) A human rights model

The majority of participants described the CHFCs as a relatively comprehensive set of basic rights. According to them, the CHFCs provided another way to look at basic needs and freedoms.

Well what I thought is that, this seems like a theory that is very much a human rights kind of theory... I think that it's a general human right, and so to me, it's a right. (Participant 5, pp. 1-2)

... It's like a basic rights and important to know. (Participant 5, p. 4)

It's all such different language right, ...(Participant 4, p. 2)

Many participants mentioned that the CHFCs look like a person's bill of rights. According to them, these capabilities help us understand basic human rights in a systematic way.

My general understanding is that it has to do with sort of, essential human rights, essentially, around a number of different areas, with respect around issues around life and death, around how healthy someone is, how their bodies going to be treated, what kind of thinking they can have, what sorts of affiliations they can have with other people and with nature, and other animals, and kind of how much control over their own environment and that might be political, it might just your home and places like that, where you work and things like that. That's my general understanding. (Participant 10, p. 1)

I think a lot of these rights, like right to education, right to political speech, a lot of them relate to human rights so it has to do with. (Participant 11, p. 4)

viii) Maslow's hierarchy of needs

Some participants mentioned that the CHFCs remind them some common knowledge that affect occupational therapy philosophy; such as, Maslow's hierarchy of needs.

...as I'm reading it, one of the things that comes mind is that it's sort of reflects some approaches that we have already been introduced to, either as students, or I guess as students, and may be even just sort of societal, just some level of common knowledge, I guess. For example, one of them, approaches are models I think about is "Maslow hierarchy of needs", and I see many of the things here vary, kind of reflecting some of what he was already talking about, so I guess that's an example. (Participant 1, p. 1)

I guess it talks a little bit about Maslow's Hierarchy, like shelter. It is the most fundamental block of Maslow's hierarchy and then you get up to the top where it's kind of the more reflective and human capabilities. I do use Maslow's hierarchy in practice and that kind of echo's what this is saying as well...(Participant 14, p. 3)

..[it's like] what is Maslow's hierarchy called, hierarchy of what? to reach the hierarchy of needs, to reach the top of that pyramid of needs. (Participant 12, p. 5)

xi) A social justice model

Some participants mentioned that there are similarities between the CHFCs and elements of social justice models. That is, everybody has equal access to achieve their basic rights.

When I read it, I thought it seems to be getting at social justice where there is a basic quality of life that everybody should be able to achieve. (Participant 7, p. 2)

so you know I mean if you look at some of our models, ...where they talk about social justice and human rights as part of the role of the occupational therapist, so I kind of thought it fit...(Participant 13, p. 1)

My general sense is yes, it is probably has some applicability but if I am looking at it under social justice model...(Participant 2, p. 2)

I saw more in the social justice approach of Townsend and what she's talked about previously in occupational therapy. (Participant 5, p. 8)

x) An advocacy role

Some participants related the CHFCs to the political and social realms; they perceived the CHFCs have similar political language. They asserted that it is more about an advocacy role in relation to occupational therapy practice.

So I think that some of this is a little bit more in advocacy area...Some of it relates to advocacy like being part of organization and protecting organizations ...We can address them by doing advocacy with employers, advocacy with educational system. The OTs can do that, or we can support broader movements that are like community awareness campaign, and things like that, we can support them. That's really our role specifically...(Participant 1, p. 2)

I think a lot of them look to me like it has to do with political rights and so it would involve advocacy. (Participant 11, p. 4)

3.5 Limitations and Delimitations

Limitations are those elements that the researcher has no control over. Phase One of the study could be challenging to replicate due to the inherent nature of qualitative research. The primary limitation of this phase is related to interview. As the interview was the only method for collecting data, there is a number of potential validity problems associated with self-reported

information. A second notable limitation is related to researcher bias. As the researcher was the key instrument of the data collection, it was possible that the researcher's opinions about the CHFCs influenced the collection, analysis and interpretation of the data. Several methods were applied to minimize the researcher's biases. These included journaling and memo writing to reveal her biases and assumptions, and to identify anything new or surprising in the data collection or analysis, and identify unexpected or incidental finding.

Delimitations are the elements of research design over which the researcher has control. The notable delimitation of this phase is related to the small sample size of 14 OTs. Also, all participants were recruited from British Columbia.

3.6 Summary

The main purpose of this study was to explore and describe the views of Canadian occupational therapists with respect to their understandings and perceived relevance of Nussbaum's ten CHFCs to their professional practices. An exploratory sequential mixed methods study was conducted in two phases. This chapter describes the qualitative exploration of the views of OTs about the CHFCs with respect to their understandings and perceived relevance of these capabilities to their professional practices. Semi-structured interviews with 14 OTs in British Columbia, Canada, were conducted. The data from the qualitative interviews were analyzed thematically. The findings included 11 parts and 22 categories consisting of 75 themes. The findings generated from Phase One informed the development of the questionnaire survey that was used to collect data from a larger population of Canadian OTs in Phase Two that is now described in Chapter 4.

3.7 Table

Table 3.1 Phase One Participants' Description

| N | Employer Type | Clinical experience years | Position | Clients population |
|----|---|---------------------------|---|--------------------|
| 1 | Mental Health Hospital/Facility | 10 | Direct service provider Manger Researcher Educator | Mixed |
| 2 | Mental health Hospital/Facility | 20 | Professional leader/Coordinator Educator | Adult |
| 3 | School Community health center | 12 | Direct service provider | Children |
| 4 | Private practice | 30 | Direct service provider | Children |
| 5 | Mental health | 20 | Professional leader/Coordinator | Adult |
| 6 | Rehabilitation Hospital/Facility Community | 25 | Direct service provider Researcher Educator | Mixed |
| 7 | Solo professional practice/ Business | 25 | Direct service provider Researcher Educator | Children |
| 8 | General Hospital | 27 | Direct service provider | Adult |
| 9 | Community Health center | 9 | Direct service provider | Adult |
| 10 | Educational Institution General Hospital | 27 | Faculty member Researcher | Children |
| 11 | Educational Institution Mental Health Hospital | 5 | Faculty member Researcher | Adult |
| 12 | Community health center | 32 | Professional leader/Coordinator | Mixed |
| 13 | General Hospital | 34 | Professional leader/Coordinator Administrator | Mixed |
| 14 | Community health center | 2 | Direct service provider | Adult |

4 THE VIEWS OF OCCUPATIONAL THERAPISTS ABOUT CENTRAL HUMAN FUNCTIONAL CAPABILITIES WITH RESPECT TO THEIR PROFESSION AND PRACTICE: ONLINE SURVEY

A cross-sectional survey of a population of occupational therapists (OTs) practicing in Canada was conducted in Phase Two of this study to determine the applicability of Phase One findings to a broader group of OTs from across Canada about the Central Human Functional Capabilities (CHFCs) with respect to their profession and practice. This chapter outlines the research design, sampling, survey development and procedures, data analysis and limitations, and survey finding related to Phase Two.

4.1 Study Design

A cross-sectional survey study of a population of OTs who are registered with the Canadian Association of Occupational Therapists (CAOT)⁴ was conducted to extend the results of Phase One. A non-experimental, descriptive, cross-sectional questionnaire design (Jackson & Furnham, 2000) was used. The questionnaire is the most popular data-gathering tool used in survey research. The questionnaire is designed to gather information about people's knowledge, and perception (Shepard, 1993, p.177). With this design, data are collected at one point in time from a sample of population, which is considered useful when trying to measure attitudes or opinions at a given time (Jackson & Furnham, 2000).

4.1.1 Research Questions

With respect to exploring OTs view about the CHFCs in more detail, this design was selected to answer the same research questions as that in Phase One. These are:

1. What are OTs' understandings of the CHFCs?
2. How may the CHFCs be relevant to OTs' practices?

⁴ There are over 15,000 practicing occupational therapists in Canada. At the time of the study CAOT had a membership of approximately 7,000.

4.1.2 Sampling

Canadian OTs were identified as the population for this study. Survey respondents were recruited through the CAOT membership database. The CAOT membership service was contacted and the email addresses of all 2011-2012 CAOT members was purchased. The initial list of those who indicated their preferences to give their names, and their email addresses out for networking/education purposes when they renewed their membership consisted of 849 members. As described on the CAOT website, there are three types of CAOT membership: “full-time member; part-time member; and, non-practicing member” (<http://www.caot.ca/default.asp?pageid=2061>).

The CAOT provided no demographic information about this population other than they were 2011-2012 members of all member types. The majority of the members were practicing members, and less than 100 members were non-practicing members.

4.2 Survey Development

4.2.1 Validity

When designing a questionnaire, the most important validity consideration is content validity (Shepard, 1993). The content validity “is an important part of validating the use of a test for a particular purpose, especially when the test is educational in nature, such as when it is desired to measure a person's knowledge of specific subject matter” (Sireci, 2003, p.1076). Lynn (1986) asserted that content validity is “the determination of the content representativeness or content relevance of the elements/items of an instrument by the application of a two-stage (development and judgment) process” (p.382). According to her, it is essential to use the two-stages for content validity. In this research, the content validity was based on the development of major findings and expert review. Jackson and Furnham (2000) stated that content validity is most often established through the process of expert review. In this research, effort was made to strengthen the content validity of the questionnaire by piloting and expert review.

4.2.2 Survey Design

Purposive sampling was used to identify four participants for the pilot interviews to refine an initial survey and its administration and to assist with feedback on “the clarity of instructions, the comprehensibility and logical ordering of questions and the approximate length of time needed to complete the questionnaire”. The pilot interviews enhance the reliability of the questionnaire (Shepard, 1993, p.191).

A questionnaire for this phase was developed based on survey design requirements, and the 11 parts with 22 categories consisting of 75 themes identified from the interviews in Phase One (Chapter 3). Minor modifications to the themes were recommended by the four participants in the pilot group for clarification of some themes. These included dividing the themes “Life Capability is relevant to occupational therapy practice as related to acute care, palliative care, and end of life care” to “acute care” and “palliative care, and end of life care”; “Bodily Integrity Capability is relevant to occupational therapy practice as related to a social justice and an advocacy perspectives” to “a social justice perspective” and “an advocacy perspective”; “Practical Reason Capability is about making personal decisions” to “making personal decisions” and “helping clients to make personal decisions”; “Affiliation Capability is relevant to occupational therapy practice with respect to developing friendships, social network, and social skills” to “developing friendships, social network” and “social skills”; “Other Species Capability is relevant to occupational therapy practice because relationship with animals and nature affects health” to “relationship with animals affects health” and “relationship with nature affects health”. The result of this pilot study improved the final version of the survey.

4.3 Survey Procedure

The “Exploration of the Capabilities Approach in Contemporary Occupational Therapy” survey examined OTs’ views regarding the themes that emerged from Phase One. This survey used a five-point Likert scale to examine the responses to questions related to OTs’ views (1= ‘strongly disagree’ to 5 = ‘strongly agree’). The survey was designed in three parts: (1) 23 closed-ended questions consisting of 80 statements about the meaning and relevance of the CHFCs to occupational therapy. The five-point Likert scale assessed perceptions about these statements. The participants were asked to score them from ‘strongly disagree’ to ‘strongly

agree'; (2) 11 open-ended questions were designed to capture the participants' additional thoughts and comments; and (3) ten closed-ended questions were designed to obtain demographic information, including the participants' gender, qualifying certification in occupational therapy, highest degree achieved, place of graduation, place of work, years of experiences, type of employer, area(s) of practice, type(s) of position, and the clients group. The survey questionnaire appears in Appendix G.

The final version of the survey was hosted at the website FluidSurveys®: <http://fluidsurveys.com>. The researcher selected FluidSurveys® over other online surveys because of its simplicity: allowed open and closed-ended questionnaire, flexibility, ease of use, secure, useful video tutorials, and accessibility of the support team. As well, this software enabled the researcher not only to send out personalized email invitations, but also send reminders to participants who failed to complete the survey.

The survey was available on the Internet using FluidSurveys® to collect and analyze data. An email was sent on August 22, 2012 by Information Technology Services inviting 849 OTs to participate in the study. In total of 69 OTs were excluded based on 40 automatic responses received stating they were not available during the period of study, 27 bounced back and 2 showed unsubscribed status. Thus 780 OTs received. The cover email appears in Appendix G. Participants interested in participating in the study were instructed to click on the link (<http://fluidsurveys.com/surveys/tahereh/disability-and-human-rights-ii/>) provided at the bottom of the invitation email. Participants were informed that if they clicked to continue they agreed to be part of the study. If they completed the survey they were eligible for a draw for a \$100 gift certificate and offered an electronic version of the results of the study.

First reminder emails were sent on September 10, 2012 to participants who did not complete the survey within three weeks of the initial email. Second reminder emails were sent on September 17, 2012 to individuals who did not complete the survey after a week. The survey went offline on October 15, 2012. After the close of the survey, the results of the study were sent to participants interested in receiving them. Based on the participants who responded to the survey, one name was randomly drawn to identify the winner of the \$100 gift certificate.

4.4 Data Analysis

Quantitative data from the survey responses were analyzed with SPSS™ Student Version 18. Basic descriptive statistics (percentages and frequencies) were calculated for the nominal and ordinal data. Descriptive statistics (percentages means, and medians) were calculated for the ratio data. Content analysis was used for the qualitative data.

4.5 Survey Results

The survey yielded 109 responses for an overall response rate of 14% with 3 follow-ups. Some 78 respondents completed all questions and some 31 provided partial responses, so the number of respondents who answered each question (or statements) vary. There were 90 questions within 12 sections (the demographic information, the ten capabilities, and general views). Table 4.1 shows the minimum and maximum number of survey respondents to the questions in each section. Overall, 109 participants entered the draw for the gift of appreciation. The following sections summarize the responses to the questionnaire items.

4.5.1 Demographic Information

The demographic data included: gender, qualifying certification in occupational therapy, highest degree achieved, place of graduation, place of work, years of experience, type of employer, area(s) of practice, type(s) of position, and the predominant client group with whom they worked.

Personal information (Table 4.2). Of the 84 OTs who responded to the gender question, the majority of survey respondents (94%) were women. The disproportionate number of female OTs was consistent with the literature which identifies women as comprising the majority of the OT population in Canada (91.8%) (Canadian Institute for Health information (CIHI), 2011, p. 2). Based on 85 OTs who responded to the question about their certification in occupational therapy, 61 (72%) had bachelor's degree. In terms of the highest degree achieved, based on 83 survey respondents who responded to the question, 34 (40%) had a master's degree or higher. According to the 2011 CIHI, between 2006 and 2011, the proportion of the occupational therapy workforce with a baccalaureate in occupational therapy declined from 81.6% to 74.9%, whereas the number of OTs with master's degrees in occupational therapy increased from 10.8% to

22.0%. Some 28% of the OT workforce had a master's or doctorate degree as the highest overall level of education. Of the 85 OTs who answered the question about how many years they have been OTs, 41 (48%) had over 20 years' experience.

Location of Education (Table 4.3). Survey participants were asked to identify place of graduation in occupational therapy. Of the 85 OTs who responded to this question, 81 (95%) were Canadian-educated. Based on the 2011 CIHI, 7.1% of the OT workforce was educated outside Canada, and the remainder (92.8%) obtained their basic education in occupational therapy in Canada. Of the 85 respondents who identified where they practiced, the majority (39%) practiced in Ontario; and less than 1% in Quebec. Based on the 2011 CIHI, of the OTs who were educated within Canada, 36.6% completed their basic education in occupational therapy in Ontario, 32.0% did so in Quebec and 12.9% in Alberta.

Practice Area (Table 4.4). Of the 85 OTs who identified their type of employer, the majority worked in General Hospitals (28%) and Community Health Centers (26%). Based on the 2011 CIHI, 47.6% of the occupational therapy workforce worked in hospitals, 30.8% worked in the community and 11.2% worked in a professional practice (CIHI, 2011). In terms of areas of practice, of the 85 OTs, the majority worked in Neurorehabilitation (44%), Musculoskeletal/Orthopedic (36%), and Mental Health (29%) areas. In terms of their primary positions, of the 83 OTs who responded to this question, 60 (72%) were Direct Service Providers. Based on the 2011 CIHI, most OTs (84.7%) were employed as direct service providers, while the remainder were managers (6.1%), professional leaders/coordinators (3.4%), educators or researchers (2.5%) or held other positions (2.7%) (CIHI, 2011). Regarding the age of their clients, of the 85 OTs who responded to this question, most respondents (n=39 or 46%) were working with adults, 25 (30%) were working with seniors, and 19 (22%) were working with children and adolescents.

This sample is consistent with the 2011 CIHI database in terms of gender, occupational therapy degree, education, and position, but it does not map with place of practice, and type of employer.

4.5.2 Occupational Therapists' Views of Central Human Functional Capabilities

This section examines participants' responses to the questions about each of the 10 CHFCs and their overall views about them. Of the 109 respondents, 78 completed all questions and 31

provided partial responses, thus the number of participants who answered each question (or statement) varies.

Life Capability

With respect to OTs' understandings of Life Capability, 82% of 106 respondents agreed or strongly agreed that "Life Capability is about basic human rights", and 90% of 107 respondents agreed or strongly agreed that "Life Capability is about basic quality of life". In comparison to these themes, the respondents less supported theme that "Life Capability is about longevity". Despite this, 57% of 104 respondents were agreed or strongly agreed.

Regarding the relevance of Life Capability to occupational therapy practice, 95% of 108 respondents agreed or strongly agreed that "Life Capability is relevant to occupational therapy practice as related to quality of life", 90% of 108 survey respondents agreed or strongly agreed that "Life is relevant to occupational therapy practice as related to working with people with mental health issues", 97% of 108 survey respondents agreed or strongly agreed that "Life Capability is relevant to occupational therapy practice as related to working with seniors", 82% of 108 respondents agreed or strongly agreed that "Life Capability is relevant to occupational therapy practice as related to acute care", and 92% of 109 survey respondents "Life Capability is relevant to occupational therapy practice as related to palliative care and end of life care". Table 4.5 shows OTs' views of the Life Capability.

In an open-ended question, respondents were asked to add any comments regarding their views of the Life Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from the 14 participants appear in Appendix I. For example, some participants asserted that Life Capability was a new concept. Others mentioned that there is lack of clarity around "life not worth living". Another noted that it is about longevity:

Children with chronic health conditions such as cerebral palsy and spina bifida often live shortened lives. Life Capability is extremely relevant for this population". (Participant 5)

One participant mentioned that OTs have roles in promoting Life Capability:

I also think OT has to do with the potential for life capability in prevention of disability or occupational barriers due to environmental concerns (early learning), occupational barriers in adult life due to early barriers or lack of social opportunities for meaningful lifelong occupation. (Participant 9)

Some participants noted that the Life Capability is relevant to occupational therapy practice in pediatrics, neonatal intensive care, oncology, working with children with chronic health conditions, home care, long term care, and chronic disease management.

Bodily Health Capability

With respect to OTs' understandings of Bodily Health Capability, 96% of 103 survey respondents agreed or strongly agreed that "Bodily Health Capability is a basic human right", 85% of 102 survey respondents agreed or strongly agreed that "Bodily Health Capability is about health promotion", and 93% of 102 survey respondents agreed or strongly agreed that "Bodily Health is interconnected with Life Capability".

With respect to the relevance of Bodily Health Capability to occupational therapy practice, 93% of 102 survey respondents agreed or strongly agreed that "Bodily Health Capability is relevant to occupational therapy practice as related to promoting health and preventing diseases", 92% of 101 survey respondents agreed or strongly agreed that "Bodily Health Capability is relevant to occupational therapy practice as related to feeding and/or eating", 88% of 101 survey respondents agreed or strongly agreed that "Bodily Health Capability is relevant to occupational therapy practice as related to working with people with mental health issues", 91% of 101 survey respondents agreed or strongly agreed that "Bodily Health Capability is relevant to OT practice as related to advocating for adequate shelter and basic nutrition". When queried about whether "Bodily Health Capability is relevant to occupational therapy practice as related to reproductive health", this level of agreement was reduced for 46% of 99 survey respondents, 38% were not sure, and 15% disagreed or strongly disagreed. Table 4.6 shows the OTs' views of Bodily Health Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Bodily Health Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 9 participants appear in Appendix J. For example, one participant mentioned that the Bodily Health Capability is important when "addressing mental health issues for those with physical health problems" (Participant 2). One noted it is linked to Life Capability: "It seems this is further clarifying the previous Life Capability" (Participant 2). Although one says it is interesting to include reproductive health (Participant 7), another stated that the occupational therapy workload does not allow therapists to include reproductive health related issues in their practices:

OT practice cannot encompass everything. I agree physical health for mentally ill, reproductive health and adequate shelter and nutrition are vital, but not at the top of the list of things an OT would advocate for - we do not have time. We barely have time for health promotion - we are not supported by administration for this - our resources are maxed by "putting out fires". (Participant 8)

Bodily Integrity Capability

With respect to the OTs' understandings of Bodily Integrity Capability, 98% of 101 survey respondents agreed or strongly agreed that "Bodily Integrity Capability is about basic human rights".

With respect to the relevance of Bodily Integrity Capability to occupational therapy practice, 87% of 98 survey respondents agreed or strongly agreed that "Bodily Integrity Capability is relevant to occupational therapy practice as related to a client-centered approach", 89% of 97 survey respondents agreed or strongly agreed that it is relevant to their practice as related to a social justice perspective, 85% of 99 survey respondents agreed or strongly agreed that Bodily Integrity Capability is relevant to occupational therapy practice as related to an advocacy perspective, 79% of 99 survey respondents agreed or strongly agreed that Bodily Integrity Capability is relevant to occupational therapy practice as related to providing (emotional) trauma-informed care, 86% of 98 survey respondents agreed or strongly agreed that it is relevant as related to addressing mobility issues, and 83% of 99 survey respondents agreed or strongly agreed that Bodily Integrity Capability is relevant to occupational therapy practice as related to referring clients to resources. Table 4.7 shows the OTs' views of Bodily Integrity Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Bodily Integrity Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 10 participants appear in Appendix K. Participants believe that Bodily Integrity Capability is also about "respect for an individual's body", "quality of life", "accessibility", and "advocacy". One participant explained it as:

this relates to advocacy for universal access to services and healthcare to ensure that individuals can move physically from place to place (for example from province to province) and not to be disadvantaged by such movement. (Participant 6)

One participant mentioned that trauma-informed care is not relevant to occupational therapy practice (Participant 9). In contrast, other mentioned that all can be relevant in a holistic approach (Participant 10).

Senses, Imagination, and Thought Capability

With respect to the OTs' understandings of Senses, Imagination, and Thought Capability, 90% of 91 survey respondents agreed or strongly agreed that "Senses, Imagination, and Thought Capability is about expressing oneself in various ways".

Regarding the relevance of Senses, Imagination, and Thought Capability to occupational therapy practice, 95% of 89 survey respondents agreed or strongly agreed that Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to people with mental health issues, 95% of 89 survey respondents agreed or strongly agreed that Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to children with disabilities, and, 94% of 89 survey respondents agreed or strongly agreed that Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to self-expression. Table 4.8 shows the OTs' views of Senses, Imagination, and Thought Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Sense, Imagination, and Thought Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 16 participants appear in Appendix L. Some participants mentioned this capability "...is the right to expression", "perception", and "experience". This capability was thought to be relevant to all populations (Participant 12) including "adults with ABI (acute brain injury), neurological impairment, people with physical health issues that impact on their senses, creativity and thought processes, dementia" (Participant 7).

Emotions Capability

With respect to the OTs' understandings of Emotions Capability, 91% of 88 survey respondents agreed or strongly agreed that "Emotions Capability is about basic needs and rights" from strongly disagree to strongly agree.

Regarding the relevance of Emotions Capability to occupational therapy practice, 96% of 85 survey respondents agreed or strongly agreed that "Emotions Capability is relevant to occupational therapy practice with respect to people with mental health issues", 95% of 85

survey respondents agreed or strongly agreed that “Emotions Capability is relevant to occupational therapy practice with respect to children with disabilities”, 91% of 87 survey respondents agreed or strongly agreed that “Emotions Capability is relevant to occupational therapy practice with respect to all those seen by OTs”, 89% of 87 survey respondents agreed or strongly agreed that “Emotions Capability is relevant to occupational therapy practice in relation to finding support systems”, 93% of the 88 survey respondents agreed or strongly agreed that “Emotions Capability is relevant to occupational therapy practice in relation to helping people manage their emotions”, 92% of 88 survey respondents agreed or strongly agreed that “Emotions Capability is relevant to occupational therapy practice in relation to teaching anxiety management skills”. Table 4.9 shows the OTs’ views of Emotions Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Emotions Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 13 participants appear in Appendix M.

Although some participants noted that anxiety management is an important area of occupational therapy practice to improve Emotions Capability and it “would be only one possible intervention that would be used to facilitate health promotion and resilience” (Participant 5), some mentioned “unfortunately, do not always have the time or expertise to teach anxiety management skills, except in a mental health setting” (Participant 12). But from a holistic approach, Emotions Capability is relevant to occupational therapy programs in many settings:

“again, in a holistic practice all the Emotions Capability is interrelated to the client and client’s support system or family and can’t be separate whether a client is in acute care or long term mental illness in the community”. (Participant 13)

Some participants mentioned that OTs have roles in enhancing Emotions Capability both through building skills and advocacy. For example, one noted that, “Not only teaching anxiety management skills, but other teachings like dialectical behavior therapy and chronic disease self-management [can develop Emotions Capability]”. (Participant 11)

One also asserted that OTs have advocacy role for preventing emotional harm for their client:

Additional OT Roles ~ Advocating at a policy level for prevention of harm (i.e., involved in child welfare from an occupational justice perspective); teaching children mindfulness

as a self-awareness technique with to be in touch and accepting of their emotions and state. (Participant 8)

Practical Reason Capability

With respect to the OTs' understandings of Practical Reason Capability, 97% of 88 survey respondents agreed or strongly agreed that "Practical Reason Capability is about making personal decisions" from strongly disagree to strongly agree.

With respect to the relevance of Practical Reason Capability to occupational therapy practice, 96% of 87 respondents agreed or strongly agreed that "Practical Reason Capability is relevant to occupational therapy practice from a client-centered perspective", 89% of 87 survey respondents agreed or strongly agreed that "Practical Reason Capability is relevant to occupational therapy practice from helping clients to make personal decisions", 87% of 87 survey respondents agreed or strongly agreed that "Practical Reason Capability is relevant to occupational therapy practice from providing educational and supportive strategies for caregivers". Table 4.10 shows OTs' views of Practical Reason Capability.

In an open-ended question, respondents were asked to add any further comments regarding their views of the Practical Reason Capability with respect to their understandings and perceived relevance of this capability to their professional practice. A total number of nine participants' quotes provided appear in Appendix N.

Although for some participants the definition was not clear, some asserted that it is relevant to both clients and practitioners. For them, OTs need to be reflection, i.e., "as clinicians they are reflective practitioners" (Participant 2), and need to respect their clients' capacities and understand their "cognitive strengths and limitations" (Participant 1) because "the therapist is facilitating and not directing" (Participant 9).

Affiliation Capability

With respect to OTs' understandings of Affiliation Capability, 90% of 85 survey respondents agreed or strongly agreed that "Affiliation Capability is about basic needs and rights, 93% of 84 survey respondents agreed or strongly agreed that "Affiliation Capability is about social relations".

Regarding the relevance of Affiliation Capability to occupational therapy practice, 74% of 83 survey respondents agreed or strongly agreed that "Affiliation Capability is relevant to occupational therapy practice with respect to helping clients to identify their interests", 83% of

84 survey respondents agreed or strongly agreed that “Affiliation Capability is relevant to occupational therapy practice with respect to developing friendships and social network”, 92% of 85 survey respondents agreed or strongly agreed that “Affiliation Capability is relevant to occupational therapy practice with respect to advocating for their clients”, 94% of 84 survey respondents agreed or strongly agreed that “Affiliation Capability is relevant to occupational therapy practice with respect to social skills”, 94% of 84 survey respondents agreed or strongly agreed that “Affiliation Capability is relevant to occupational therapy practice with respect to working with clients with mental illness”. Table 4.11 shows the OTs’ views of Affiliation Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Affiliation Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 12 participants’ appear in Appendix O. Some participants asserted that it is about “occupational justice” (Participant 1), and “discrimination”: “Within and OT realm this should likely include discrimination as a result of disability versus ability. (Participant 5)

Some indicated this Capability is more related to OTs who “working with clients with physical disabilities” (Participant 3) in terms of accessibility:

social interactions are often times dependent upon physical accessibility to environments that allow for these interactions to flourish. I am not quite sure why the thinking or description has parceled out mental health as if it happens in isolation from physical health. (Participant 8)

Other Species Capability

With respect to OTs’ understandings of Other Species Capability, 92% of 83 survey respondents agreed or strongly agreed that “Other Species Capability is about the environment”.

Regarding the relevance of Other Species Capability to occupational therapy practice, 66% of 83 survey respondents agreed or strongly agreed, 25% were not sure that “Other Species Capability is relevant to occupational therapy practice because relationship with animals affects health”, 77% of 83 survey respondents agreed or strongly agreed that “Other Species Capability is relevant to occupational therapy practice because relationship with nature affects health”, 80% of 85 survey respondents agreed or strongly agreed that “Other Species Capability is relevant to occupational therapy practice from a spirituality perspective”,

87% of 84 survey respondents agreed or strongly agreed that “Other Species Capability is relevant to occupational therapy practice from a client-centered perspective”, 77% of 84 respondents agreed or strongly agreed that “Other Species Capability is relevant to occupational therapy practice from an environmental perspective”, 44% of 83 respondents agreed or strongly agreed, 34% were not sure, 21% disagreed or strongly disagreed that “Other Species Capability is not the main focus of occupational therapy practice”. Table 4.12 shows the OTs’ views of Other Species Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Other Species Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 15 participants appear in Appendix P.

A few participants mentioned that Other Species Capability is not relevant to occupational therapy practice. But the majority noted “depending on the client it may well be the main focus” (Participant 10) and mentioned OTs have to respect their clients’ choices:

It may not be the main focus of OT, however our occupational relationship with other species can be integral to the client's role in the community/world, and impacts personal growth which impacts well-being. (Participant 8)

While a client's relationship with the environment may not be the focus of occupational therapy, it may be an important component of strong programming by offering effective strategies and tools for a particular client (particularly one who is highly connected to animals, nature and the environment). (Participant 11)

Generally speaking, Other Species Capability is relevant to occupational therapy from a client-centered perspective:

With a client centered approach this could be a critical component of a person's wellbeing and enjoyment, and fulfillment of their life, and thus become a focus. (Participant 7)

If human relationships are important in the development of a sense of self, then so too are relationships to the environment, etc. in developing a fully engaged and interactive self within the environment that an individual exists. (Participant 9)

Finally, some participant mentioned that as “we need more relationships to the natural world in diverse ways” (Participant 15), “this [Other Species Capability] is integral to the practice of occupational therapy and to human life”. (Participant 13)

Play Capability

Regarding the OTs' understandings of Play Capability, 100% of 84 survey respondents agreed or strongly agreed that "Play Capability contributes to human happiness", 95% of 83 survey respondents agreed or strongly agreed that "Play Capability contributes to or preserves quality of life", 91% of 82 survey respondents agreed or strongly agreed that "Play Capability contributes achieves a work/life balance".

With respect to the relevance of Play Capability to occupational therapy practice, 93% of 84 survey respondents agreed or strongly agreed that "Play Capability is relevant to occupational therapy practice with respect to serving as a primary therapeutic approach in pediatric practice", 87% of 82 survey respondents agreed or strongly agreed that "Play Capability is relevant to occupational therapy practice with respect to serving as a therapeutic approach when working with persons with mental health issues", 98% of 85 survey respondents agreed or strongly agreed that "Play Capability is relevant to occupational therapy practice with respect to its importance for everyone". Table 4.13 shows OTs' views of Play Capability.

In an open-ended question, respondents were asked to add any further comments regarding their views of the Play Capability with respect to their understandings and perceived relevance of this capability to their professional practice. A total number of nine participants' quotes provided appear in Appendix Q. The majority of participants mentioned that the Play Capability is relevant to older adults too: "I believe this is of major importance for the geriatric population as well". (Participant 4)

Control over One's Environment Capability

Regarding the OTs' understandings of Control over Ones' Environment Capability, 83% of 83 survey respondents agreed or strongly agreed that "Control over One's Environment Capability is about decision-making", 89% of 83 survey respondents agreed or strongly agreed that "Control over One's Environment Capability is about a basic human right", 60% of 83 survey respondents agreed or strongly agreed, 24% not sure, 16% disagreed or strongly disagreed that "Control over One's Environment Capability is about political opinions".

With respect to the relevance of Control over Ones' Environment Capability to occupational therapy practice, 85% of 82 survey respondents agreed or strongly agreed that "Control over One's Environment Capability is relevant to occupational therapy practice with respect to developing decision-making", 84% of 82 survey respondents agreed or strongly agreed that

“Control over One’s Environment Capability is relevant to occupational therapy practice with respect to helping clients gain and retain employment”, 90% of 83 survey respondents agreed or strongly agreed that “Control over One’s Environment Capability is relevant to occupational therapy practice with respect to advocating for their clients”. Table 4.14 shows the OTs’ views of the Control over One’s Environment Capability.

In an open-ended question, respondents were asked to add comments regarding their views of the Control over One’s Environment Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 10 participants appear in Appendix R. Although for the majority of participants the definition was not clear, a few participants mentioned that this capability is a “fundamental inclusion” (Participant 1) as “enabling people to form opinions, validating opinions, building confidence/self-esteem” (Participant 2).

General Views of Central Human Functional Capabilities

With respect to OTs’ general understanding of the ten CHFCs, 46% of 81 respondents agreed or strongly agreed, were 28% not sure, 26% disagreed that “CHFCs constitutes a new approach”, 94% of 83 respondents agreed or strongly agreed that “CHFCs encompasses a range of occupational therapy practices”, 32% of 82 respondents agreed or strongly agreed, 30% were not sure, 38% disagreed or strongly disagreed that “CHFCs is more theoretical than practical”, 10% of 82 survey respondents agreed or strongly agreed, 13% were not sure, 77% disagreed or strongly disagreed that “CHFCs is more related to mental health practice”, 68% of 83 survey respondents agreed or strongly agreed, were 26% not sure that “The construct of function is common to the CHFCs as well as occupational therapy models, 66% of 82 survey respondents agreed or strongly agreed, 24% were not sure, and 10% disagreed that “They overlap each other”.

Regarding the relevance of CHFCs to occupational therapy practice, 80% of the 81 survey respondents agreed or strongly agreed that “CHFCs is consistent with the Canadian Model of Occupational Performance”, 65% of 80 survey respondents agreed or strongly agreed, 30% not sure that “the Human Occupational Model”, 72% of 78 survey respondents agreed or strongly agreed and 22% not sure that “the Person Environment Occupation Model”, 95% of 81 survey respondents agreed or strongly agreed that “CHFCs is consistent with a client-centered approach”, 43% of 80 survey respondents agreed or strongly agreed and 52% not sure that

“CHFCs is consistent with a recovery philosophy”, 86% of 80 survey respondents agreed or strongly agreed that “CHFCs is consistent with a framework for health and wellness”, 88% of 80 survey respondents agreed or strongly agreed that “CHFCs is consistent with a human rights model”, 60% of 80 survey respondents agreed or strongly agreed and 28% not sure that “CHFCs is consistent with Maslow’s hierarchy of needs”, 78% of the 80 survey respondents agreed or strongly agreed and 21% not sure that “CHFCs is consistent with a social justice model”, 84% of 81 survey respondents agreed or strongly agreed and 14% not sure that “CHFCs is consistent with an advocacy approach”. Table 4.15 shows the OTs’ general views of the CHFCs.

In an open-ended question, respondents were asked to add comments regarding their general views of the CHFCs with respect to their understandings and perceived relevance of this capability to their professional practice. Quotes from 7 participants appear in Appendix S. While few participants noted some the definitions of the CHFCs “are too abstract and/or multifocal” (Participant 4), others asserted that,

“Some of the thoughts fit with many OT frameworks but none of them fit with any one framework”. (Participant 1)

But it is more related to occupational therapy practice from a holistic perspective (Participant 2).

“Though this is a theoretical model, I think it just puts what we practice into words. It frames holistic practice”. (Participant 5)

“I think it is an interesting and comprehensive model worth exploring for OT application”. (Participant 7)

Finally, one participant saw the potential of the CHFCs to serve as a model for practice.

I like the capabilities approach though and would see benefit in having a capabilities model for OT. (Participant 2)

4.6 Limitations and Delimitations

The most notable limitation was that the low respondents’ rate. Only 14% of the survey was returned rate is considered low. This may be related to the fact that the respondents’ rate of return relied on the accuracy of email addresses and was dependent upon OTs who opened their e-mails and chose to respond to an invitation to complete an online survey. Also, survey topic was new for OTs and no related studies have been reported to date. Despite piloting questions and reviewing procedures of the survey, some questions remained unclear to some participants,

which may have resulted in misinterpretation of the survey questions. As well, this return rate may have introduced non-response bias, in which participants who returned the survey may be distinct from those who did not respond. It is possible that those who have strong opinion were more likely to respond. Efforts were made to increase the return rate; one factor that may have influenced this return rate could have been ambiguity and uncertainty about the Capabilities Approach.

The most notable delimitation of Phase Two was the use of an online survey. Strategies were implemented to maximize the response rate to the online questionnaire; such questionnaires typically have low response rates (Lozar Manfreda, et al., 2008; Aitken, Power, & Dwyer, 2008). The researcher used several strategies to maximize the response rate of this survey, e.g., inclusion of closed-ended questions; straightforward, unambiguous questions, carefully ordered questions; addressing the respondents by name; follow-up after one week; timing of the survey, i.e., at an appropriate time of year; inducements to attract the attention of respondents; offer to send a summary of the results (Miller, Salkind, & Shepard, 2002; Shepard 1993). In addition, the researcher used a modified version of Dillman's Total Design Method (2007) to maximize survey response, such as minimizing the time for responding, making the survey interesting using carefully constructed questions (e.g., well-structured first question, easy to answer), and following up. The second delimitation of Phase Two was that the participants were drawn from CAOT members who indicated their preferences for sharing their names and their email addresses for networking/education purposes when they renewed their memberships. Therefore, the survey results do not represent OTs beyond this group. The third, length of the survey completed with time constraints. The survey required about 20 minutes to complete. Because of workload issues, OTs may be less likely to respond to a survey or do not have time to complete it.

4.6 Summary

The findings generated from Phase One (Chapter 3) informed the development of the survey that was used to collect data from a larger population of Canadian OTs in Phase Two reported in this chapter. This phase consisted a survey that used a five-point Likert scale to examine the responses to questions related to OTs' views about the ten CHFCs, and was hosted at the website FluidSurveys®: <http://fluidsurveys.com>.

Themes that emerged from the interviews (Phase One) were compared with items from the survey (Phase Two). In general, information was consistent across both. Table 4.16 compares interview themes and survey responses about the CHFCs and general views about them expressed by the occupational therapy respondents.

In the following chapter, we integrate the findings and results from the analysis of the interviews and survey and discuss how they relate to one another and the existing literature.

4.7 Tables

Table 4.1 Survey Response Rate

| Sections | Numbers of questions per section (Total Q=90) | Minimum and maximum amount of survey respondents in each section | Percentage |
|--|--|--|------------|
| 1. Life Capability | 8 | 104-109 | 95%-100% |
| 2. Bodily Health Capability | 8 | 99-103 | 90%-94% |
| 3. Bodily Integrity Capability | 7 | 97-101 | 89%-94% |
| 4. Sense, Imagination and Thought Capability | 4 | 89-91 | 78%- 83% |
| 5. Emotions Capability | 7 | 85-88 | 78%-81% |
| 6. Practical Reason Capability | 4 | 88-87 | 81%-90% |
| 7. Affiliation Capability | 6 | 83-85 | 76%-78% |
| 8. Other Species Capability | 7 | 83-85 | 76%-78% |
| 9. Play Capability | 6 | 82-85 | 75%-78% |
| 10. Control over Ones Environment Capability | 6 | 82-83 | 75%-76% |
| 11. General views Capability | 17 | 78-84 | 72%-77% |
| 12. Demographic information Capability | 10 | 83-85 | 76%-78% |

Table 4.2 Personal Demographic Information

| Variable | Category | Survey Respondents (N) | Survey Respondents (Percentage) | 2011 CIHI* n=14,237 |
|--|-----------------------|------------------------|---------------------------------|---------------------|
| Gender | | 84 | | |
| | Female | 79 | 94% | 91.8% |
| | Male | 5 | 6% | |
| Qualifying Certification | | 85 | | |
| | Diploma | 5 | 6% | |
| | Baccalaureate | 61 | 72% | 74.9% |
| | Master's | 10 | 12% | 22.0% |
| | Professional Master's | 7 | 8% | |
| | Doctorate | 2 | 2% | |
| Highest Education Level of the Occupational Therapists | | 83 | | |
| | Diploma | 2 | 2% | |
| | Baccalaureate | 47 | 57% | |
| | Master's | 20 | 24% | 28.5% |
| | Professional Master's | 7 | 8% | |
| | PhD | 7 | 8% | |
| Years of Experience | | 85 | | |
| | 1-5 years | 9 | 11% | |
| | 6-10 years | 7 | 8% | |
| | 11-15 years | 16 | 19% | |
| | 16-20 years | 12 | 14% | |
| | 21-25 years | 14 | 16% | |
| | 26-30 years | 12 | 14% | |
| | More than 30 years | 15 | 18% | |

*CIHI: Canadian Institute for Health information

Table 4.3 Location Demographic Information

| Variable | Category | Survey Respondents (N) | Survey Respondents (Percentage) | 2011 CIHI* n=14,237 |
|---|--------------------------|------------------------|---------------------------------|---------------------|
| Place of Graduation | | 85 | | |
| | Canadian-educated | 81 | 95% | 92.8% |
| | Internationally-educated | 4 | 5% | 7.1% |
| Region of Canada Where Respondent Currently Working | | 85 | | |
| | Alberta | 14 | 16% | 1,532 |
| | British Columbia | 10 | 12% | 1,749 |
| | Manitoba | 6 | 7% | 555 |
| | New Brunswick | 3 | 4% | 314 |
| | Newfoundland | 2 | 2% | 173 |
| | Nova Scotia | 7 | 8% | 404 |
| | Ontario | 33 | 39% | 4,506 |
| | Quebec | 2 | 2% | 3,895 |
| | Saskatchewan | 7 | 8% | 302 |
| | Other | 1 | 1% | 71 |

*CIHI: Canadian Institute for Health information

Table 4.4 Practice Demographic Information

| Variable | Category | Survey Respondents (N) | Survey Respondents (Percentage) | 2011 CIHI* n=14,237 |
|--------------------|---|------------------------|---------------------------------|---------------------|
| Type of Employer | | | | |
| | General Hospital | 24 | 28% | 47.6% |
| | Rehabilitation Hospital/Facility | 13 | 15% | |
| | Mental Health Hospital/Facility | 9 | 11% | |
| | Residential Care Facility | 3 | 4% | 30.8% |
| | Assisted Living Residence | 1 | 1% | |
| | Community Health Center | 22 | 26% | |
| | Group Professional Practice/Clinic | 3 | 4% | 11.2% |
| | Solo Professional Practice/Business | 5 | 6% | |
| | Post-secondary Educational Institution | 6 | 7% | |
| | School or School Board | 10 | 12% | |
| | Association/Government/Para-Governmental | 5 | 6% | |
| | Consultative | 4 | 5% | |
| | Other | 9 | 11% | |
| Areas of Practice | | 85 | | |
| | Mental Health | 25 | 29% | |
| | Neurorehabilitation | 31 | 36% | |
| | Musculoskeletal/Orthopedic | 37 | 44% | |
| | Cardiovascular and Respiratory System | 10 | 12% | |
| | General Physical Health | 35 | 41% | |
| | Vocational Rehabilitation | 3 | 4% | |
| | Palliative Care | 15 | 18% | |
| | Health Promotion and Wellness | 15 | 18% | |
| | Other Areas of Direct Service | 11 | 13% | |
| | Service Administration | 5 | 6% | |
| | Client Service Management | 5 | 6% | |
| | Medical/Legal-Related Client Service Management | 3 | 4% | |
| | Teaching | 12 | 14% | |
| | Research | 11 | 13% | |
| | Other | 14 | 16% | |
| Position | | 83 | | |
| | Manager | 6 | 7% | 6.1% |
| | Professional Leader/Coordinator | 8 | 10% | 3.4% |
| | Direct Service Provider | 60 | 72% | 84.7% |
| | Educator | 11 | 13% | 2.5% |
| | Researcher | 8 | 10% | |
| | Other | 4 | 5% | 2.7% |
| Clients Age Ranges | | 85 | | |
| | Children and adolescents (0-18) | 19 | 22% | |
| | Adult (19-64) | 39 | 46% | |
| | Seniors (65 and older) | 25 | 29% | |
| | Mixed | 22 | 26% | |
| | None | 9 | 11% | |

*CIHI: Canadian Institute for Health information

Table 4.5 Occupational Therapists' Views of Life Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|---|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Life Capability | | | | | | | | | |
| | Basic human rights | 2 (2%) | 8 (8%) | 9 (8%) | 39 (37%) | 48 (45%) | 106 | 4.2 | 4.0 |
| | Quality of life | 2 (2%) | 6 (6%) | 3 (3%) | 32 (30%) | 64 (60%) | 107 | 4.4 | 5.0 |
| | Longevity | 1 (1%) | 20 (19%) | 23 (22%) | 46 (44%) | 14 (13%) | 104 | 3.5 | 4.0 |
| Relevance of Life Capability to occupational therapy practice | | | | | | | | | |
| | Quality of life | 1 (1%) | 4 (4%) | 1 (1%) | 32 (30%) | 70 (65%) | 108 | 4.5 | 5.0 |
| | Working with people with mental health issues | 1 (1%) | 2 (2%) | 7 (6%) | 50 (46%) | 48 (44%) | 108 | 4.3 | 4.0 |
| | Working with seniors | 0 (0%) | 1 (1%) | 3 (3%) | 47 (44%) | 57 (53%) | 108 | 4.5 | 5.0 |
| | Acute care | 1 (1%) | 5 (5%) | 13 (12%) | 50 (46%) | 39 (36%) | 108 | 4.1 | 4.0 |
| | Palliative care and end of life care | 0 (0%) | 4 (4%) | 5 (5%) | 39 (36%) | 61 (56%) | 109 | 4.4 | 5.0 |

Table 4.6 Occupational Therapists' Views of Bodily Health Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|--|--|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Bodily Health Capability | | | | | | | | | |
| | A basic human right | 1 (1%) | 1 (1%) | 2 (2%) | 35 (34%) | 64 (62%) | 103 | 4.6 | 5.0 |
| | About health promotion | 0 (0%) | 4 (4%) | 11 (11%) | 55 (54%) | 32 (31%) | 102 | 4.1 | 4.0 |
| | Interconnected with the Life Capability | 0 (0%) | 1 (1%) | 6 (6%) | 56 (55%) | 39 (38%) | 102 | 4.3 | 4.0 |
| Relevance of Bodily Health Capability to occupational therapy practice | | | | | | | | | |
| | Promoting health and preventing diseases | 0 (0%) | 3 (3%) | 4 (4%) | 52 (51%) | 43 (42%) | 102 | 4.3 | 4.0 |
| | Feeding and/or eating | 0 (0%) | 6 (6%) | 2 (2%) | 54 (53%) | 39 (39%) | 101 | 4.2 | 4.0 |
| | Addressing physical health for those with mental illness | 1 (1%) | 4 (4%) | 7 (7%) | 54 (53%) | 35 (35%) | 101 | 4.2 | 4.0 |
| | Advocating for adequate shelter and basic nutrition | 0 (0%) | 2 (2%) | 8 (8%) | 48 (48%) | 43 (43%) | 101 | 4.3 | 4.0 |
| | Addressing reproductive health | 2 (2%) | 13 (13%) | 38 (38%) | 35 (35%) | 11 (11%) | 99 | 3.4 | 3.0 |

Table 4.7 Occupational Therapists' Views of Bodily Integrity Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|---|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understanding of Bodily Integrity Capability | | | | | | | | | |
| | Basic human rights | 0 (0%) | 0 (0%) | 2 (2%) | 28 (28%) | 71 (70%) | 101 | 4.7 | 5.0 |
| Relevance of Bodily Integrity Capability to occupational therapy practice | | | | | | | | | |
| | A client-centered approach | 0 (0%) | 4 (4%) | 9 (9%) | 43 (44%) | 42 (43%) | 98 | 4.3 | 4.0 |
| | A social justice perspective | 0 (0%) | 1 (1%) | 9 (9%) | 46 (47%) | 41 (42%) | 97 | 4.3 | 4.0 |
| | An advocacy perspective | 0 (0%) | 1 (1%) | 13 (13%) | 49 (49%) | 36 (36%) | 99 | 4.2 | 4.0 |
| | Providing (emotional) trauma-informed care | 0 (0%) | 4 (4%) | 16 (16%) | 49 (49%) | 30 (30%) | 99 | 4.1 | 4.0 |
| | Addressing mobility issues | 0 (0%) | 7 (7%) | 7 (7%) | 41 (42%) | 43 (44%) | 98 | 4.2 | 4.0 |
| | Referring clients to resources | 0 (0%) | 4 (4%) | 12 (12%) | 44 (44%) | 39 (39%) | 99 | 4.2 | 4.0 |

Table 4.8 Occupational Therapists' Views of Sense, Imagination, and Thought Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|--|------------------------------------|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational Therapists' understandings of Sense, Imagination, and Thought Capability | | | | | | | | | |
| | Expressing oneself in various ways | 0 (0%) | 1 (1%) | 8 (9%) | 45 (49%) | 37 (41%) | 91 | 4.3 | 4.0 |
| Relevance of Sense, Imagination, and Thought Capability to occupational therapy practice | | | | | | | | | |
| | People with mental health issues | 0 (0%) | 1 (1%) | 4 (4%) | 46 (52%) | 38 (43%) | 89 | 4.4 | 4.0 |
| | Children with disabilities | 0 (0%) | 1 (1%) | 3 (3%) | 42 (47%) | 43 (48%) | 89 | 4.4 | 4.0 |
| | Self-expression | 0 (0%) | 2 (2%) | 4 (4%) | 46 (52%) | 37 (42%) | 89 | 4.3 | 4.0 |

Table 4.9 Occupational Therapists' Views of Emotions Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|---|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Emotions Capability | | | | | | | | | |
| | Basic needs and rights | 0 (0%) | 2 (2%) | 6 (7%) | 39 (44%) | 41 (47%) | 88 | 4.4 | 4.0 |
| Relevance of Emotions Capability to occupational therapy practice | | | | | | | | | |
| | People with mental health issues | 0 (0%) | 0 (0%) | 3 (4%) | 41 (48%) | 41 (48%) | 85 | 4.4 | 4.0 |
| | Children with disabilities | 0 (0%) | 1 (1%) | 3 (4%) | 41 (48%) | 40 (47%) | 85 | 4.4 | 4.0 |
| | All those seen by Occupational therapists | 0 (0%) | 2 (2%) | 6 (7%) | 41 (47%) | 38 (44%) | 87 | 4.3 | 4.0 |
| | Finding support systems | 0 (0%) | 1 (1%) | 8 (9%) | 50 (57%) | 28 (32%) | 87 | 4.2 | 4.0 |
| | Helping people manage their emotions | 0 (0%) | 1 (1%) | 6 (7%) | 48 (55%) | 33 (38%) | 88 | 4.3 | 4.0 |
| | Teaching anxiety management skills | 0 (0%) | 1 (1%) | 6 (7%) | 47 (53%) | 34 (39%) | 88 | 4.3 | 4.0 |

Table 4.10 Occupational Therapists' Views of Practical Reason Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|---|--|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Practical Reason Capability | | | | | | | | | |
| | Making personal decisions | 0 (0%) | 0 (0%) | 3 (3%) | 50 (57%) | 35 (40%) | 88 | 4.4 | 4.0 |
| Relevance of Practical Reason Capability to occupational therapy practice | | | | | | | | | |
| | From a client-centered perspective | 0 (0%) | 0 (0%) | 4 (5%) | 38 (44%) | 45 (52%) | 87 | 4.5 | 5.0 |
| | Helping clients to make personal decisions | 0 (0%) | 3 (3%) | 7 (8%) | 46 (53%) | 31 (36%) | 87 | 4.2 | 4.0 |
| | Providing educational and supportive strategies for caregivers | 0 (0%) | 2 (2%) | 9 (10%) | 49 (56%) | 27 (31%) | 87 | 4.2 | 4.0 |

Table 4.11 Occupational Therapists' Views of Affiliation Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|--|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Affiliation Capability | | | | | | | | | |
| | Basic needs and rights | 0 (0%) | 0 (0%) | 8 (9%) | 31 (36%) | 46 (54%) | 85 | 4.4 | 5.0 |
| | Social relations | 0 (0%) | 0 (0%) | 6 (7%) | 37 (44%) | 41 (49%) | 84 | 4.4 | 4.0 |
| Relevance of Affiliation Capability to occupational therapy practice | | | | | | | | | |
| | Helping clients to identify their interests | 1 (1%) | 10 (12%) | 10 (12%) | 41 (49%) | 21 (25%) | 83 | 3.9 | 4.0 |
| | Developing friendships and social network | 0 (0%) | 3 (4%) | 11 (13%) | 47 (56%) | 23 (27%) | 84 | 4.1 | 4.0 |
| | Advocating for their clients | 2 (2%) | 0 (0%) | 5 (6%) | 51 (60%) | 27 (32%) | 85 | 4.2 | 4.0 |
| | Developing social skills | 0 (0%) | 1 (1%) | 4 (5%) | 46 (55%) | 33 (39%) | 84 | 4.3 | 4.0 |
| | Working with clients with mental illness | 0 (0%) | 0 (0%) | 5 (6%) | 45 (54%) | 34 (40%) | 84 | 4.3 | 4.0 |

Table 4.12 Occupational Therapists' Views of Other Species Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|--|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Other Species Capability | | | | | | | | | |
| | People's relationship with the environment | 0 (0%) | 1 (1%) | 5 (6%) | 41 (49%) | 36 (43%) | 83 | 4.3 | 4.0 |
| Relevance of Other Species Capability to occupational therapy practice | | | | | | | | | |
| | Because relationship with animals affects health | 1 (1%) | 6 (7%) | 21 (25%) | 39 (47%) | 16 (19%) | 83 | 3.8 | 4.0 |
| | Because relationship with nature affects health | 0 (0%) | 4 (5%) | 15 (18%) | 43 (52%) | 21 (25%) | 83 | 4.0 | 4.0 |
| | From a spirituality perspective | 1 (1%) | 1 (1%) | 15 (18%) | 42 (49%) | 26 (31%) | 85 | 4.1 | 4.0 |
| | from a client-centered perspective | 0 (0%) | 1 (1%) | 10 (12%) | 48 (57%) | 25 (30%) | 84 | 4.2 | 4.0 |
| | From an environmental perspective | 0 (0%) | 4 (5%) | 15 (18%) | 42 (50%) | 23 (27%) | 84 | 4.0 | 4.0 |
| | Not the main focus of occupational therapy practice | 2 (2%) | 16 (19%) | 28 (34%) | 31 (37%) | 6 (7%) | 83 | 3.3 | 3.0 |

Table 4.13 Occupational Therapists' Views of Play Capability

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|---|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Play Capability | | | | | | | | | |
| | Contributes to human happiness | 0 (0%) | 0 (0%) | 0 (0%) | 24 (29%) | 60 (71%) | 84 | 4.7 | 5.0 |
| | Preserves quality of life | 0 (0%) | 1 (1%) | 3 (4%) | 23 (28%) | 56 (67%) | 83 | 4.6 | 5.0 |
| | Achieves a work/life balance | 1 (1%) | 0 (0%) | 6 (7%) | 24 (29%) | 51 (62%) | 82 | 4.5 | 5.0 |
| Relevance of Play Capability to occupational therapy practice | | | | | | | | | |
| | Serving as a primary therapeutic approach in pediatric practice | 1 (1%) | 0 (0%) | 5 (6%) | 32 (38%) | 46 (55%) | 84 | 4.5 | 5.0 |
| | Serving as a therapeutic approach when working with persons with mental health issues | 0 (0%) | 0 (0%) | 11 (13%) | 48 (59%) | 23 (28%) | 82 | 4.1 | 4.0 |
| | Its importance for everyone | 1 (1%) | 0 (0%) | 1 (1%) | 32 (38%) | 51 (60%) | 85 | 4.6 | 5.0 |

Table 4.14 Occupational Therapists' Views of Control over Ones' Environment

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|---|--|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' understandings of Control over Ones' Environment | | | | | | | | | |
| | About decision making | 1 (1%) | 3 (4%) | 10 (12%) | 44 (53%) | 25 (30%) | 83 | 4.1 | 4.0 |
| | A basic human right | 1 (1%) | 1 (1%) | 7 (8%) | 35 (42%) | 39 (47%) | 83 | 4.3 | 4.0 |
| | About political opinions | 3 (4%) | 10 (12%) | 20 (24%) | 38 (46%) | 12 (14%) | 83 | 3.6 | 4.0 |
| Relevance of Control over Ones' Environment Capability to occupational therapy practice | | | | | | | | | |
| | Developing decision-making | 1 (1%) | 1 (1%) | 10 (12%) | 50 (61%) | 20 (24%) | 82 | 4.1 | 4.0 |
| | Helping clients gain and retain employment | 1 (1%) | 4 (5%) | 8 (10%) | 50 (61%) | 19 (23%) | 82 | 4.0 | 4.0 |
| | Advocating for their clients | 1 (1%) | 0 (0%) | 7 (8%) | 51 (61%) | 24 (29%) | 83 | 4.2 | 4.0 |

Table 4.15 Occupational Therapists' General Views of the Ten Central Human Functional Capabilities

| Variable | Categories | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree | Total Responses | Mean | Median |
|--|---|-------------------|----------|----------|----------|----------------|-----------------|------|--------|
| Occupational therapists' general understandings of the ten Central Human Functional Capabilities | | | | | | | | | |
| | Constitutes a new approach | 0 (0%) | 21 (26%) | 23 (28%) | 32 (40%) | 5 (6%) | 81 | 3.3 | 3.0 |
| | Encompasses a range of occupational therapy practices | 0 (0%) | 1 (1%) | 4 (5%) | 55 (66%) | 23 (28%) | 83 | 4.2 | 4.0 |
| | Is more theoretical than practical | 3 (4%) | 28 (34%) | 25 (30%) | 19 (23%) | 7 (9%) | 82 | 3.0 | 3.0 |
| | Is more related to mental health practice | 9 (11%) | 54 (66%) | 11 (13%) | 8 (10%) | 0 (0%) | 82 | 2.2 | 2.0 |
| | The construct of function is common to the "Central Human Functional Capabilities" as well as occupational therapy models | 1 (1%) | 4 (5%) | 22 (26%) | 49 (58%) | 8 (10%) | 84 | 3.7 | 4.0 |
| | They overlap each other | 0 (0%) | 8 (10%) | 20 (24%) | 46 (56%) | 8 (10%) | 82 | 3.7 | 4.0 |
| Relevance of the Central Human Functional Capabilities to occupational therapy practice | | | | | | | | | |
| | The Canadian Model of Occupational Performance | 0 (0%) | 6 (7%) | 10 (12%) | 56 (69%) | 9 (11%) | 81 | 3.8 | 4.0 |

Table 4.15 Occupational Therapists' General Views of the Ten Central Human Functional Capabilities

| | | | | | | | | | |
|--|---|--------|--------|----------|----------|----------|----|-----|-----|
| | The Human Occupational Model | 0 (0%) | 4 (5%) | 24 (30%) | 47 (59%) | 5 (6%) | 80 | 3.7 | 4.0 |
| | The Person Environment Occupation Model | 0 (0%) | 5 (6%) | 17 (22%) | 46 (59%) | 10 (13%) | 78 | 3.8 | 4.0 |
| | A client-centered approach | 1 (1%) | 1 (1%) | 2 (2%) | 54 (67%) | 23 (28%) | 81 | 4.2 | 4.0 |
| | A recovery philosophy | 1 (1%) | 3 (4%) | 42 (52%) | 27 (34%) | 7 (9%) | 80 | 3.5 | 3.0 |
| | A framework for health and wellness | 0 (0%) | 3 (4%) | 8 (10%) | 49 (61%) | 20 (25%) | 80 | 4.1 | 4.0 |
| | A human rights model | 0 (0%) | 1 (1%) | 8 (10%) | 45 (56%) | 26 (32%) | 80 | 4.2 | 4.0 |
| | Maslow's hierarchy of needs | 3 (4%) | 7 (9%) | 22 (28%) | 38 (48%) | 10 (12%) | 80 | 3.6 | 4.0 |
| | A social justice model | 0 (0%) | 1 (1%) | 17 (21%) | 43 (54%) | 19 (24%) | 80 | 4.0 | 4.0 |
| | An advocacy approach | 0 (0%) | 2 (2%) | 11 (14%) | 56 (69%) | 12 (15%) | 81 | 4.0 | 4.0 |

Table 4.16 Comparison of Themes between Phase One and Phase Two

| Phase One Themes from Semi-structured Interviews | Phase Two: Survey Responses (Percentage of Agree and Strongly agree) |
|--|---|
| <i>1) Life Capability</i> | |
| I: Occupational therapists' understandings of Life Capability | |
| Themes: | |
| Life Capability is about basic quality of life | (90%) |
| Life Capability is about basic human rights | (82%) |
| Life Capability is about basic longevity | (57%) |
| II: Relevance of Life Capability to occupational therapy practice | |
| Themes: | |
| Life Capability is relevant to occupational therapy practice as related to working with seniors | (97%) |
| Life Capability is relevant to occupational therapy practice as related to quality of life | (95%) |
| Life Capability is relevant to occupational therapy practice as related to palliative care and end of life care | (92%) |
| Life Capability is relevant to occupational therapy practice as related to working with people with mental health issues | (90%) |
| Life Capability is relevant to occupational therapy practice as related to acute care | (82%) |
| <i>2) Bodily Health Capability</i> | |
| I: Occupational therapists' understandings of Bodily Health Capability | |
| Themes: | |
| Bodily Health Capability is a basic human right | (96%) |
| Bodily Health Capability is interconnected with the Life Capability | (93%) |
| Bodily Health Capability is about health promotion | (85%) |
| II: Relevance of Bodily Health Capability to occupational therapy practice | |
| Themes: | |
| Bodily Health Capability is relevant to occupational therapy practice as related to promoting health and preventing diseases | (93%) |
| Bodily Health Capability is relevant to occupational therapy practice as related to feeding and/or eating | (92%) |
| Bodily Health Capability is relevant to occupational therapy practice as related to advocating for adequate shelter and basic nutrition | (91%) |
| Bodily Health Capability is relevant to occupational therapy practice as related to addressing physical health for those with mental illness | (88%) |
| Bodily Health Capability is relevant to OT practice as related addressing reproductive health | (46%) |

Table 4.16 Comparison of Themes between Phase One and Phase Two

| <i>Phase One Themes from Semi-structured Interviews</i> | Phase Two: Survey Responses (Percentage of Agree and Strongly agree) |
|--|---|
| <i>3) Bodily Integrity Capability</i> | |
| I: Occupational therapists' understanding of Bodily Integrity Capability | |
| Theme: | |
| Bodily Integrity Capability is about basic human rights | (98%) |
| II: Relevance of Bodily Integrity Capability to occupational therapy practice | |
| Themes: | |
| Bodily Integrity Capability is relevant to occupational therapy practice as related to a social justice perspective | (89%) |
| Bodily Integrity Capability is relevant to occupational therapy practice as related to client-centered approach | (87%) |
| Bodily Integrity Capability is relevant to occupational therapy practice as related to addressing mobility issues | (86%) |
| Bodily Integrity Capability is relevant to occupational therapy practice as related to an advocacy perspective | (85%) |
| Bodily Integrity Capability is relevant to occupational therapy practice as related to referring clients to resources | (83%) |
| Bodily Integrity Capability is relevant to occupational therapy practice as related to providing (emotional) trauma-informed care | (79%) |
| <i>4) Sense, Imagination, and Thought Capability</i> | |
| I: Occupational therapists' understandings of Sense, Imagination, and Thought Capability | |
| Themes: | |
| Senses, Imagination, and Thought Capability is about expressing oneself in various ways | (90%) |
| II: Relevance of Sense, Imagination, and Thought Capability to occupational therapy practice | |
| Themes: | |
| Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to self-expression | (95%) |
| Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to people with mental health issues | (95%) |
| Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to children with disabilities | (94%) |

Table 4.16 Comparison of Themes between Phase One and Phase Two

| <i>Phase One Themes from Semi-structured Interviews</i> | Phase Two: Survey Responses (Percentage of Agree and Strongly agree) |
|--|---|
| <i>5) Emotions Capability</i> | |
| I: Occupational therapists' understandings of Emotions Capability | |
| Theme: | |
| Emotions Capability is about basic needs and rights | (91%) |
| II: Relevance of Emotions Capability to occupational therapy practice | |
| Themes: | |
| Emotions Capability is relevant to occupational therapy practice with respect to people with mental health issues | (96%) |
| Emotions Capability is relevant to occupational therapy practice with respect to children with disabilities | (95%) |
| Emotions Capability is relevant to occupational therapy practice with respect to all those seen by occupational therapists | (91%) |
| Emotions Capability is relevant to occupational therapy practice in relation to helping people manage their emotions | (93%) |
| Emotions Capability is relevant to occupational therapy practice in relation to teaching anxiety management skills | (92%) |
| Emotions Capability is relevant to occupational therapy practice in relation to finding support systems | (89%) |
| <i>6) Practical Reason Capability</i> | |
| I: Occupational therapists' understanding of Practical Reason Capability | |
| Theme: | |
| Practical Reason Capability is about making personal decisions | (97%) |
| II: Relevance of Practical Reason Capability to occupational therapy practice | |
| Themes: | |
| Practical Reason Capability is relevant to occupational therapy practice from a client-centered perspective | (96%) |
| Practical Reason Capability is relevant to occupational therapy practice from helping clients to make personal decisions | (89%) |
| Practical Reason Capability is relevant to occupational therapy practice from providing educational and supportive strategies for caregivers | (87%) |

Table 4.16 Comparison of Themes between Phase One and Phase Two

| <i>Phase One Themes from Semi-structured Interviews</i> | Phase Two: Survey Responses (Percentage of Agree and Strongly agree) |
|---|---|
| <i>7) Affiliation Capability</i> | |
| I: Occupational therapists' understandings of Affiliation Capability | |
| Themes: | |
| Affiliation Capability is about social relations | (93%) |
| Affiliation Capability is about basic needs and rights | (90%) |
| II: Relevance of Affiliation Capability to occupational therapy practice | |
| Themes: | |
| Affiliation Capability is relevant to occupational therapy practice with respect to working with clients with mental illness | (94%) |
| Affiliation Capability is relevant to occupational therapy practice with respect to advocating for their clients | (92%) |
| Affiliation Capability is relevant to occupational therapy practice with respect to developing friendships, social network, and social skills | (83%) |
| Affiliation Capability is relevant to occupational therapy practice with respect to helping clients to identify their interests | (74%) |
| <i>8) Other Species Capability</i> | |
| I: Occupational therapists' understandings of Other Species Capability | |
| Theme: | |
| Other Species Capability is about the environment | (92%) |
| II: Relevance of Other Species Capability to occupational therapy practice | |
| Themes: | |
| Other Species Capability is relevant to occupational therapy practice from a client-centered perspective | (87%) |
| Other Species Capability is relevant to occupational therapy practice from a spirituality perspective | (80%) |
| Other Species Capability is relevant to occupational therapy practice because relationship with nature affects health | (77%) |
| Other Species Capability is relevant to occupational therapy practice from an environmental perspective | (77%) |
| Other Species Capability is relevant to occupational therapy practice because relationship with animals affects health | (66%) |
| Other Species Capability is not the main focus of occupational therapy practice | (44%) |

Table 4.16 Comparison of Themes between Phase One and Phase Two

| <i>Phase One Themes from Semi-structured Interviews</i> | Phase Two: Survey Responses (Percentage of Agree and Strongly agree) |
|--|---|
| <i>9) Play Capability</i> | |
| I: Occupational therapists' understandings of Play Capability | |
| Themes: | |
| Play Capability contributes to human happiness | (100%) |
| Play Capability contributes preserves quality of life | (95%) |
| Play Capability contributes achieves a work/life balance | (91%) |
| II: Relevance of Play Capability to occupational therapy practice | |
| Themes: | |
| Play Capability is relevant to occupational therapy practice with respect to its importance for everyone | (98%) |
| Play Capability is relevant to occupational therapy practice with respect to serving as a primary therapeutic approach in pediatric practice | (93%) |
| Play Capability is relevant to occupational therapy practice with respect to serving as a therapeutic approach when working with persons with mental health issues | (87%) |
| <i>10) Control over Ones' Environment Capability</i> | |
| Theme I: Occupational therapists' understandings of Control over One's Environment Capability | |
| Themes: | |
| Control over One's Environment Capability is about a basic human right | (89%) |
| Control over One's Environment Capability is about decision-making | (83%) |
| Control over One's Environment Capability is about political opinions | (60%) |
| II: Relevance of Control over Ones' Environment Capability to occupational therapy practice | |
| Themes: | |
| Control over One's Environment Capability is relevant to occupational therapy practice with respect to advocating for their clients | (90%) |
| Control over One's Environment Capability is relevant to occupational therapy practice with respect to developing decision-making | (85%) |
| Control over One's Environment Capability is relevant to occupational therapy practice with respect to helping clients gain and retain employment | (84%) |

Table 4.16 Comparison of Themes between Phase One and Phase Two

| <i>Phase One Themes from Semi-structured Interviews</i> | Phase Two: Survey Responses (Percentage of Agree and Strongly agree) |
|---|---|
| <i>11) General Views</i> | |
| I: Occupational therapists' general understandings of the Ten Central Human Functional Capabilities (CHFCs) | |
| Themes: | |
| CHFCs encompasses a range of occupational therapy practices | (94%) |
| The construct of function is common to the CHFCs as well as OT models | (68%) |
| They overlap each other | (66%) |
| CHFCs constitute a new approach | (46%) |
| CHFCs are more theoretical than practical | (32%) |
| CHFCs are more related to mental health practice | (10%) |
| II: Relevance of CHFCs to occupational therapy practice | |
| Themes: | |
| CHFCs are consistent with a client-centered approach | (95%) |
| CHFCs are consistent with a human rights model | (88%) |
| CHFCs are consistent with a framework for health and wellness | (86%) |
| CHFCs are consistent with an advocacy approach | (84%) |
| CHFCs are consistent with the Canadian Model of Occupational Performance | (80%) |
| CHFCs are consistent with a social justice model | (78%) |
| CHFCs are consistent with the Person Environment Occupation Model | (72%) |
| CHFCs are consistent with the Human Occupational Model | (65%) |
| CHFCs are consistent with Maslow's hierarchy of needs | (60%) |
| CHFCs are consistent with a recovery philosophy | (43%) |
| CHFCs are consistent with the International Classification of Functioning, Disability and Health | (42%) |

5 DISCUSSION, IMPLICATIONS, AND CONCLUSIONS

To explore the views of Canadian occupational therapists (OTs) with respect to their understandings and perceived relevance of the ten Central Human Functional Capabilities (CHFCs) to their professional practices, an exploratory sequential two-phase mixed methods study was conducted. We now discuss the results that emerged from our analyses of the qualitative and quantitative data in this study. In exploratory mixed methods designs, qualitative data are mixed in relation to the quantitative data (Creswell & Plano Clark, 2007). Thus, data from both phases are used to provide a full description of the OTs' views about the CHFCs.

We discuss our findings as follows. The first section describes the participants in the study overall, while the second section discusses the participants' views of the CHFCs within Nussbaum's framework in relation to the Capabilities Approach and the commonalities and distinctions. Third, the overall findings in relation to the occupational therapy profession are discussed in terms of the profession's established models and approaches. This also includes being consistent with such professionally-valued constructs as client-centered care, human rights, health, and social justice. Fourth, these findings are discussed in relation to the occupational science literature. Following these discussions, the strengths and limitations of the study overall are presented. These findings are also considered in terms of their implications for theory and practice, policy makers, and future research and practice.

5.1 Participant Description

All participants in Phase One were recruited from British Columbia, whereas the survey respondents were recruited from across Canada. Almost all participants in both phases were women (in Phase One all were women and 94% of survey respondents in Phase Two were women). The participants ranged in age. Most participants in the two phases of the study were working with adults. The majority of participants in Phase One (71%) held professional master certification or higher level of education, and in Phase Two 40% held a master's degree or higher level of education. Given our participants had a high level of education, their knowledge may have been more informed than participants with less education.

Almost all the participants (95%) in both phases were Canadian-educated (only 5% of survey participants were internationally-educated). All participants in Phase One were from British

Columbia, whereas participants in Phase Two were from across Canada. The highest numbers of participants in Phase Two were from the province of Ontario (39%) and only 2% were from the province of Quebec.

The majority of participants in both phases had over twenty years of experience as OTs. Given they likely had a higher level of skills and knowledge because of this experience, their views and thoughts may have been more informed than participants with less experience.

Although participants in both phases had experience working in multiple settings, the majority had worked mainly in hospitals and community settings.

In terms of areas of practice, the study participants represented a diverse group of OTs that was reflective of the demographics of OTs working in Canada, in general. Although the study participants worked in *a range of* areas, most were Direct Service Providers.

Despite working in various settings and areas of practice with a range of client groups, participants generally agreed about the relevance of the CHFCs to occupational therapy practice. In the following section of this discussion, data from both phases regarding each of the capabilities and the general views of the participants about the CHFCs are mixed to provide a complete description of the views of OTs with respect to their understandings of the CHFCs and their perceived relevance to occupational therapy practice.

5.2 Discussion of Findings in Relation to the Capabilities Approach Literature

To frame our mixed findings within meaningful contexts, first, we summarized the overall findings in relation to what has been reported by the participants about their understanding of the CHFCs and relevance to their practices, rather than what is occupational therapy established practice competencies. Also, the findings are discussed in relation to the theoretical underpinnings of Nussbaum's descriptions of the CHFCs. This enabled us to establish commonalities and distinctions among them.

5.2.1 Occupational Therapists' Views of Life Capability

This section describes the views of OTs about the Life Capability with respect to their understandings of this capability and its perceived relevance to their professional practices, with reference to Nussbaum's description. Nussbaum described Life Capability as "Being able to live

to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living".

Occupational Therapists' Understandings of Life Capability

In the analysis of Phase One, our study identified three themes from which the term Life Capability was stated: Quality of life, Basic human rights and needs, and Longevity.

The first theme was "Life Capability as quality of life". In Phase Two, 90% of the survey respondents agreed or strongly agreed with this idea. Based on the Capabilities Approach literature, a list of capabilities would be used in defining and measuring quality of life (Sen, 1985; Nussbaum, 2000, 2006). The Capabilities Approach "specifies a space within which comparisons of life quality (how well people are doing) are most revealingly made among nations" (Nussbaum, 2000, p. 6). According to Sen (1985), quality of life is not simply a matter of what the person achieves, but also it is about the actual opportunity or freedom that people have to achieve what they want to do. Similar to the Capabilities Approach literature, the participants of our study acknowledged that quality of life pertains to what "everybody should be able to achieve" (Participant 7, p. 1).

The second theme was "Life Capability is about basic rights and needs". The participants of our study mentioned that the right to life constitutes a basic human right that is fundamental to the human condition. In Phase Two, 82% of survey respondents agreed or strongly agreed with this claim. As we discuss later, the majority of participants of our study described the ten CHFCs in terms of basic rights and needs. Therefore, the participants of our study suggested that human rights can be seen as claims to certain basic capabilities or as entitlements to capabilities (Sen, 1999, 2005; Nussbaum, 2000, 2006). Nussbaum argued that the ten CHFCs "have a very close relationship to human rights, as understood in contemporary international discussions" (Nussbaum, 2000, p. 97). Nussbaum (2000) stated that "it seems valuable to understand these rights in terms of capabilities" (p. 99). According to her, "the idea of human rights is by no means a crystal-clear idea". For her, the language of capabilities helps to better understand the construct of rights. In other words, this language helps to understand "what the motivating concerns are and what the goal is". Nussbaum referred to Bernard Williams' citation to support the ideas she has developed:

I am not very happy myself with taking rights as the starting point. The notion of a basic human right seems to me obscure enough, and I would rather come at it from the perspective of basic human capabilities. I would prefer capabilities to do the work, and if

we are going to have a language or rhetoric of rights, to have it delivered from them, rather than the other way round (Williams, 1987, p. 100).

The third theme was “Life Capability is about longevity”. The study participants asserted that Life Capability is about “a normal life expectancy”. In comparison with the “Life Capability which was about basic human rights and needs”, and “quality of life”, the respondents noted Life Capability as less about longevity. Despite this, 57% of respondents agreed that Life Capability is about longevity. The study participants’ perspectives were consistent with Nussbaum’s idea about Life Capability, which is that all human and non-human beings are entitled to continue their lives. With respect to non-humans or animals, she explained that Life Capability could even be used to guide public policy in dealing with animals. Specifically, Nussbaum stated:

Utilitarian approaches focus only on sentience, and thus give animals no entitlement to life except to the extent that the interest in continuing life is one of their conscious interests. In the capabilities approach, all animals are entitled to continue their lives, whether or not they have such a conscious interest, unless and until pain and decrepitude make death no longer a harm” (Nussbaum 2006, p. 392).

This quotation is consistent with the finding that Life Capability is about longevity, but not exclusively. Nussbaum that even

a permanent vegetative state of a (former) human being, that this just is not a human life at all, in any meaningful way, because possibilities of thought, perception, attachment, and so on are irrevocably cut off,... The job of a decent society is to give all citizens the (social conditions of the) capabilities, up to an appropriate threshold level (Nussbaum, 2006, pp. 181-182).

In summary, in comparison with Nussbaum’s definition of the Life Capability, our findings are consistent with that in the Capabilities Approach literature.

Relevance of Life Capability to Occupational Therapy Practice

In addition, respondents to the study suggested that Life Capability is relevant to occupational therapy practice with respect to working with seniors (97%), palliative care and end of life care (92%), working with people with mental health issues (90%), and acute care (82%). Our findings indicated that OTs develop interventions to promote their clients’ quality of life and to enjoy a healthy life expectancy. The participants of our study also reported that OTs contribute to enhancing the Life Capability of their clients through promoting health and preventing injuries and disease, reducing the side effects of medications, providing a supportive

environment, implementing self management programs, reducing the impact of negative determinants of health such as poverty, helping clients to be gainfully employed, and increasing their social participation and interaction. Also, the participants suggested that OTs along with other health professionals have a role in preserving their clients' Life Capability and promoting a full life expectancy. They indicated that OTs focus on meaningful engagement in occupation as key to enhancing the Life Capability of their clients.

5.2.2 Occupational Therapists' Views of Bodily Health Capability

This section describes the views of OTs about the Bodily Health Capability with respect to their understandings and perceived relevance of this capability to their professional practice in reference to Nussbaum's description. Nussbaum described Bodily Health Capability as "Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter."

Occupational Therapists' Understandings of Bodily Health Capability

Based upon the results of the qualitative interviews conducted in Phase One, Bodily Health Capability was reflected in three themes: Basic human right, Interconnected with the Life Capability, and Health promotion.

The first theme was to view Bodily Health Capability as basic human rights and needs. This claim was strongly supported by 96% of Phase Two's respondents. Some participants of Phase One explained the Bodily Health Capability as the right to be physically healthy, have shelter, and have enough food. They mentioned that Bodily Health Capability is essential and worth achieving before occupational therapy interventions. This understanding is similar to the right to health (Art. 25) of the 1948 Universal Declaration of Human Rights. With respect to the right to health, the UN Committee on Economic, Social and Cultural Rights has similarly stressed that states have a core minimum obligation to ensure:

The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; Access to the minimum essential food which is nutritionally adequate and safe; Access to shelter, housing and sanitation and an adequate supply of safe drinking water; The provision of essential drugs; Equitable distribution of all health facilities, goods and services (UN-WHO, 2008, p. 25).

The participants in the study asserted that people with disabilities are more likely to experience failure in being healthy and being able to achieve this capability in terms of basic needs. The views of the participants were consistent with the UN proclamation that “Persons with disabilities face various challenges to the enjoyment of their right to health” (UN-WHO, 2008, p. 16).

The second theme revealed in Phase One was that Bodily Health Capability overlaps with Life Capability. This was strongly supported by 93% of survey respondents. Thus, Bodily Health and Life Capabilities were described as being linked given both involve longevity and survival.

The third theme from which the Phase One participants described the Bodily Health Capability was related to health promotion. In Phase Two, 85% of survey respondents strongly supported this idea. The majority of participants described the Bodily Health Capability as a physical conception of health that includes nutrition, exercise, and sleep similar to what Nussbaum described. They also agreed that the Bodily Health Capability could subsume such constructs as wellness and lifestyle management.

In summary, compared with Nussbaum’s definition of Bodily Health Capability, our findings showed two distinctions. First, Life Capability and Bodily Health Capability are described as being similar with no clear distinction between them. The second is that the concept of health promotion, central to an OT’s perspective, is not reflected in Nussbaum’s definition.

Relevance of Bodily Health Capability to Occupational Therapy Practice

A number of participants in Phase One also reported that the Bodily Health Capability is relevant to occupational therapy practice with respect to promoting health and preventing disease, feeding and eating, addressing physical health for those with mental illness, advocating for adequate shelter and basic nutrition, and addressing reproductive health.

The participants of this research noted that OTs’ roles in dealing with feeding difficulties and advocating for nourishment and shelter, but there are uncertainties about their role in addressing reproductive health issues.

The participants suggested that improving Bodily Health Capability not only impacts physical health but also mental health. They emphasized the importance of having an interprofessional approach to work with other health professionals to foster clients’ Bodily Health Capability. However, although improving the Bodily Health Capability is important to OTs, managing time and workload priorities may compete with this goal.

5.2.3 Occupational Therapists' Views of Bodily Integrity Capability

The this section describes the views of OTs on the Bodily Integrity Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Nussbaum described Bodily Integrity Capability as “Being able to move freely from place to place; having one’s bodily boundaries treated as sovereign, i.e., being able to be secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.”

Occupational Therapists' Understandings of Bodily Integrity Capability

The first theme that emerged from which the majority of participants in Phase One described Bodily Integrity Capability was to see it as “basic human rights”. Almost all survey respondents (98%) agreed or strongly agreed with this idea. Some participants defined Bodily Integrity Capability as a basic human right to protect individuals’ against violations, harms, and injures. This constitutes a basic human right. Some participants acknowledged that people with disabilities are more likely to be treated differently than people who are able-bodied. They experience more violations of bodily integrity than people without disabilities.

A few participants concurred that the Bodily Integrity Capability is essential to our rights as citizens. Here, basic rights includes both to move freely from place to place, and to protect body against violation, abuse, and harm. It means everyone has the right to protect his or her body against violations including physical, emotional, and harm and injures.

In this sense, our study participants’ views are similar to what Nussbaum proposed. They are described people with disabilities as vulnerable to physical violence and sexual abuse. For example, participants who work with people with mental illness mentioned that these individuals are more likely to be mistreated than those who are able-bodied. Those participants asserted that in contrast to common views that people who live with mental health issues are violent, they are several times more prone to violence against them (Participant 2). Some respondents stated that many women and children with mental health issues have been sexually assaulted, abused as children, and subjected to domestic violence (Participant 12), and further, people with mental illness often have less capability of bodily integrity in that they are unable to move freely from place to place; their rights as citizens have been compromised (Participant 1).

The participants also suggested that Bodily Integrity Capability is important when working with people with disabilities. For example, as Participant 7 asserted, a traumatic life is definitely part of Aboriginal background, so they lose their freedom to live in their place and freely move from place to place. For some participants, the Bodily Integrity Capability is a form of the principle of non-maleficence in that everyone should be protected from unnecessary treatment. Many persons with disabilities, specifically people with mental health issues however, are not capable of making healthcare decision for themselves that would limit unnecessary tests and treatment. Our finding is consistent with Nussbaum's definition of Bodily Integrity Capability.

Relevance of Bodily Integrity Capability to Occupational Therapy

With respect to the relevance of the Bodily Integrity Capability, the majority of participants in Phase One described it as being relevant to practice in terms of a client-centered approach, a social justice perspective, and an advocacy perspective. The participants reported that OTs improve the Bodily Integrity Capability through building basic skills that help clients do what they want to do and are able to do; providing trauma-informed care to help people with mental illness who have been exposed to violence and sexual assault; advocating for their clients such as retaining or gaining jobs; addressing mobility issues; providing training to reduce safety risks in moving freely from place to place; giving clients necessary tools; providing communication devices; advocating for reasonable accessibility; and, empowering people with disabilities to advocate for themselves.

5.2.4 Occupational Therapists' Views of Sense, Imagination, and Thought Capability

This section describes the OTs' views about the Senses, Imagination, and Thought Capability with respect to their understandings and perceived relevance of this capability to their professional practice, in reference to Nussbaum's description.

Nussbaum described Senses, Imagination, and Thought Capability as "Being able to use the senses, to imagine, think, and reason – and to do these things in a "truly human" way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing self-expressive works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic

speech, and freedom of religious exercise. Being able to search for the ultimate meaning of life in one's own way. Being able to have pleasurable experiences, and to avoid non-necessary pain."

Occupational Therapists' Understandings of Sense, Imagination, and Thought Capability

This study identified one theme regarding this capability: Expressing oneself in various ways. Based upon the results of the qualitative interviews conducted in Phase One, the majority of participants described this capability as freedom to be able to express yourself in various ways, or simply freedom. This idea was supported by 90% of the survey participants. These participants explained this capability as the ability to determine your meaning of life and the freedom to express your emotional, social, and political thoughts. Furthermore, many participants described it as freedom to determine your own life and your meaning of life. Also it was defined as freedom of expression, or a justice exercise to express one's thoughts. In her book, *Frontiers of Justice*, Nussbaum stated:

For humans, this capability creates a wide range of entitlements: to appropriate education, to free speech and artistic expression, to freedom of religion. It also includes a more general entitlement to pleasurable experience and the avoidance of nonbeneficial pain (Nussbaum, 2006, p. 396).

Similarities are seen between Nussbaum's definition of the Senses, Imagination, and Thought Capability and these participants' understandings. These participants emphasized the existence of structural barriers within our society that prevent people from feeling as if they have that freedom of expression, to participate, and to express their thoughts and in some ways (Participant 13).

Relevance of Sense, Imagination, and Thought Capability to Occupational Therapy Practice

Many participants in Phase One reported that the Senses, Imagination, and Thought Capability is relevant to occupational therapy practice with respect to: Self-expression, People with mental health issues, and Children with disabilities. The survey participants strongly agreed with these themes.

The participants noted that OTs have a major role in promoting this capability by *enabling their clients* to express themselves freely and explore what they want to do. They also stated that improving the Sense, Imagination and Thought Capability is an area of occupational therapy related to mental health and pediatric occupational therapy. They mentioned that OTs have an

important role in promoting this capability when examining what people can do and what they want to do. They suggested that OTs use a range of activities; e.g., art and play, as indirect means to help their clients communicate and express their imaginations and thoughts. According to them, OTs improve this capability by employing learning processes and coping strategies, problem solving and planning, and decision making, building communication skills and promoting literacy, providing assistive technologies, and helping clients and families to have pleasurable experiences.

5.2.5 Occupational Therapists' Views of Emotions Capability

This section describes the OTs' views about the Emotions Capability with respect to their understandings and perceived relevance of this capability to their professional practice. Nussbaum described Emotions Capability as "Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by overwhelming fear and anxiety, or by traumatic events of abuse or neglect. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.)."

Occupational Therapists' Understandings of Emotions Capability

This study identified one theme regarding this capability: Basic needs and rights. A number of participants stated the Emotions Capability as a basic need and right. It was noted as the right to have the sense of safety, love and belonging. For them, this capability was described as fundamental. For the majority of the participants in Phase One, the Emotions Capability is about a basic human right. 91% of the survey respondents strongly support this claim. They spoke of the critical role of this capability with respect to individual's well-being and childhood development. A few participants described it as right to be loved and belonging. This finding is consistent with Nussbaum's definition. Some participants suggested that the Emotions Capability reflects baseline and bottom level of needs: "I think it's in a way it's sort of like Bodily Health. Like, you need the basics in order to be able to move on to other goals" (Participant 3). Described in this way, the Emotions Capability is consistent with Maslow's hierarchy of basic needs necessary to achieve one's full potential (Participant 12).

Relevance of Emotions Capability to Occupational Therapy Practice

The majority of participants in this study reported that Emotions Capability is relevant to occupational therapy practice with respect to: People with mental health issues, Children with disabilities, All those seen by OTs, Finding support systems, Helping people manage their emotions, and Teaching anxiety management skills. Therefore, this study supported that the Emotions Capability described by OTs as being relevant across areas of occupational therapy practice, from mental health to pediatric acute care. A number of participants mentioned that people with mental health issues and children with disabilities are emotionally more vulnerable which was an insight that emerged with respect to their perceptions about the Bodily Integrity Capability. Based on this perception, the Emotions Capability reflects many areas consistent with occupational therapy interventions for those populations.

Some participants of the study described the Emotions Capability as important by OTs in early childhood development and leads to the development of healthy personalities. According to them, enhancing Emotions Capability is a fundamental component of children's well-being. Children with behavioural issues have problems with emotional development. They mentioned that OTs work on Emotions Capability in early childhood development; such as attachment, appropriate behaviour, sensory processing, and developing basic skills.

Further, according to the participants, OTs help people with mental health issues to manage their emotional health and help overcome their emotional problems. They suggested that OTs try to find social, emotional, educational supports for their clients through improving families' relationships and friendship. According to them, occupational therapy services help to incorporate family members and extend support networks and friendship for the clients.

Many participants mentioned that OTs help people to manage their emotions through developing communication skills that enable them to express their emotions. As well, they asserted that OTs provide communication devices to clients to enable them to make choices, communicate, and deal with their emotions.

In summary the majority of participants of this study indicated that OTs can support the Emotions Capability by helping clients engage in activities and groups; helping them to reintegrate into their lives after a traumatic event; teaching them anxiety management skills to control their emotions when re-engaging in previous activities or engaging in new ones; developing healthy emotional expression by supporting what they want to do; and providing

knowledge and sympathy and support to help their clients and their families to manage their fears and anxiety.

5.2.6 Occupational Therapists' Views of Practical Reason Capability

This section describes the views of OTs about the Practical Reason Capability with respect to their understandings of this capability and its perceived relevance to their professional practices, with reference to Nussbaum's description. Nussbaum described Practical Reason Capability as "Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience)."

Occupational Therapists' Understandings of Practical Reason Capability

This study identified one theme regarding his capability: Making personal decisions. A number of participants defined the Practical Reason Capability as making personal decisions. They stated that this capability is about making good choices and having the ability to exercise control over one's environment. According to these participants, the Practical Reason Capability is the ability to make decisions and to make good choices. 97% of the survey respondents confirmed that this capability is about making personal decisions. Some participants noted that Practical Reason Capability is about reasoning and autonomy to control over one's environment.

Nussbaum argued that this capability is "a key architectonic entitlement in the case of human beings. It pervades and informs all the others, making their pursuit fully human" (Nussbaum, 2006, p.398). Similarities are seen between Nussbaum's definition and the participants' views. In addition, the participants mentioned factors that impact one's reasoning to make decisions. In particular, they raise the issue of "the information that you need" about your health conditions that influences decision making.

The majority of the study participants described the Practical Reason Capability as being relevant to practice with respect to helping clients make personal decisions. Some 89% of survey participants agreed or strongly agreed. According to them, OTs try to identify meaningful activities for their clients to improve Practical Reason through reflection. For them, reflection is an important part of occupational therapy practice as a means of enabling clients to plan their lives.

Relevance of Practical Reason Capability to Occupational Therapy Practice

Based upon the interviews conducted in Phase One, this study identified that the Practical Reason Capability is relevant to OT practice from a client-centered perspective. Most survey respondents (96%) supported this idea. The majority of participants mentioned that in client-centered practice, OTs are regarded as facilitators who assist their clients to control their environment as much as possible. They suggested OTs provide clients with necessary information to make their own decision. According to them, OTs respect client's autonomy and their independence, and try to assist them with what they want to do and able to do. Although the client-centered practice is the preferred approach in occupational therapy practice, a few participants identified ambiguities and barriers that can impact a client's ability to exercise the autonomy and planning necessary to make plans in life.

Some participants indicated that the Practical Reason Capability was particularly relevant to outpatient care. They indicated that the capacity to plan life depends on one's health condition. For example, people who are physically disabled are capable of making decisions in their lives, while people with critical health conditions, mental health illnesses, and children are less or unable to make decisions (Participant 12).

On the other hand, some participants noted the Practical Reason Capability as a basic skill that is relevant to occupational therapy practice across settings. They stated that OTs improve the Practical Reason Capability by providing opportunities and strategies to make decisions, even simple choices, for all clients seen by OTs. For example, although people with severe disabilities are less or incapable of reflecting on their lives, they may be capable of making simple decisions about daily life with support: "They're not maybe able to make those big life decisions, but they're able to make decisions around a very concrete activity... So I'm going to give them the opportunity to decide. We give them the strategies; the tools to use..." (Participant 6, p. 9).

Some participants of the study suggested that OTs believe they improve the Practical Reason Capability by providing educational strategies. They mentioned that OTs offer options and choices when working with their clients at their levels of ability. They also noted that the Practical Reason Capability is relevant to occupational therapy practice with respect to providing educational and supportive strategies for caregivers. The majority of participants (87%) agreed or strongly agreed. Supportive strategies for caregivers must include opportunities for actual

choices as Nussbaum stated: “Again, good support for practical reason in this area would be public policies that make the choice to care for a dependent a real choice, not an imposition born of social indifference (Nussbaum, 2006, pp. 170-171).

5.2.7 Occupational Therapists’ Views of Affiliation Capability

This section describes the OTs’ views about the Affiliation Capability with respect to their understandings of this capability to their professional practice. Nussbaum described Affiliation Capability as “A. Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another and to have compassion for that situation: to have the capability for both justice and friendship. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.) B. Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails, at a minimum, protections against discrimination on the basis of race, sex, sexual orientation, religion, caste, ethnicity, or national origin. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.”

Occupational Therapists’ Understandings of Affiliation Capability

This study identified two themes regarding this capability: Social relation, and Basic needs and rights. The first theme from which the majority of participants of Phase One stated the Affiliation Capability was to see it as “social relation”. Most survey participants (93%) strongly supported this idea as well. They argued that this capability is “key to living”, so it’s sort of “you give and you get”. They suggested the Affiliation Capability is essential to living healthily, and it is critical for maintaining relationships and achieving needs. The study participants’ views are consistent with Nussbaum’s claim that the Affiliation Capability stands out as of “special importance” (Nussbaum, 2000, p. 82).

The participants of this study suggested that the Affiliation Capability is about belonging and how people belong. In other words, “it is kind of seeking social support through attachment and pursuing social support through others” (Participant 13). A number of participants spoke of the importance of belonging, and social interactions. Some participants noted that the Affiliation

Capability is about belonging and how people belong through attachment and social support with others, and it is fundamental to social relations as well.

According to many participants in Phase One, Affiliation Capability is relevant to occupational therapy practice with respect to advocating for their clients. This claim was strongly supported by 92% of survey respondents. Further, they acknowledged that the Affiliation Capability is relevant to occupational therapy practice with respect to developing friendships, social network, and social skills. Many participants (83%) agreed or strongly agreed with this idea.

The second theme from which Phase One's some participants noted the Affiliation Capability was to see it as "basic needs and rights". The majority of participants of Phase Two (90%) of the participants supported this idea. According to them, basic rights and needs described as meaning being treated with dignity, being considered equal to others, being able to meet freely and speak freely with respect to politics, and being able to work with people in a mutually respectful way. They described it as being critical for health and function as well. For them, the Affiliation Capability means being treated with dignity, and having a sense of belonging. This finding revealed that there were two types of remarks about basic human rights and needs: those referring to the basic rights, such as being treated with dignity and equality. For example, Participant 10 said:

This is about being treated with dignity, being considered equal to others...we are very much involved in our clients and their relationships with other people and seeing them as having their own rights to engage the life they want to have and being treated with respect and with equality. That's right, and we're super involved politically with equal rights for those who are disabled. (p. 6)

And, those were referring to basic needs, such as the sense of belonging. For example, Participant 7 claimed: "Again it goes back to that sense of belonging, possibly as a basic kind of human need" (p. 6).

Relevance of Affiliation Capability to Occupational Therapy Practice

In Phase One, the Affiliation Capability was also described as being relevant to occupational therapy practice with respect to helping clients identify their interests. In Phase Two, 74% of survey respondent affirmed this idea. The participants described the Affiliation Capability as being particularly relevant to occupational therapy practice in the mental health area. A number of participants indicated that people with mental illnesses have deficiencies in the Affiliation

Capability. Most survey participants (94%) strongly agreed or agreed with this idea.

In summary, based on most of the study participants' views, OTs can contribute to promoting Affiliation Capability through helping clients identify their interests and needs; developing friendships, social network and relationships; advocating for their clients; educating family members and others; and providing assistive technology as needed. From their perspectives, OTs help to reintegrate clients into society through developing social skills. According to them, OTs foster the Affiliation Capability in their clients through the development of meaningful relationships based on mutual respect.

5.2.8 Occupational Therapists' Views of Other Species Capability

This section describes the views of OTs about the Other Species Capability with respect to their understandings of this capability and its perceived relevance to their professional practices, with reference to Nussbaum's description. Nussbaum described Other Species Capability as "Being able to live with concern for and in relation to animals, plants, and the world of nature."

Occupational Therapists' Understandings of Other Species Capability

This study identified one theme regarding this capability: the idea of environment. Based upon the results of the qualitative interviews conducted in Phase One, some participants spoke of it as a sense of belonging and attachment to other creations. It is about people's relationship with the environment including animals, plants, and nature as described by the participants. It was described as the relationship with the living environment. Most survey participants (92%) supported this theme as well. Similar to Nussbaum's definition, many participants defined this capability as relationship with animals, plants, and nature. In addition, they indicated that the concept of health is deeply affected by human-environment interactions in some population. For example, "Aboriginal people, connectivity and relationships with animals, plants, the land, nature, is an important part of I think how health is perceived and experienced" (Participant 7, p. 7).

Relevance of Other Species Capability to Occupational Therapy Practice

Some participants in Phase One also reported that Other Species Capability is relevant to occupational therapy practice because relationships with animals and nature affect health. Human-animal interactions can develop social and communication skills. They asserted that having a relationship with animals depends on factors such as the cultural background of family,

the client's character, and the adequacy of training of the pet (Participant 4). The relationship with animals can be explained from the perspective of animal-assisted therapy (Participant 12). Sometimes, animals such as dogs are more efficient than any of the tools provided for autistic children, people with visual impairments, and people with physical disabilities to improve their relationships and to help keep them safe (Participant 6). Not only the relationship with animals, but also the relationship with nature affects both physical and mental health (Participant 7). But, human-environment interaction depends on a client's age and interests (Participant 5).

Some participants of this research mentioned that the relevance of the Other Species Capability to occupational therapy practice can be explained from a client-centered perspective. They noted that OTs need to identify their clients' beliefs, values and interests and respect them in order to maximize their Other Species Capability. If the relationship with the living environment is important to a client, according to the participants, OTs can help him or her explore what ways this could be achieved. They also stated that the relevance of the Other Species Capability to occupational therapy practice can be explained from a spirituality perspective as well. For some populations, according to the participants' perspectives, the concept of health is affected by human-environment interactions and human spiritual beliefs. As well, these participants described the relevance of the Other Species Capability to occupational therapy practice from an environmental perspective. Some participants asserted that considering person-environment interaction is fundamental to occupational therapy practice.

Although including the Other Species Capability in occupational therapy practice is important, it may not be a focus of occupational therapy practice according to a few participants. For them, OTs may not be able to focus on developing the Other Species Capability because of such barriers as the OTs' backgrounds, OTs' workloads, cost, and clients' housing, and nature of their illness. Just under half of participants (44%) indicated that Other Species Capability is not the main focus of occupational therapy practice.

5.2.9 Occupational Therapists' Views of Play Capability

This section describes the views of OTs about Play Capability with respect to their understandings of this capability and its perceived relevance to their professional practices, with reference to Nussbaum's description. Nussbaum described Play Capability as "Being able to laugh, to play, to enjoy recreational activities."

Occupational Therapists' Understandings of Play Capability

This study identified three themes regarding this capability: Human happiness, Quality of life, and Work/life balance. All participants noted that the Play Capability contributes to human happiness and in turn health, in terms of recreational activities. They described the Play Capability as meaningful activities that enhance the individual's quality of life and well-being. They also indicated that it contributes to work/life balance and managing stress.

One of the themes from which almost all participants described Play Capability was to see it as happiness. This perspective strongly supported by all survey participants. Happiness was described as being different things to different people from their perspectives. For some participants of this study, happiness meant the ability to pursue "your joy". On further analysis of this finding, recreational activities and happiness were described as being closely intertwined.

The second theme from which some participants described Play Capability was to see it as quality of life. In Phase Two, 95% of survey participants support this idea. The participants of this study indicated that recreational activities can be considered as meaningful activities that enhance the individual's quality of life. Some participants asserted that the ability to engage in recreational activities support individual's quality of life and its well-being.

The third theme from which some participants described Play Capability was to see it as contributing to work/life balance. Most survey participants (91%) support this idea. This finding suggested that there is an imbalance in our lives between our acts. *The majority of participants* noted that achieving life/work balance and bringing joy into your life improves happiness and life satisfaction. One of the interesting points of this finding was that the participants described the Play Capability not only as bringing joy and balance into your life, but also reducing stress and pressure in daily life. Thus, according to them, play can be described as being therapeutic.

Compared to Nussbaum's definition, this inquiry found the OTs used the term 'play' in three ways. One way was to see Play Capability as happiness. The second way was to use the term as quality of life. The third way was to use the term to express work/life balance.

Relevance of Play Capability to Occupational Therapy Practice

Some participants in Phase One also reported Play Capability as being relevant to occupational therapy practice with respect to being a primary therapeutic approach. According to them, play can be a powerful therapeutic tool. Occupational therapists, as the participants mentioned, focus on play in various ways. From their point of views, play provides learning

opportunity to develop basic physical and mental skills for children. As they noted, it also can be considered as a way to enable therapists to build therapeutic relationships and enable the parents to connect with their children.

The participants asserted that the Play Capability is important for building a therapeutic relationship in adult with physical and mental disabilities as well. According to them, OTs can adapt activities for people with cognitive and physical disabilities to develop their basic skills and to promote their ability to be able to have fun and enjoy recreational activities.

The participants of this study noted that play is important for everyone. The majority of participants asserted that play affects individuals' health. The Play Capability was described as more than leisure activities for some participants. For them, it helps to develop positive attitudes towards self through activities. The participants mentioned that OTs consider play for all ages as important in promoting health. They asserted that play activities can be used across occupational therapy settings including acute care. From their perspectives, OTs engage their clients in leisure activities and recreational activities in order to help them to maintain their quality of life and to achieve a balance in daily life.

Some participants reported that although the Play Capability is important in promoting health, its improving likely depends on clients' interests. They stated that despite the recognized importance of play, there are barriers in occupational therapy services to including the Play Capability across settings such as: consumer expectations, occupational therapy workload, and lack of guidelines.

5.2.10 Occupational Therapists' Views of Control over One's Environment Capability

This section describes the OTs' views about the Control over One's Environment Capability with respect to their understandings and perceived relevance of this capability to their professional practice, with reference to Nussbaum's description. Nussbaum described Control over One's Environment Capability as "A. Political. Being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association. B. Material. Being able to hold property (both land and movable goods), not just formally but in terms of real opportunity; and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure."

Occupational Therapists' Understandings of Control over Ones' Environment Capability

Consistence with Nussbaum's definition, the majority of our research participants reported three themes regarding this capability: A basic human right, Decision-making, and Political opinions.

One of the themes from which the participants noted the Control over One's Environment Capability was to see it as a basic human right. Most survey participants (89%) supported this idea. In the analysis process, the researcher found that some participants described this capability in two ways. One way was to use the term to indicate it as a basic right. From their perspectives, basic rights were interpreted as citizenship rights that everyone as a citizen has a right to control over his/her environment. For example, "being able to own property and participate in political events, having the right to seek employment on an equal basis so it means that you wouldn't be discriminated against, so again I think it's largely human rights" (Participant 5, p. 7). The other way was to use the term as related to basic needs. For example, one participant mentioned that "So part of it, was making sure the individuals had the needed supplies and resources, food, shelter, meaningful occupation, that kind of thing... a lot of these individuals need diapers, they need feeding tubes, they need feeding supplies...Very basic needs!" (Participant 6, p. 12). Those participants were primarily concerned about "the necessary to make sure that people with vulnerable position access to resources and their basic needs"(Participant 12, p. 11).

The second theme from which a number of participants mentioned that the Control over One's Environment Capability was to see it as being able to make their own decisions. Some 83% of the participants confirmed this idea. A few of participants not only discussed the importance of making decisions to control your environment, but also with respect to a "treatment decision making" perspective. The study participants suggested that some people, such as people with disabilities or individuals with acute conditions, do not have control over their environment and they lose their power to make decisions.

The third theme from which some participants described the Control over One's Environment Capability was to see it in terms of political opinion. In comparison with the two previous perspectives, survey respondents supported this theme less. Despite this, 60% of them agreed or strongly agreed with this idea. A few of participants noted that this capability is about political thought and political choices. This finding indicated that this capability was described as meaning rights to privacy and freedom of expression, that is, political thought to be able to

govern, contribute, and participate in your environment. Nussbaum generally views the Capabilities Approach as a political doctrine, she states:

The capabilities approach is a political doctrine about basic entitlements, not a comprehensive moral doctrine. It does not even claim to be a complete political doctrine, since it simply specifies some necessary conditions for a decently just society, in the form of a set of fundamental entitlements of all citizens (Nussbaum, 2006, p. 155).

Similarities are seen between Nussbaum's notion of the Capabilities Approach and some participants' understandings of Control over One's Environment Capability. In summary, some participants of our study confirmed the importance of both political and material parts of this capability. Nussbaum asserted that

This capability has two prongs, the political and the material. The political is defined in terms of active citizenship and rights of political participation. On the material side, the human form of the capability includes certain sorts of protection for property rights and employment rights, including the right to form unions and the free choice of occupation (Nussbaum, 2006, p. 400).

A few of the study participants indicated that the challenges faced by people with disabilities to exercise control over their environments. They refer to the ethical challenges raised in related to "treatment decision making" and "political choices impact the delivery of health care".

Relevance of Control over Ones' Environment Capability to Occupational Therapy Practice

A number of participants in Phase One also reported that OTs improve the Control over One's Environment Capability by promoting relevant skills, developing decision-making, helping clients gain and retain employment, advocating for their clients, and adapting their environments to participate in society. These participants noted that OTs have important roles in helping their clients seek employment by having realistic views about disability issues. They indicated that OTs advocate for their clients in two ways; first, through building their skills and empower them to advocate for themselves; Second, they advocate in terms of assisting clients access resources and other resources. For example, Participant 12 asserted that OTs advocate for their clients across levels: individual level through building skills and developing awareness and decision-making; through family level by supporting families to advocate for their children's needs, through school boards to foster inclusion policies, and through the organizational level to identify efficient ways of accessing services and resources for their clients.

Finally, OTs improve their clients' Control over One's Environment Capability through understanding their clients' interests in order to help them do what they want to do, identify barriers to participation, and potentially beneficial occupational therapy interventions and other resources.

5.2.11 Occupational Therapists' General Views of the CHFCs

This section discusses the OTs' general views about the ten CHFCs with respect to their overall understandings of the ten CHFCs to occupational therapy philosophy, models, and approaches, and their perceived relevance to their professional practices, with reference to Nussbaum's descriptions.

Occupational Therapists' General Understandings of the Ten CHFCs

The majority of study participants reported that although Nussbaum's ten CHFCs constituted a new approach, the concepts themselves were familiar. In other words, although the terminology is distinct, it is not necessarily a new approach. They stated that the CHFCs provide a broad perspective and encompass the range of settings of occupational therapy practice. For many participants in this study, the CHFCs encompassed a range of occupational therapy practices; 94% of the survey participants strongly confirmed this idea. They noted that the CHFCs are related to occupational therapy practice, although they are framed differently.

Although the findings of Phase One indicated that the CHFCs are more related to mental health practice, only 10% of the survey respondents agreed with this. This finding indicated that they are related across occupational therapy practice areas from mental health, pediatrics, seniors, and acute and palliative care.

Although the majority of participants who were interviewed (Phase One) mentioned that the CHFCs are more theoretical than practical, only 32% of the survey respondents (Phase Two) supported this idea. This finding indicated that the CHFCs are applicable in both occupational therapy theory and practice. The CHFCs were described by these participants as providing a broad perspective that not only aligns with occupational therapy conceptual models, but also with many areas of occupational therapy practice.

For many participants in Phase One, the construct of function is common to the CHFCs as well as OT models. Some 68% of the survey respondents supported this idea. According to

them, OTs' goal is to help clients develop or regain capabilities to achieve maximal function, or compensate for loss of function.

In *Women and Human Development*, Nussbaum noted that the list of CHFCs is “a list of capabilities or opportunities for functioning, rather than of actual functions; in part it is because the list protects spaces for people to pursue other functions that they value” (Nussbaum, 2000, p.74). Like Sen, Nussbaum distinguished between capability and functioning (p.14). Nussbaum noted “with the right educational and material support”, all human beings should be able to engage fully in the CHFCs (p.83). Nussbaum stated for protecting pluralism, capability rather than functioning is “the appropriate political goal” (Nussbaum, 2000, p.87; Nussbaum, 2006, p.97). Nussbaum asserted that we have to respect individuals' choices, in other word, we have to give them the chance or opportunity to make choices, and we cannot force them to functioning.

With regard to people with disabilities, Nussbaum raised the question of: “Is it just capability that should be promoted in each of these areas, or actual functioning?” She answered “with items such as political participation, religious functioning, and play, it seems obvious that it is the capability or opportunity to engage in such activities that is the appropriate social goal.” But in other areas things such as promote actual health, self-respect, and dignity itself actual functioning should be the appropriate aim of public policy (Nussbaum, 2006, pp.171-172).

In addition, Nussbaum assumed that children and individuals with mental health problems “functioning, rather than capability, will be an appropriate goal” (Nussbaum, 2006, 174). For those people, we have to promote “actual functioning (for example, in the areas of health, shelter, bodily integrity) rather than simply capability” (Nussbaum, 2000, p.90). Also, she mentioned that some of the capabilities are so important, so crucial to the development or maintenance of all the others, that we are sometimes justified in promoting functioning rather than simply capability” (p.91).

Therefore, as health professionals, OTs must enable people with disabilities to function in a fully human way. The participants of this research reported that the main goal of both the CHFCs and occupational therapy practice is to achieve maximal function.

Many participants in Phase One of this study asserted that the CHFCs are interrelated, and there is overlap among the ten capabilities. This claim was supported by 66% of the survey participants. They noted that all are interlinked, and they are interconnected and impact on each individual. For example, they asserted that there is overlap between the first and the second

capabilities (Life and Bodily Health), and between the fourth and the fifth (Sense, Imagination, and Thought, and Emotions) capabilities. Although Nussbaum stated that:

The list is, emphatically, a list of separate components. We cannot satisfy the need for one of them by giving a larger amount of another one. All are of central importance and all are distinct in quality. The irreducible plurality of the list limits the trade-offs that it will be reasonable to make, and thus limits the applicability of quantitative cost benefit analysis (Nussbaum, 2000, p. 81).

For Nussbaum, “a list of separate components” does not mean that they are not overlapping in some aspects, but she stressed that there is no priority of one over others. For example, she mentioned that “Reproductive health is related in many complex ways to practical reason and bodily integrity”. This gives us still more reason to avoid promoting one at the expense of the others (p. 81).

Relevance of CHFCs to Occupational Therapy Practice

A number of participants of this study described the relevance of the CHFCs in relation to occupational therapy conceptual models, and approaches as well. Ten themes emerged from the analysis of the OTs’ perspectives on the relevance of the ten CHFCs to occupational therapy practice in Phase One. The survey participants supported these themes in this order: a client-centered approach (95%), a human rights model (88%), a framework for health and wellness (86%), an advocacy approach (84%), the Canadian Model of Occupational Performance (80%), a social justice model (78%), the Person Environment Occupation Model” (72%), the Human Occupational Model” (65%), Maslow’s hierarchy of needs (60%), a recovery philosophy (43%), and the International Classification of Functioning, Disability and Health (ICF) (42%).

Although this finding showed the relevance of the CHFCs to the models and approaches mentioned above, our general findings are more consistent with a client-centered approach, a human rights model, a framework for health and wellness, an advocacy approach and a social justice model.

5.3 Discussion of Findings in Relation to the Occupational Therapy Literature

To discuss the perceived relevance of the CHFCs to occupational therapy practices, we chose to examine these findings in relation to established models of and approaches to occupational

therapy practice. Thus, we discuss our findings in relation to occupational therapy literature as follows:

- CHFCs as a client-centered approach
- CHFCs as a human rights model
- CHFCs as a framework for health and well-being
- CHFCs as a social justice approach and advocacy perspective

5.3.1 CHFCs as a Client-centered Approach

For the majority of the participants in this study, the CHFCs are consistent with a client-centered approach (95%). The participants of our study mentioned many examples that indicated the consistency of CHFCs with a client-centered approach. For example, our findings revealed that Bodily Integrity Capability is relevant to occupational therapy practice as related to the client-centered approach (87%). This finding indicated that enhancing bodily integrity is important to occupational therapy practice in that it reflects the process of helping to establish what clients are able to do and what they want to do. Most survey participants (96%) confirmed that Practical Reason Capability is relevant to occupational therapy practice from a client-centered perspective. In Phase Two, 74% of the participants confirmed that Affiliation Capability is relevant to occupational therapy practice with respect to helping clients to identify their interests. For example, Participant 13 indicated that OTs are able to involve the clients in various social relations but this depends on what the person wants to do. The majority of participants (87%) of participants noted that Other Species Capability is relevant to occupational therapy practice from a client-centered perspective. Some participants of the study indicated that improving Other Species Capability depends on clients' interests. If Other Species Capability is something that is meaningful to the client, OTs will exploit this to help the client do what is meaningful to them (Participant 5).

Client-centered practice is “a commonly used term in occupational therapy and other health professions” (Restall, Ripat, & Stern, 2003, p. 104). Client-centered practice is described as “an approach to service which embraces a philosophy of respect for, and partnership with, people receiving services” (Law, Baptiste & Mills, 1995, p.253; Law, 1998, p. 3). The concept of client-centered practice has been fundamental to occupational therapy profession since the 1990s (Law,

1998; Sumsion, 1999). Based on the occupational therapy literature, client-centered practice is an enabling process and OTs have a role in enabling clients to choose and perform what they want to do. Clients know what they want from therapy as they are experts about their problems (McColl et al., 1997; Townsend, 1998; Sumsion, 1999). Similarly, the participants of this research noted that occupational therapy practice is focused on what clients want to do and how they achieve their goals in pursuit of a meaningful life. The participants of our study stressed that OTs could be involved in developing the ten CHFCs within their clients but it depends on what they want to do and what able to do. For example, Participant 5 mentioned that clients are “the driver’s seat; not us, they determine what they want” (P. 6).

Our findings showed that one way of conceptualizing client-centered practice is respecting clients’ preferences and decisions. For example, 97% of participants asserted that the Practical Reason Capability is about making personal decisions. Corring and Cook (1999) noted that “client involvement in decision-making and client empowerment is thought to be fundamental elements of this [client-centered] approach to practice” (p.71). Some participants of our study indicated that OTs respect clients’ autonomy and their decisions, and try to assist them in gaining insight into their lives with respect to what they want to do and are able to do. Law et al. (1995) stated, “there may be situations when a therapist is uncomfortable with the client’s choice, more because of a difference in values than the fact that the client is not competent to make that choice” (p. 252).

Some participants of this inquiry indicated that although OTs’ goals and values may be distinct from those of clients. The OTs’ goals need to match the clients’ goals; the clients’ preferences have priority in determining their goals. A few participants of our study asserted that OTs give clients specific information that enable them to make appropriate decisions that fit their situations rather than what may important for therapists.

Respondents of the study suggested that another way of promoting client-centered practice in occupational therapy is to provide educational and supportive strategies for both clients and their caregivers (87%). The participants of the study indicated that OTs use strategies that enable people to reach their goals and make decisions; for example, “OTs help them to figure out what their interests and goals are; enable them to reach their goals by helping to understand what the barriers are now, and help to find the possible ways to do what they want to do. But all depends on the person’s goals and values and ability are” (Participant 12, p. 9). Also, OTs help caregivers

to understand of “how they can engage in a new process through information and education from an occupational therapist and that way they’re able to promote more independence for their kid” (Participant 4, pp. 7-8).

The majority of participants asserted that OTs give opportunities and strategies to make decisions including simple choices, and that this is important for all clients seen by OTs even people with cognitive disability. The participants noted that OTs offer options and choices to clients in conjunction with work with them at their ability levels. It is similar to what Nussbaum asserted, “good care for a person with a mental impairment (including elderly people with dementia or Alzheimer’s) is individualized care” (Nussbaum, 2006, p. 170). Based on what the participants stated, OTs are considered as facilitators who create an environment to assist clients to achieve their goals, and promote their independence.

The participants of the study also indicated that there are barriers that impact one’s ability to exercise autonomy and planning with respect to one’s life. These include health conditions, socioeconomic factors, gender, power, culture, and age. For example, this study revealed that one of the challenges in client-centered practice is the power issue around who makes decisions. Some participants emphasized that family, caregivers, or people in authority have more power to make decisions for clients than they do. Thus, this power may disempower people with disabilities (Participant 7).

Implementing strategies to determine barriers is central to client-centered practice (Sumsion, 1999; Sumsion & Smyth, 2000; Wilkins et al., 2001; Restall, Ripat, & Stern 2003). It has been suggested the knowledge and skills of therapists are often inadequate to overcome the barriers to full client-centered practice; therefore they need to be empowered by ensuring they understand the meaning of client-centered philosophy (Wilkins et al., 2001). Sumsion and Smyth (2000) stated that therapists’ education can be considered a way to overcome the barriers to client-centered practice. The participants of the study noted that an understanding of the CHFCs may help OTs better understand client-centered philosophy.

Sumsion (1999) asserted, “the application of a client-centered approach is not simple” (p. 4). There is no clear definition and there are no guidelines for client-centered practice (Gage, 1994; McColl & Pranger, 1994; Sumsion, 1999; Stewart, 2001). Our findings indicated that the CHFCs could address a range of issues that would enable OTs to better understand client-centered

practice. The participants of this study asserted that the CHFCs can apply to both theory and practice by providing a framework that facilitates the implementation of client-centered practice.

A client-centered approach applies across areas of occupational therapy practice (Hobson, 1996; Sumsion, 1999; Stewart, 2001). Similar to client-centered practice, this research findings revealed that the CHFCs apply across areas of occupational therapy practice, from pediatrics, adults with physical and mental health issues, and across settings, including inpatient and outpatient care. Based on the study participants' views, the CHFCs can apply to clients in various setting including hospitals and facilities in the community.

The occupational therapy literature also indicated that the client-centered approach reflects other philosophies and approaches. Sumsion (1999) asserted that the client-centered approach "can readily be combined with other approaches to practice or other models" (p. 11). For example, the Canadian Model of Occupational Performance is considered a client-centered approach because a person is located at its center (Law et al., 1997, p. 33). Similar to a client-centered approach, this inquiry indicated that the CHFCs are consistent with a variety of occupational therapy models, such as the Canadian Model of Occupational Performance (80%), the Person Environment Occupation Model (72%), and the Human Occupational Model (65%), or, other models of client-centered practice such as Maslow's hierarchy of needs (60%).

Finally, according to the participants' perspectives, the CHFCs could be a useful framework for client-centered occupational therapy practice as these capabilities impact a client's life in relevant and important ways, that link his or her care to functioning and participating effectively in society.

I think it's a great frame work though and good to recognize that all these things make a huge impact on someone's life, so in that sense OT should all be cognizant and recognize that these are all in play for everyone, and that the individual might be having difficulty with one or two of the areas, knowing to at least address it and refer on if needed (Participants 9, p. 8).

5.3.2 CHFCs as a Human Rights Model

For many of the participants in this study, CHFCs are about basic human rights (88%). We observed many examples that showed the relationship between the CHFCs and basic human rights and needs. The majority of participants asserted that people with disabilities are more likely to experience failure to achieve these capabilities as basic needs and rights. From the

participants' perspectives, people with disabilities are more vulnerable to physical violence and sexual abuse. For example, participant 2 who works with mental illness noted that these people are more likely to be treated different than others, and that they are several times more prone to violence against them. Some participants stressed that many women and children with mental health issues have sexual assault, child abuse, and domestic violence in their backgrounds. People with mental illness likely have less capability of bodily integrity and cannot move freely from place to place, so they are losing their rights as citizens. The participants suggested that basic human rights include both citizenship rights and basic needs. Basic rights refer to the concept of citizenship, that is, being able to participate in the political, social, and economic parts of your society. It is about equality such as the right to seek employment on an equal base with others. It also includes basic needs. Some participants asserted that OTs need to ensure that people in vulnerable positions have access to resources to meet their basic needs. Our findings showed that the majority of OTs noted the CHFCs as being associated with both "rights" and "needs". The idea of basic human rights and needs originates from the Universal Declaration of Human Rights that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or lack of livelihood in circumstances beyond his control" (Article 25(1)). Basic rights include the right to life with disregard for race, sex, and nationality. Basic needs "are the fundamental requirements sustaining healthy development, survival, and the inherent value of human beings, or the tools necessary to achieve full personal growth" (Braid, 2006). Basic needs include food, water, clothing, housing, healthcare services, and necessary social services. As discussed earlier, our findings support that human rights can be seen as claims to certain basic capabilities (Sen, 1999, 2005; Nussbaum, 2000, 2006). Therefore, the CHFCs have a close relationship to human rights, and the language of capabilities helps us to better understand the concept of rights, and "what the goal is" (Nussbaum, 2006). For example, Nussbaum (2006) stated that

One way of thinking about the capabilities list is to think of it as embodied in a list of constitutional guarantees, in something analogous to the Fundamental Rights section of the Indian Constitution or the (shorter) Bill of Rights of the U.S. Constitution (p. 155).

There is debate about human rights in occupational therapy practice particularly in the context of occupational rights (Wilcock and Townsend 2000; Kronenberg & Pollard, 2005; Pollard, Alsop & Kronenberg, 2005; Townsend & Wilcock, 2004; Galvin, Wilding, & Whiteford, 2011). Townsend & Wilcock (2004) defined occupational rights “to experience meaning and enrichment in one’s occupations; to participate in a range of occupations for health and social inclusion; to make choices and share decision-making power in daily life; and to receive equal privileges for diverse participation in occupations” (p. 80). Wilcock (2006) noted that occupational rights can be considered as basic needs. She asserted that human beings as occupational beings need and want to engage in doing, being, and becoming (Wilcock, 1998, 2006).

The literature emphasizes that OTs need to consider human rights issues in their practices (World Federation of Occupational therapists, 2006; Wilcock, 2006; Galvin, Wilding and Whiteford, 2011). A recent study conducted by Galvin, Wilding and Whiteford (2011) examined OTs’ understandings of human rights theory and occupational justice in their practice. They studied nine therapists from various practice areas. They reported that there are difficulties with respect to the practice of human rights within occupational therapy, and it is “not easy to apply”. They noted, “there is a gap between occupational therapists’ understandings and practice of human rights” (p. 379). They asserted that there is need to pay more attention to human right issues, and OTs need to engage theoretically and practically in this discussion. They believe that

A human rights framework may have great potential for helping occupational therapists to better see and address issues of enabling occupation and justice, not only at a population level, but also as part of their work with individual clients. To facilitate the translation of utopian ideals into practice reality, localised, contextualised discussions may prove to be most effective (pp. 383-384).

Wilcock (2006) noted that the occupational therapy profession can support the Universal Declaration of Human Rights through the concept of enabling occupation and occupational justice. Our findings showed OTs support the Universal Declaration of Human Rights through enhancing CHFCs in their clients. Hammell (2008) noted, “Occupational therapy could be the profession committed to attaining occupational rights and to enabling people to engage in meaningful occupations” (p. 63). The participants of this study asserted that OTs could improve the occupational rights of their clients through enabling people to achieve the CHFCs.

In contrast to the study by Galvin, Wilding and Whiteford (2011) that reported OTs work in relation to the basic needs of their clients rather than in recreational activities, our findings indicated that OTs view themselves as supporting the ten CHFCs in relation to recreational as well as basic needs.

According to our study participants' views, consideration of the applicability of the CHFCs in occupational therapy practice may reflect a greater sense of responsibility of OTs to their clients. Therefore, OTs are required to do a lot more than what they do currently (Participant 2, p. 3). Similarly, Galheigo's study (2011) noted "Addressing human rights issues brings forth ethical and political responsibilities for OTs and requires new epistemological and educational approaches" (p. 60).

Galheigo also noted "Addressing human rights requires new approaches to problems and new conceptual tools for occupational therapy and rehabilitation" (p. 64). We assume that CHFCs can be considered as a conceptual framework for addressing human rights as part of established occupational therapy practice. Finally, based on the majority of our participants' views, the CHFCs constitute another way to think about basic rights and needs. The CHFCs challenge OTs to consider occupational rights in the broad context of human rights.

I think it gives a little bit of fresh air or play to think about the things that we think about in a bit of a different way. I think if you're saying this is, these are the kind of rights of people, is this a rights-based thing, then I think we have a lot more work to do than we do currently. So, it may propel our profession to attend to some of these issues in a more deliberate way (Participant 2, p. 14).

5.3.3 CHFCs as a Framework for Health and Well-being

The participants of this study suggested that CHFCs is consistent with a framework for health and wellness (86%). They noted that health has a broader definition than physical health. The World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). A number of our participants asserted that health is a multi-dimensional construct that includes domains related to physical, emotional, social, and environmental factors. Our findings revealed two ways of addressing the CHFCs as a framework for health and well-being: "quality of life" (QoL), and "health promotion".

One way of presenting the CHFCs as a framework for health and well-being is related to

QoL. The construct of health and well-being is related to the construct of QoL (Guyatt, Feeny, & Patrick, 1993; Wilson & Cleary, 1995; Zikmund, 2003). Based on our findings, the CHFCs are related to QoL. For example, our findings showed that Life Capability is about basic QoL (90%). Or, Play Capability contributes to and preserves QoL (95%), and helps achieve a work/life balance (91%).

Quality of life has been defined by many thinkers and philosophers and widely used across disciplines and academic areas, e.g., healthcare, economics, and the social sciences (Cummins, 2005). There are varying views regarding the conceptualization and measurement of QoL across disciplines (Velde, 2001; Ruta, Camfield, & Donaldson, 2007; Cummins, 2005). Today, QoL is being given increasing attention in the rehabilitation sciences literature. The rehabilitation literature includes more than 100 definitions and models of QoL (Velde, 2001). Conceptualizing and assessing QoL have been documented extensively in the occupational therapy literature as well. *Willard & Spackman's Occupational Therapy* defined QoL as “Engagement in or creation of opportunities for occupation to whatever extent possible on a physical, social, cultural, emotional, symbolic, sexual or spiritual level” (Hopkins & Smith, 1993, p. 855). Quality of life is evaluated in part in occupational therapy practice through the evaluation of an individual’s meaningful activities. As cited: “Engaging in meaningful activities that lead to developing new skills and pleasurable interaction with the social and inanimate environment can be seen as leading to an enhanced QoL” (Hopkins & Smith, 1993, p. 422). As the literature indicated, occupational therapy programs increase the QoL of people with disabilities through engaging them in meaningful and purposeful activities, or creating opportunities for them to be or do whatever they wish.

According to some participants in this study, increasing and improving clients’ QoL is the main focus of occupational therapy practice. For some of our participants, QoL refers to “improving a life worth living” for people with disabilities. For them, OTs can help start building a life worth living through improving clients’ capabilities. In other words, OTs try to focus on enhancing CHFCs as the key to promote clients’ QoL.

Occupational therapists have been reported to augment QoL in various groups and settings, e.g., patients with stroke (Adkins, 1993; Gillen & Burkhardt, 1998; Mayo, Wood-Dauphine & Cote, 2000); elderly people through meaningful activities (Glass et al., 1999; Lennartsson, & Silberstein, 2001); and people with developmental disabilities (Lee et al., 2008); those with

intellectual disabilities (ID) (Cummins, 1991; Cummins, 2005), and families with children with disabilities (Lee et al., 2008). Comparable to the literature, our findings showed that improving QoL across areas of occupational therapy practice, including working with children with disabilities and their families, people with mental health issues, seniors, and palliative care and end of life care. For example, our finding indicated that OTs improve QoL for both clients and their caregivers by creating supportive environments:

Occupational therapists are involved in creating an environment that supports normal development and that also supports family interaction and promotes health for the family but also the baby, so we are part of that team that tries to, I'm not going to use the word normalize, because it's never going to be a normal environment, but tries to have an environment that is supportive of a healthy life, as much as possible. (Participant 10, p. 3)

Some participants of the study not only emphasized the OTs' role in improving the clients' QoL, but also their roles in enhancing their caregivers' QoL. This is similar to Nussbaum's claim about the necessity of supporting caregivers:

On the side of the caregiver, we have, once again, a wide range of concerns. Caregivers frequently lose out in all sorts of ways through bad arrangements. Their health suffers; their emotional equanimity is sorely compromised; they lose many other capabilities they otherwise would have had. A decent society cannot ensure that all caregivers actually have happy lives: but it can provide them with a threshold level of capability in each of the key areas. (Nussbaum, 2006, p. 170)

Quality of life is described in the occupational therapy literature in relation to health related factors such as physical, functional, emotional and mental well being, and to non-health related elements such as jobs, family, friends, and other life circumstances (Gill & Feinstein, 1994; Velde, 2001). Similarly, based on the study participants' views, OTs promote their clients' QoL by considering both health and non-health factors. For example, as they mentioned, OTs contribute in increasing the clients' QoL through promoting health, preventing injury, implementing self management programs, increasing social participation and interaction, and providing a supportive environment.

The multidimensional construct concepts of QoL in the occupational therapy literature is consistent with Sen's conceptualization of QoL. From Sen's perspective, QoL refers to the freedom or real opportunities people have, to do what they want to do rather than what results in the best consequences (Sen, 1985, Nussbaum, 2000, Nussbaum, 2006). Sen argued that QoL and

well-being is best understood in terms of capabilities (Gasper, 2002; Clark, 2005). Accordingly, the greater a person's capabilities, then the greater is his or her well-being (Clark, 2005).

Some participants noted that another way of integrating the CHFCs into occupational therapy practice is in relation to health promotion. The first International Conference on Health Promotion held in Ottawa in 1986, presented a charter for promoting health for all. In the Ottawa Charter, health promotion is defined as:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (WHO, 1986)

The Ottawa Charter (WHO 1986) advocated that health experts advocate for health overall, and enable people to promote their health and well-being. According to Seymour (1999), occupational therapy has an important contribution to health promotion. Finlayson and Edwards (1992) considered OTs as facilitators who link individuals and their environments in an enabling process through either advocacy or the sharing of skills and information (Dyck, 1993). Our findings showed that OTs have roles in promoting health and preventing diseases through an enabling process to improve individuals' ability to manage their own health and advocate for themselves. Scaffa, Van Slyke, and Brownson (2008) stated that there are three critical roles for OTs to contribute in health promotion and disease prevention: "to promote healthy lifestyles; to emphasize occupation as an essential element of health promotion strategies; and to provide interventions, not only with individuals but also with populations" (p. 696). Some participants of our study emphasized that OTs promote health through focusing on the CHFCs to create healthy lifestyles and changing lifestyles to prevent disease. They stressed the role of OTs in enhancing their clients' healthy lifestyles; for example, enhancing clients' Bodily Health Capability through addressing feeding issues in children with disabilities, addressing physical health for mental illness, and preventing disease for elderly.

The World Federation of Occupational Therapists states "Occupational therapy is as a profession concerned with promoting health and well being through engagement in

occupation"(WFOT, 2010). Wilcock (2006) asserted that OTs promote health and prevent disease and disability for all people through focusing on purposeful and meaningful occupations. Some participants of this research noted that OTs promote healthy lifestyle through maximizing the CHFCs of their clients.

The literature identified some barriers to promoting health in occupational therapy practice. For example, Seymour (1999), who surveyed 100 OTs in Wales, reported that restrictions such as the pressure of work, funding, and resources contribute to health promotion not being considered occupational therapy's first priority. Similar barriers were reported by Flannery and Barry (2003), who surveyed 240 members of the Association of Occupational Therapists of Ireland about their perceptions of health promotion. In addition, they found other barriers included staffing levels, lack of resources, and lack of knowledge and training. Our findings indicated that although improving health is important to OTs, managing workload priorities can be challenging.

Finally, based on some participants' views, Nussbaum's CHFCs help OTs consider more health determinants and the environmental context in their practices. For them, the CHFCs are essential for individuals' well-being. As for a health practitioner who works with vulnerable populations, as they mentioned, it is important to consider them in relation to health and functioning.

...I think it would probably be a good thing for all of us, from whatever area of life we are in to reflect on, and too see if, for ourselves personally if, what we think about, how this is playing out in our own lives, but because we're in a health care system, we certainly do need, and we have some positions of authority, power with people who are very vulnerable, then we need to be keeping capabilities like this in mind as we go through and make our decisions that affect their life, very dramatically at times.
(Participant 12, p. 1)

5.3.4 CHFCs as a Social Justice Approach and Advocacy Perspective

The present study indicated that the CHFCs are relevant to occupational therapy practice from the perspective of social justice (78%) and an advocacy perspective (84%). We observed various examples showing the relationship between the CHFCs and social justice and advocacy perspectives. For example, our study participants reported that the Bodily Integrity Capability is relevant to occupational therapy practice as related to social justice (89%); Bodily Integrity Capability is relevant to occupational therapy practice as related to an advocacy perspective

(85%); Bodily Integrity Capability is relevant to occupational therapy practice as related to referring clients to resources (83%); Emotions Capability is relevant to occupational therapy practice in relation to finding support systems (89%); Affiliation Capability is relevant to occupational therapy practice with respect to advocating for their clients (92%); and the Control over One's Environment Capability is relevant to occupational therapy practice with respect to advocating for their clients (90%). These findings indicated that the Capabilities Approach is consistent with being a social justice approach as Nussbaum (2006) claimed:

The capabilities approach simply specifies some necessary conditions for a decently just society, in the form of a set of fundamental entitlements of all citizens. Failure to secure these to citizens is a particularly grave violation of basic justice, since these entitlements are held to be implicit in the very notions of human dignity and a life that is worthy of human dignity. (p. 155)

The debate on social justice is the largest tradition in political history. Literature indicated there are two major approaches regarding social justice: social contract, and social choice theory. The social contract approach concentrated on “perfectly just social arrangements” and “just institutions”. Enlightenment thinkers who made the major contributions of the social contract approach are Thomas Hobbes, John Locke, Jean-Jacques Rousseau, and Immanuel Kant. In contemporary political philosophy, the social contract approach has been the dominant influence on John Rawls and his idea of “justice as fairness” (Sen, 2009, p.xvi). In *A Theory of Justice* (1972), Rawls outlines two principles of justice; the priority of equality and fair opportunity for all citizens. In *Political Liberalism* (1993), Rawls claims that in a pluralistic liberal society, the public conception of justice is a moral conception that considers citizens as free and equal persons. Rawls noted that right and just institutions can guarantee the priority of equality and fair opportunity for all citizens. Rawls defined justice “entirely in relation to perfectly just institutions” (Sen, 2009, p. 8).

In contrast, social choice theory concentrated on “a variety of approaches that shared a common interest in making comparisons between different ways in which people's lives may be led, influenced by institutions but also by people's actual behavior, social interactions and other significant determinants”. Major contributions to social choice theory have been made by other Enlightenment philosophers including Smith, Condorcet, Wollstonecraft, Bentham, Marx, and John Stuart Mill (Sen, 2009). Sen (2009) stated that there is no agreement about the nature of the ‘just society’. He noted that social contract theory has “far-reaching implications”. So, Sen stated

that there is “the need to focus on actual realizations and accomplishments, rather than only on the establishment of what are identified as the right institutions and rules” (p. 10). Sen stressed for understanding justice, it is important to understand ‘the kind of lives that people can actually lead’, their actual behavior; in other words, human lives and experiences. He writes: “The need for an accomplishment-based understanding of justice is linked with the argument that justice cannot be indifferent to the lives that people can actually live.” (p. 18). For Sen, the Capability or Capabilities Approach is linked to social choice theory.

In recent years, along with other professionals, OTs have demonstrated an interest in the social justice discussion. In 1993, Elizabeth Townsend noted, “The profession promotes social justice through practical approaches that enable people to develop their occupational potential” (Townsend, 1993, p. 176).

The concept of social justice is reflected in the term ‘occupational justice’ in the occupational therapy literature (Christiansen & Townsend, 2003; Townsend & Wilcock, 2004; Wilcock & Townsend, 2000, Braveman and Suarez-Balcazar 2009). Occupational justice is better understood in terms of occupational alienation, occupational apartheid occupational deprivation, occupational marginalization, and occupational rights in the occupational therapy literature (Kronenberg et al., 2005; Kronenberg & Pollard, 2006; Townsend & Wilcock, 2004; Whalley-Hammel, 2008; Whiteford, 2000; Wilcock & Townsend, 2000; Zeldenryk & Yalmambirra, 2006). Wilcock and Townsend (2000) employed the term occupational justice to refer to the "equitable opportunity and resources to enable people's engagement in meaningful occupations" (p. 85).

From some of our participants’ perspectives, occupational justice can be considered as the opportunity to achieve the CHFCs. They indicated that OTs have major roles in advocating for their clients’ CHFCs, and enabling clients to achieve them. As discussed earlier, according to them, OTs advocate for their clients through building their skills and developing their CHFCs; supporting families to advocate for their dependents, through the organizational bureaucracy, e.g., to identify efficient ways of accessing services and resources for their clients. Finally, as the participants noted, the CHFCs can be considered as a framework for understanding occupational justice and they contribute to the occupational deprivation literature described in the next section.

5.4 Discussion of the Finding in Relation to the Occupational Science Literature

To discuss the perceived relevance of the CHFCs to occupational therapy practices, we chose to discuss our finding in relation to the occupational science literature as well.

This study revealed that occupation can be conceptualized in light of the Capabilities Approach. From this perspective, occupation can be seen as opportunities to realize basic capabilities or as entitlements to capabilities. Accordingly, occupation may be operationalized as the opportunity to achieve or extend the CHFCs.

The understanding of occupation has been facilitated by the contribution of multiple disciplines from psychology, sociology, geography and economics, to leisure science, public health and occupational therapy (Yerxa et al., 1990). Occupation has become an inclusive term such that it has relevance to health and healthcare including activities of daily living (Yerxa et al., 1990; Zemke & Clark, 1996; Hinojosa & Kramer, 1997; Law, Polatajko, Baptiste, & Townsend, 1997); goal-directed activities (Christiansen, Baum, & Bass-Haugen, 2005); and activities or situations in which “people engage to fulfill their time and give life meaning” such as avocations and vocations (Hinojosa & Kramer, 1997, p. 865). Occupation can also be viewed in relation to other constructs. For example, social ecologist, Brian Little (1983), developed the personal projects approach (Christiansen, Little, & Backman, 1998; Christiansen, Backman, Little, & Nguyen, 1999). Based on this approach, activities are understood as a way to link “motives or needs to specific goal-directed behaviors” (Christiansen, Little, & Backman, 1998, p. 439). Occupation can also be viewed from the perspective of activity theory rooted in the work of Marx, Vygotsky, and Leont'ev (Engestrom, 2000; Shanahan, 2009, 2010). Based on this theory, activities are considered in relation to subject, object, actions, and operations (Shanahan, 2010). “In activity theory, the distinction between short-lived goal-directed action and durable, object-oriented activity is of central importance” (Engestrom, 2000, p. 960). These various unique and overlapping perspectives are useful in further exploration of the construct of occupation.

Occupation can also be characterized and described through the framework of person-centered, context-centered, and person/context-centered perspectives. Based on these perspectives, several additional theories and models can be used to augment our understanding of occupation.

The Person-centered Framework of Occupation

The person-centered framework of occupation consists of four components including physical-biomedical (Stewart, 2003), emotional-psychological (Krupa, 2003), spiritual (Urbanowski & Vargo, 1994; Christianson, 1997; McColl, 2000), and cognitive-neurological (Doubt, 2003). Identifying and labelling these person-centered components of occupation facilitates broader discussion and supports the need for contributions from various disciplines.

The physical-biomedical component of the person focuses on functional movement related to occupational engagement and applies mechanical principles to effect physical movement (Pedretti & Early, 2001). This dimension is best evaluated by such metrics as joint range of motion, capacity for motion, strength, stability, control, and endurance that are needed during meaningful tasks and activities (Dutton, 1995, 1998; Pedretti & Early, 2001; Kielhofner, 2004; Stewart, 2003). With cardiopulmonary, musculoskeletal, neurological, endocrine and immune dysfunction, the physical-biomedical dimension of occupation is disrupted (*Hinojosa, Kramer, & Nuse, 1996; Dutton, 1998*). Remediation of physical-biomedical impairment is the basis of most medical and rehabilitation practices.

Theories, models, and approaches based on the emotional-psychological component of the person concentrate on meaningful engagement in occupation as “the key to creating a healthy body and mind” (Schwartz, 2003, p. 8). This dimension focuses on the therapeutic, valued and creative nature of a person’s occupations. Engaging in pleasurable, meaningful, employment-related or educational occupations is thought to support the physical body, nurture the mind, and influence “a new life upon recovery” (Barton, 1920, p. 307, cited in Schwartz, 2003). Conversely, occupations that erode these occupational attributes can erode a person’s self-esteem and self-worth (Hochschild, 1983; Grandey, 2000; Brotheridge & Lee, 2002; Grandey, 2003).

Various approaches have been used to address the emotional-psychological dimension of the person. For example, behavioral therapy is used to improve self-awareness, self-expression, and self-esteem (*Jodrell & Sanson-Fisher, 1975; Stein, 1982; Duncombe, 1988*); learning theory and approaches may be implemented to improve functional skills (*Maslen, 1982; Mosey, 1986; Nickel, 1988; Early, 1996; Cronin, 1996; Neistadt & Crepeau, 1998*); a psycho-educational approach to build understanding and skills to facilitate self-management (Barlow, Turner, Wright, 2000; Lorig et al., 1999); and a motivational approach to mitigate deficits related to

emotional health that affect behavior and occupational engagement (Sharrott & Cooper-Fraps, 1986; Schwammle, 1996).

The spiritual component of the person and its relationship to occupation is integral. Spirituality has been defined as the experience of meaning and purpose in daily activities and all aspects of life (Urbanowski and Vargo, 1994; Christianson, 1997; McColl, 2000; CAOT, 1991) is now a core construct within the Canadian Model of Occupational Performance (Wilson, 2010; Barry & Gibbens, 2011; CAOT, 1997). Approaches addressing the spiritual component focus on the individual's religious and spiritual beliefs systems and ways of being (Christiansen, 1997; Howard & Howard, 1997; Engquist et al., 1997; McColl, 2003).

Engaging in meaningful activities can serve as a vehicle for a person to express and nurture spiritual needs (Egan & De Laat, 1994; McColl, 2000; Tse et al., 2005; Bassett et al., 2008; Feeney & Toth-Cohen 2008; Barry & Gibbens, 2011). McColl (2000) proposed that spirituality provides meaning to activities, and meaningful activities can promote spirituality. In turn, religious and spiritual beliefs may influence occupational choices and level of engagement.

The cognitive-neurological component of the person has become better understood with the growing body of knowledge in the neurosciences (Doubt, 2003). Approaches to address deficits of the cognitive-neurological component focus on perceptual, sensorimotor, executive function and neurodevelopmental skills that use purposeful activities to achieve functional outcomes (Bruce & Borg, 1993; Dickerson, 1992; Pedretti & Early, 2001; Doubt, 2003). The most recognized approaches and theories include Bobath and Brunnstrom techniques, sensory integration approach, proprioceptive neuromuscular facilitation; and strategies that have emerged from research in motor control theory and motor learning theory (Doubt, 2003). These approaches focus on the person from the perspective of his or her cognitive, perceptual, and neurological abilities and focus on occupation and related tasks throughout the remediation process (Doubt, 2003).

The person-centered framework of occupation situates the issues, problems and successes within the individual. This approach attributes the extent of occupational engagement or challenges to it, to the person. There are advantages and disadvantages that underlie the person-centered framework of occupation. Advantages include ease of problem identification related directly to the person, and treatment strategies and outcomes that focus on individual issues. The disadvantages include its inherent narrow focus and lack of inclusion of a range of determinants

of occupational engagement. In the person-centered approach, occupation is described as an individual responsibility, thus relinquishing society's responsibility and minimizing the role of social, political and economic influences exerted through policy and enacted by law, social norms and social programs. Finally, potential social-environmental barriers to occupational engagement such as discrimination are not reflected in this approach.

Context-centered Framework of Occupation

The context-centered framework of occupation includes cultural and environmental influences. Given the breadth of these influences, this framework reflects perspectives from a rich diversity of disciplines (McColl, 2003; *Bonder et al., 2004*).

To embrace culturally diverse influences scholars have argued that the construct of occupation needs to be “culturally relative (Darnell, 2002; Whiteford, 2000), ...a form of colonization (McKinley, 2002), ... a communitarian necessity (Townsend & Christiansen, 2004), ... the basis of civil society (Thibeault, 2002) and ... an economic concern (Wilcock, 2001)” (cited in Whiteford, 2005). Culture constitutes people's identity and influences occupation, health, and well-being (Bonder, Martin, & Miracle, 2004). Coupled with globalization, there are increasing requirements to recognize and understand cultural variations (Dickie, 2004). Awareness of cultural influences with respect to the construct of occupation assists in achieving an appreciation and tolerance for occupational variations and choices among people.

The environmental influences that affect occupation and its engagement include physical, social, economic and political (Law, 2003). The impact of the environment may constitute the most important determinant that fosters or limits occupational engagement of an individual or a group of individuals (Law et al., 1996, p. 155).

Awareness of the environmental influences of occupation by healthcare workers can help them adapt an individual's environment to improve occupational performance. The environmental influences determining occupational engagement locate “the source of occupational performance problems entirely outside of the person” (Law, 2003, p. 177).

The person-centered and context-centered frameworks of occupation are limited in that they assume a dichotomy of influences that impact occupational engagement. More likely, occupational engagement reflects individual influences interfacing with factors associated with

his or her unique context. An approach that embraces each of these components and offers insights into the optimal interventions to foster engagement and limit deprivation is required.

Person/Context-centered Framework of Occupation

A person/context-centered framework of occupation is reflected in models in occupational science and occupational therapy including the Model of Human Occupation (MOHO) (Kielhofner, 1995), the Occupational Adaptation Model (Schkade & Schultz, 1998), and the framework based on the Ecology of Human Performance (EHP) (Dunn, McClain, Brown, & Youngstrom, 1998).

According to the MOHO, occupational engagement is a complex interaction between multiple personal and environmental factors and describes occupational behavior, motivation and patterns, occupational dysfunction, occupational engagement, and the effect of environment on occupation (Kielhofner & Barrett, 1998, p. 527). This model describes three subsystems, “the volition subsystem (personal causation, values, and interests), the habituation subsystem (habits and roles), and the performance subsystem (the skills of the mind, brain, and body working together)” and posits that engagement in occupation takes place in the environment that provides information and feedback on these subsystems in order to create an individual’s capability and performance (Pedretti & Early, 2001, p. 9).

The Occupational Adaptation Model defined adaptation as “an interaction between the person and occupational environments (consisting of work, play and leisure, and self-maintenance functions) in response to occupational challenges” (Schkade & Schultz, 1998, p. 530).

The basis of the Ecology of Human Performance model rests on the “ecology, or the interaction between a person and the context, affects human behavior and task performance” (Dunn, McClain, Brown, & Youngstrom, 1998, p. 531). Based on this model, changing the person, the context, the task, or the relationship between these influences will cause a change (improvement or deterioration) in performance.

Our findings showed that the Capabilities Approach can incorporate the person and context in relation to the multi-dimensional nature of occupation. As discussed earlier, the idea of “capability” refers to “the opportunity to achieve valuable combinations of human functionings, [that is] what a person is able to do or be” (Sen, 1992, 1999, 2004, 2005; Nussbaum, 2000, 2006). Similar to capability, occupation can be understood in terms of opportunities to achieve valuable functions, or what a person is able to do or be.

Our findings revealed that the CHFCs can be considered could be a useful framework for understanding the construct of occupation and the tenets of occupation could be useful in implementing the Capabilities Approach. Accordingly, occupation may be operationalized as the opportunity to achieve or extend these ten capabilities. The implications for framing the Capabilities Approach to the constructs of occupation are presented on Table 5.1.

Based on our findings, the CHFCs encompass both the person and contextual aspects of occupation. These capabilities can be characterized as person-centered and person/context-centered. Person-centered capabilities include those capabilities that focus on person-centered aspect of occupation such as Life; Bodily Health; Senses, Imagination and Thought; and, Practical Reason. Person/context-centered capabilities are those capabilities that focus on both person-centered and context-centered aspects of occupation such as Bodily Integrity; Emotions; Affiliation; Other species; Play; and, Control over One's Environment.

Accordingly, occupation can be considered as an opportunity to improve or extend person-centered capabilities. In other words, occupation can be used to achieve the capability of improving QoL, having a healthy life expectancy, promoting health and manage lifestyle, accessing an appropriate level of nourishment, employment, and housing, experiencing self-expressive and creative activities, planning one's life, making good choices, and using the idea of reflection to impact future choices.

Occupation can be considered an opportunity or a means to achieve or extend person/context-centered capabilities. This includes being able to move freely from place to place as citizens, to be secure against violation, assault, discrimination, and abuses, to express feelings, to have attachments to family and friends, to cope with stress and anxiety, to have meaningful relations and interactions, to improve communication skills, to have access to environments, to develop friendship, social interaction, and participation, to promote relation to animals, plants, and the world of nature, to have empathy for non-human beings, to improve spirituality, to engage in leisure and recreational activities, to choose who's governing you, to develop making decision skills and speak up for yourself, and to adapt the environment to be as independent as possible.

Our study showed that through the use of occupation, the tenets of the CHFCs can be operationalized. It is also imperative, however, to understand that the CHFCs shape occupational life and their deficiency contributes to occupational deprivation.

The construct of occupational deprivation has been discussed in the occupational science

literature for two decades. It refers to a state in which people are excluded from opportunities to engage in meaningful and purposeful occupations because of personal, cultural, social and political factors (Whiteford, 1997, 2000, 2005; Hocking, 2012).

Hocking (2012) asserted that occupational deprivation refers to “inequalities in people’s opportunities to participate in occupations that hold personal, social or cultural meaning” (p. 391). According to Wilcock (1998), deprivation not only results from personal restrictions, but from environmental social, cultural and political exclusions.

Within the occupational deprivation discourse, the need for theory development and practice-based research to examine the relevance of these ideas across disciplines is warranted (Whiteford, 2005, 2011). In the context of the Capabilities Approach, occupational deprivation may be alternatively or reinterpreted as arising from the relationship between a person and his or her environment. This relationship is not only affected by age, gender, and geography and culture, but also by lack of freedom and opportunity.

Based on our study, occupational deprivation can be conceptualized in terms of “capabilities deprivation”. Accordingly, occupational deprivation is not merely failure to achieve basic capabilities that result from personal and environment factors. In the light of the Capabilities Approach, actual occupational deprivation results from restricted freedoms or opportunities to achieve CHFCs.

To sum up, application of the Capabilities Approach to the construct of occupation could assist in developing a framework that supports the inclusion of the person as an occupational being participating in the micro to macro contexts of life. Applying the Capabilities Approach to the construct of occupation recognizes the equality of people in terms of their accessing occupational opportunities. The Capabilities Approach could provide a means of unifying the existing underlying constructs of occupation and related capabilities that are fundamental to occupational science. Occupational opportunities are then basic to the CHFCs and essential to informing social organization entrenched in political, legislative, and legal structures in society, globally.

5.5 Study Strengths and Limitations

The strengths of this study center on its novelty in that it has not been done previously. First this study explained the meaning, relevance and applicability of the CHFCs to the contemporary

practices of OTs. The findings could enable OTs better understand and consider their roles in maximizing the capabilities in a holistic manner, of people with disabilities. Also, our findings could be used to extend existing models of occupational therapy and occupational science with attention to overarching constructs of human right and social justice. Second, using mixed experimental methods to collect and analyze quantitative and qualitative data in a single study enhances the credibility of the research findings. Data triangulation and methods triangulation were used to collect data from two sources, interviews and survey, so that differences among the participants were balanced. Also, choosing an exploratory sequential mixed methods design for the study enabled the researcher to explore this new research topic in a novel manner and to determine rich textural meaning among a larger sample. Third, selecting a purposeful group of participants in Phase One helped to maximize the chance of acquiring a range of perspectives based on the participants' diverse experiences, educationally and professionally. Fourth, using thematic analysis and In Vivo coding allowed clear identification of prominent themes, and enabled the researcher to transform the qualitative data into quantitative data. Fifth, using a national survey in Phase Two strengthened the results from Phase One and allowed the researcher to understand the OTs' views nationally and benefit from multiple opinions. Sixth, selecting FluidSurveys® over other online surveys allowed for open- and closed-ended questionnaire items, and was flexibility, easy to use, and was secure. As well, this survey method enabled the researcher not only to send out personalized email invitations, but also send reminders to participants who failed to complete the survey. Seventh, the participants in Phase One and in Phase Two had experience working in diverse settings and areas of practice with various clients groups. The majority had over twenty years of experience as OTs. As they had a higher level of skills and knowledge, their views and thoughts were informed from a broader range of factors. And eighth, coherence of study themes was observed between Phase One and Phase Two of the study.

In addition to the limitations noted for each phases and the attempts to minimize these ,there were limitations for using a mixed methods design itself. First, this design may be a more complex research design than simply a qualitative or quantitative design, requiring the researcher to have experiences in both methods. Second, the mixed methods approach requires not only to engage in qualitative and quantitative research separately, but to combine the results of both phases. Sometimes the combining of results was challenging that is the comments of

participants in Phase One and the degree of agreement among the respondents in Phase Two.

The identification of these limitations provides support for the credibility and rigor of this study. In our view, the use of mixed methods helped to minimize these limitations and enhanced the quality of the research, and triangulating data from the two research methods and sources helped the researcher present the results more effectively.

5.6 Implications

5.6.1 Implications for Theory and Practice

In light of the research results and the discussion above, our findings have potential implications for occupational therapy practitioners, educators, and researchers. Participants in both phases in this study recognize the importance of CHFCs in occupational therapy practice. Our findings revealed that the CHFCs provide a broad perspective and encompass the range of settings of occupational therapy practice. For many participants in this study, the CHFCs encompass a range of occupational therapy practices.

For practitioners, this study suggests that OTs can improve and enhance the ten CHFCs when considering application to their clients. Occupational therapists will need to understand these capabilities as “a bare minimum of what respect for human dignity requires”, and consider them as all are important. They “cannot satisfy the need for one of them by giving a larger amount of another one” (Nussbaum, 2000, p.81). If OTs are educated about the CHFCs, they may better help clients to achieve their basic needs and rights while improving their functional capacities. The results of this research can be used to inform client-centered occupational therapy. Occupational therapists may use the CHFCs to guide occupational therapy assessment, intervention and outcome of client-centered practice. Further, they may apply them for practice of human rights and social justice in occupational therapy interventions. Finally, they may consider them as framework for health in their practices.

With regard to educators, the results of this study identify the knowledge areas used by these participants, thus providing topics for theoretical course on occupational therapy and occupational science, consistent with a client-centered approach. Our findings are also consistent with the broad picture and view subsumed in occupational therapy about what constitutes occupation, occupational rights, occupational justice, and occupational deprivation.

For the researchers, the findings of this study expanded our understanding about OTs' views on human rights and social justice issues. There is a call for research to address human rights and social justice in occupational therapy practice (World Federation of Occupational therapists, 2006; Wilcock, 2006; Galvin, Wilding and Whiteford, 2011). This dissertation was conducted in response to the gap identified in the research to advance human rights and social justice, and enhance client-centered practice. Our findings showed the CHFCs can be considered as a client-centered approach, a human rights model, a framework for health and well-being, and a social justice approach. Such a foundation could enable OTs to frame the science and practice of occupational therapy more broadly in relation to constructs that have garnered international priority.

For those outside the field of occupational therapy, this research provides a new perspective for health professionals in terms of their service delivery, which could help extend the applicability of the Capabilities Approach.

5.6.2 Implication for Policy Makers

Our emerging understanding of the CHFCs in occupational therapy practice informed by this study has implications for organizations with respect to health policy and may assist planners in their decision making. Policy makers and health professionals may benefit from an understanding of the CHFCs in order to develop and provide the services that best promote clients' rights and needs. Provincial and national associations also have a role to play in advocating for "individual care", raising awareness of the important contribution of occupational therapy in promoting the clients' CHFCs. Although OTs can develop many interventions to increase their clients' CHFCs and provide opportunity for the clients to achieve what they want to do, there are barriers in occupational therapy services to including the CHFCs across settings. These include consumer expectations, OTs' workloads, and lack of guidelines about their integration into and use in practice and other domains of the profession. Participants frequently made reference to barriers, e.g., workload issues. For example Participant 12 mentioned that although improving the Bodily Health Capability is important to OTs, managing time and workload priorities may compete with this goal. "...but it's so very difficult, just because the workload is high everywhere" (Participant 12, p. 2). Or, Participant 9 mentioned workload issues may contribute to OTs paying less attention to the Play Capability: "In adults, we often don't

have time for it, just that things are so busy and there are so many people to see” (p. 7). Finally, the findings of this research support the need for change in health care policy to allow OTs to facilitate these capabilities that are fundamental to social justice and human rights, as well as being common to many of the aims of occupational therapy practice.

5.6.3 Implication for Further Research

This study has highlighted the importance of considering CHFCs in the design, planning and delivery of occupational therapy services. Although this study established that the CHFCs are fundamentally aligned with the role of OTs, how they may be translated into basic assessment and intervention warrants development.

While this study purposely did not seek analysis of the skills and knowledge necessary for integrating the premise and values of the CHFCs into occupational therapy practice, the findings do offer some insight. Occupational therapy clinical practice guidelines need to be operationalized across settings and areas of practice and client groups.

For example, Participant 4 said that “I work with children, and so I would have to reframe it towards a model with kids and so I think some of these aspects perhaps might hold a bit more weight for adults, but I think as an expression of a family value perhaps some of the more adult, because we work with the family and the child, not just the child.” (p. 1) Or, Participant 1 asserted, “In mental health a lot of these things I think are very relevant, as I am saying, it might be important also to talk to people who are working in physical rehab, because in mental health, this is very much a big part of what we’re doing.” (p. 3).

In addition, future research needs to explore CHFCs from the points of view of clients and their families. Research such as participatory action research need to be done to create new forms of knowledge through a range of understandings and experiences of those involved in various parts of the research process, and combining ‘research, education, and action’ to empower people with disabilities (De Koning & Martin, 1996; Kemmis & McTaggart, 2000; Liamputtong & Ezzy, 2005).

Research is also needed to elucidate the degree to which the values embedded within the CHFCs are inherent within the theory and practice of occupational science and occupational therapy. Such research would help establish how the Capabilities Approach might extend the values and tenets of existing models of occupational therapy and occupational science with

attention to human right and social justice.

5.7 Further Insights

This study provides insights in terms of what the basic capabilities are and how OTs can enhance their clients' capabilities. It provides a new conceptual framework for practitioners and researchers to pay more attention to their clients' urgent needs and rights, rather than simply focusing on their medical ones.

While similarities are seen between Nussbaum's definitions of the CHFCs and the participants' understandings, there are some differences. First, OTs not only understood CHFCs as basic human needs and rights, but as basic health needs. This study shows that the concept of health is central to OTs' perspectives. Second, although "Practical Reason" and "Affiliation" capabilities was highlighted in Nussbaum as key capabilities, our participants highlighted "Sense, Imagination, and Thought", "Emotions", and "Play" capabilities.

This study also provides insights in terms of the applicability of CHFCs in both occupational therapy theory and practice. Also, the role of OTs in enhancing these capabilities through: building basic skills, and developing social skills; helping clients identify their interests and needs; advocating for their clients, and empowering them; assisting clients access resources; giving clients necessary tools; providing educational and supportive strategies; and, identifying barriers, and adapting their environments

Finally, while this study provides insights into the relevance of the CHFCs to occupational therapy practice, these insights could be further examined in terms of how can be these capabilities assessed? Or, what are the best model for practice to address these capabilities?

5.8 Concluding Thoughts

This study contributes to the literature in that an exploration of Nussbaum's Capabilities Approach has helped explain the meaning, relevance and applicability of the CHFCs to the contemporary practices of OTs; establish the perceived importance of expanding the basic capabilities of people with disabilities for promoting their basic rights; constitute a basis for debate and discussion within the occupationally-related disciplines and health professions; and contribute to the advancement of occupational therapy and occupational science models with the potential for enriching them. The findings will help OTs better understand and consider their

roles in promoting the capabilities of people with disabilities by providing an overarching framework. According to some participants, OTs have a broad professional role and contribute to many health services areas. The CHFCs may be a useful tool to augment occupational therapy outcomes.

I think OTs have a much broader role and could contribute in a lot of areas, but because they haven't traditionally been in those areas, it's difficult to make in roles, and unless there are models for them to consider, it's difficult for them to conceptualize what it is that they could contribute (Participant 12, p. 13).

Finally, considering the applicability of the CHFCs to their practices, OTs may discover they have an even greater professional responsibility to their clients than they presently believe they do.

[CHFCs] are relevant to anybody who's providing care for people with disabilities, and OTs being one of those people, certainly have a responsibility to provide services for people in these areas, if people are to have a good life (Participant 2, p. 3).

5.9 Table

Table 5.1 Central Human Functional Capabilities: Determinants and Implications in Relation to Occupation

| Central Human Functional Capabilities | Determinants | Implication in Relation to Occupation |
|---------------------------------------|--|--|
| Life | Biomedical-physical | Opportunity, through occupation, to extend capability of living a normal life expectancy, and improving quality of life. |
| Bodily Health | Biomedical-physical | Opportunity to engage in occupational possibilities to enhance health, to manage lifestyle, to access to appropriate level of housing, employment, and feeding and nourishment. |
| Bodily Integrity | Biomedical-physical | Opportunity to achieve capability and occupational justice of being able to access the environments, and to be consider as active members of society. |
| Senses, Imagination, and Thought | Emotional-psychological, spiritual, and cognitive-neurological | Opportunity, though the use of occupation, to achieve capability of being able to experience self-expressive and creative activities. |
| Emotions | Emotional-psychological, cultural, and environmental | Opportunity to achieve capability of being able to express the feelings, to have attachments to family, and friends, to cope with stress and anxiety, to have meaningful relations and interactions, and to improve communication skills through, in and for meaningful occupational engagement. |
| Practical Reason | Emotional-psychological, spiritual, and cognitive-neurological | Opportunity to plan for one's own life and to make good choices related to meaningful and purposeful occupation. |
| Affiliation | Cultural, environmental | Opportunity to achieve capability of being able for friendship, social relations, and empathy, compassion for situations, and social interaction and participation. Opportunity to engage in work occupations with people in a mutually respectful way. |
| Other Species | Spiritual, cultural and environmental | Opportunity to promote relation to animals, plants, and the world of nature, to have empathy for non-human beings, to improve spirituality, and to perform tasks in living and working environments. |
| Play | Emotional-psychological, cultural, and environmental emotional-psychological, cultural, and environmental | Opportunity to achieve capability of being able to engage in leisure and recreational activities as part of one's occupational life. |
| Control over One's Environment | Cognitive-neurological, cultural, and environmental | Opportunity to achieve capability of being able to choose who's governing you, to speak up for yourself, to adapt the environment to be as independent as possible for participation in occupations. |

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APPENDICES

Appendix A: Description of the Occupational Therapy Profession

For clarification in this thesis, the term occupational therapy and occupational therapist and related scope of practice are based on established descriptions and definitions including the World Federation of Occupational Therapy (WFOT) and the Canadian Association of Occupational Therapists (CAOT).

The WFOT states that “Occupational therapy is a client-centered health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. Occupational therapists work with all age groups and in a wide range of physical and psychosocial areas. Places of employment may include hospitals, clinics, day and rehabilitation centers, home care programmes, special schools, industry and private enterprise. Many occupational therapists work in private practice and as educators and consultants” (WFOT, 2012).

Occupational therapy as defined by the CAOT is “the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life” (Townsend& Polatajko, 2007, p. 372). Specifically, the CAOT states that “Occupational therapists use a systematic approach based on evidence and professional reasoning to enable individuals, groups and communities to develop the means and opportunities to identify, engage in and improve their function in the occupations of life. The process involves assessment, intervention and evaluation of the client related to occupational performance in self-care, work, study, volunteerism and leisure. Occupational therapists may assume different roles such as advising on health risks in the workplace, safe driving for older adults, and programs to promote mental health for youth. Occupational therapists also perform functions as manager, researcher, program developer or educator in addition to the direct delivery of professional services. Occupational therapists are generally employed in community agencies, health care organizations such as hospitals, chronic care facilities, rehabilitation centres and clinics, schools; social agencies industry or are self-employed. Some occupational therapists specialize in working with a specific age group or disability such as arthritis, developmental coordination disorder, mental illness, or spinal cord injury. Occupational therapists are university-trained, regulated health professionals whose unique training enables them to understand not only the medical and physical limitations of a disability or injury, but also the psycho-social factors that affect an individual's ability to function independently. Their approach is based on research that proves that an individual's ability to engage in occupation increases health and well-being” (CAOT, 2012).

References

Canadian Association of Occupational Therapists. (2007). Profile of occupational therapy practice in Canada. Ottawa, ON: CAOT.

Canadian Association of Occupational Therapists (CAOT). (2012). Occupational therapy – Definition. Retrieved July 27, 2013 from, <http://www.caot.ca/default.asp?pageid=1344>

World Federation of Occupational Therapists (WFOT). (2012). Definition of Occupational Therapy. Retrieved July 27, 2013 from, <http://www.wfot.org/AboutUs/AboutOccupationalTherapy/DefinitionofOccupationalTherapy.aspx>

Appendix B: Interview Guide

Below are some of the main questions I would like to explore with you during our interview. Since this is simply a guide, additional questions or issues may arise during the interview, so if you have other comments, I would like to hear them.

Please read through these questions before the interview, to allow you some time for reflection on this topic. Because the relevance of the Capabilities Approach as a practice approach within the occupational therapy profession has not been previously addressed, there is no right and wrong answer. I am most interested in learning about your thoughts and views about the relevance and applicability of this approach in occupational therapy practice. I thank you in advance for sharing them your ideas and perspectives and look forward to speaking with you.

Part A- aim: To obtain demographic and clinical information

- 1) Tell me generally about your background?

Probes:

- Educational background
- Clients' group, age
- Professional experience
- Years experiences
- Role

Part B- aim: To obtain a general sense about the applicability of the Capabilities Approach to occupational therapy

- 2) Have you had hear about the Capabilities Approach before? Is it the first time? Is this new terminology for you?
- 3) What is your general sense about the applicability of the Capabilities Approach to occupational therapy, how it may be related to occupational therapy

Probes:

- Current occupational therapy philosophy
- Occupational therapy practice method
- Occupational therapy approach

Part C- aim: To explore the relevance of the ten capabilities of the Capabilities Approach within the professions of occupational therapy

For each capability (Please see Appendix):

- 4) What is your understanding of this capability based on this description?
- 5) Is this relevant to your practice? If yes, how? If not, why?
- 6) Is this relevant to total profession?
- 7) Can you give me an example?

Part D- Closing

These are all of the questions.

- 8) Do you have anything to add?
- 9) Is there anything I should have asked?
- 10) How did the interview feel for you?

Appendix C: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA



Department of Physical Therapy
Faculty of Medicine
Room 212, Friedman Building
2177 Wesbrook Mall
Vancouver, British Columbia V6T 1Z3
Phone:
Fax:
Web: www.physicaltherapy.med.ubc.ca

SUBJECT INFORMATION AND CONSENT FORM-Phase 1

STUDY TITLE: Disability and Human Rights: Exploration of the Capabilities Approach in Contemporary Occupational Therapy

Principal Investigator:

Elizabeth Dean, PhD, PT, Department of Physical Therapy
University of British Columbia, Canada

Co-Investigators:

Susan Forwell, PhD, OT, Department of Occupational Science and Occupational Therapy, UBC
Shafik Dharamsi, PhD, Department of Family Practice, UBC
Seyedeh Tahmineh Mousavi, PhD Student, University of British Columbia

1. INTRODUCTION

You are being invited to take part in this research study because we are interested in your understanding and opinions about the relevance of Nussbaum's Capabilities Approach based on human rights model to your professional practice (see Appendix).

2. YOUR PARTICIPATION IS VOLUNTARY

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done. If you wish to participate, you will be asked to sign this form. If you do not wish to participate, you do not have to provide any reason for your decision not to participate. Please take time to read the following information carefully before you decide.

3. WHO IS CONDUCTING THE STUDY?

This is a study which is part of a research degree for Ms. Seyedeh Tahmineh Mousavi who is a PhD student at the University of British Columbia.

4. BACKGROUND

The Capabilities Approach is an approach related to human rights which provides a basis for conceptualizing and framing the rights of people with disabilities. We are interested in understanding your perspectives about the relevance of Nussbaum's central human functional capabilities to your professional practice (see Appendix).

5. WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore your understanding and opinions about Nussbaum's central human capabilities so that we can establish whether the Capabilities Approach could be useful as a practice approach within the occupational therapy profession.

6. WHO CAN PARTICIPATE IN THE STUDY?

Occupational therapist practitioners, educators, faculty members, and administrators in British Columbia.

7. WHO SHOULD NOT PARTICIPATE IN THE STUDY?

Our study is restricted to occupational therapist practitioners, educators, faculty members and administrators in British Columbia.

8. WHAT DOES THE STUDY INVOLVE?

Overview of the Study

The study involves your volunteering to be interviewed by a researcher. You will be asked to participate in an one-hour semi-structured interview related to your understanding of the relevance of the ten key elements of the Capabilities Approach within the profession of occupational therapy. If you sign the consent form to participate in the study, please return it in the pre-stamped self-addressed envelope.

The principal investigator will contact you to arrange an interview time that is suitable for you.

If You Decide to Join This Study: Specific Procedures

If you agree to take part in this study, one individual interview of approximately 45 to 60 minutes will be conducted by Seyedeh Tahmineh Mousavi. During the interview you will be asked about your understanding of the ten key elements of the Capabilities Approach (See Appendix). Specifically, you will be asked about the relevance of these capabilities within the profession of occupational therapy. The interview will take place in person at a location that is convenient for you and at a mutually agreeable pre-scheduled time outside work hours.

With your permission, the interview will be audiotape recorded and later transcribed. You can ask for the tape recorder to be turned off at any time, or let the interviewer know that you do not wish to be recorded.

9. WHAT ARE MY RESPONSIBILITIES?

You have no responsibilities other than answering the questions within your level of comfort.

10. WHAT ARE THE POSSIBLE HARMS AND SIDE EFFECTS OF PARTICIPATING?

To the best of our knowledge, there are no foreseeable risks from participating in this study.

11. WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

While you may not directly benefit from taking part in this study, discussing your opinions and perceptions will allow you to reflect on your practice. We hope that the responses received from you can be used in the future to benefit people with disabilities.

12. WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. You may withdraw from this study at any time. If you choose to enter the study and then decide to withdraw at a later time, all data collected about you during your enrolment in the study will not be retained for analysis.

13. WHAT HAPPENS IF SOMETHING GOES WRONG?

This is a semi-structured interview so we do not anticipate any problems. To the best of our knowledge, there are no foreseeable risks from participating in this study. It is possible that some topics discussed may raise some issues that you are uncomfortable with but you need only answer questions or express your views when you wish to do so.

14. WHAT WILL THE STUDY COST ME?

There is no payment related to your participation in this research. Any parking expenses incurred while attending the interview will be reimbursed directly by the researcher.

15. WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Confidentiality will be respected. With your permission, the interviews will be audio-tape recorded and later transcribed. You will be identified with a pseudonym. All documents will be identified only by a code number. Any data records that are kept on a computer hard disk will be securely protected through a confidential password system. The only people who will have access to the tapes and transcripts will be the research team and the transcriptionist. To ensure confidentiality, the transcriber will be asked to also sign a confidentiality agreement. Although we may use some direct quotations from the interview in research papers and presentations, you will be given a pseudonym, and identifying information will never be used. After a 5-year period, data related to the study will be destroyed.

16. WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?

If you have any questions or desire further information about this study before or during participation, you can contact ...or ...at...

17. WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A SUBJECT DURING THE STUDY?

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, contact the Research Subject Information Line in the University of British Columbia Office Of Research Services by email at...or by phone at.....

18. AFTER THE STUDY IS FINISHED

We plan to publish the results. Please indicate if you would like a summary of our final results, and how we might best contact you with these:

I would like a summary of the results Thank you, no.

Contact information:

Please use the following contact information:

Email:

Mail Address:

19. SUBJECT CONSENT TO PARTICIPATE

Check List:

- *I have read and understood the subject information and consent form.*
- *I have had sufficient time to consider the information provided and to ask for advice if necessary.*
- *I have had the opportunity to ask questions and have had satisfactory responses to my questions.*
- *I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.*
- *I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without changing in any way the quality of care that I receive.*
- *I understand that I am not waiving any of my legal rights as a result of signing this consent form.*
- *I understand that there is no guarantee that this study will provide any benefits to me (if applicable).*
- *I have read this form and I freely consent to participate in this study.*
- *I have been told that I will receive a dated and signed copy of this form.*

SIGNATURES

Printed name of participant

Signature

Date

Printed name of principal investigator/
designated representative

Signature

Date

Appendix D: Analytic Memo

Revised Date: February 26, 2012

February 17, 2012

Critical Question: "Which coding methods are appropriate for my study?"

Reading "The coding manual for Qualitative Researchers" book by Johnny Saldana, gives me opportunity for reflection to answer this question. But before answer it, first, I have to ask myself "*Is the coding methods harmonizing with my study conceptual framework.*" The purpose of my study is to explore the views of occupational therapists about the elements of central human capabilities. This study approaches from the *interpretive paradigm*, which focuses on the understanding and perceptions of the participants (Creswell, 2003; Grbich, 1999). This paradigm enables me to understand the existence of multiple realities and views. So I use *descriptive codes* to describe participants' views in a word or short phrase.

The second question is "*Is the coding method relating or addressing my research question?* My research question is "*What are occupational therapists' understanding of "Central Human Functional Capabilities".* I think I need to employ more than one method to answer these questions. Therefore, the **First Cycle coding** of my study is as follow: (Saldana, J., The coding manual for Qualitative Researchers, pp.50-51)

1-Attribute coding is an appropriate for coding essential information about the demographic characteristic of my participants. example: age..gender (Male= 1, Female= 2)..

2-Magnitude coding helps me to use some information in form of Y=Yes/ N=No / M=Maybe/ ?= unknown or unclear/ POS= POSITIVE/ NEG=NEGATIVE/ NEU= NUTRAL/ MIX=MIXED

3-Structural Coding helps me to frame my data. for example one of my interview question is what's your understanding about "Life Capability", so structural code could be LIFE CAPABILITY. As well, this coding helps me to determine" frequencies on the basis of the number of individual participants who mention particular theme." (p.143)

4-Descriptive codes , I use this coding as sub- coding to summarize participants' views in a word or short phrase- for example: Participate M1 : "...Occupational therapists understand that to promote people's quality of life". So "QUALITY OF LIFE" can be considered a sub-coding under structural coding "Life Capability".

5- In Vivo coding refers to a word or short phrase from the actual language. Using this technique "help us to preserve participants' meanings of their views and actions in the coding itself" (Charmaz, 2006, p.55). In Vivo coding is "safe and secure coding" and enhances my understanding of participants' perspectives.

6- Process Coding. I use it for ongoing action/interaction..response to situations, or problems. (Corbin & Strauss, 2008, pp.96-97). For examples:

Participant 4 "I'm not sure about political participation, but area to participate in their decisions making, treatment decision making." MAKING DECISION

Participant 5" it is important to listen to clients." LISENING TO CLIENTS

7- Emotion Coding. I use it to label the participants' emotions and experiences. for examples:

Participant 5: "...I don't know..." UNCERTAINTY

Participant 6: "...OT is the best job in the world" EXCITING

8- Values Coding . I use it to reflect my participant's value, attitude, and beliefs.

9- Versus Coding. I use it as contrast ideas, for example:

Participant 3: " it relates to occupational therapy not physical therapy" OT VS. PT

10- Evaluation Coding . I use it to understand whether the participants make a positive (+) or negative (-) comment, recommendation (REC) tag. For examples:

-Positive Comment

Participant 2: “..I think the framework itself can push occupational therapy a little bit further”
+ CA: CAN BE “HELPFUL”

-Recommendation

Participant 3: “.. but there is not real guide to action. how do we apply it to services”
REC: GUIDE TO ACTION

I use these methods for my First Cycle coding to in-depth understanding of the participants’ views. Further, these coding methods offer me the opportunity for reflection on emerging themes.

March 15, 2012

Second Cycle Coding:

In my study, the Second Cycle Coding is an attempt “to grasp basic themes or issues in the data by absorbing them as a whole rather than by analyzing them line by line.” The purpose of my Second Cycle Coding is to develop a coherent synthesis of the data amount. So I have to answer to this question “*Is the coding methods leading I toward a new discoveries, insights, and connections about my participants’ thoughts*”. As my data analysis is thematic analysis, I found a valuable resource titled “Transforming Qualitative Information: Thematic Analysis and Code Development by Boyatzis, Sage Publications, 1998” to help me inductively develop themes. Based on Boyatzis’ book, my Second Cycle coding includes:

Stage I: Sampling and Design Issues: I select two samples of three occupational therapists work with mental health illnesses and occupational therapists work in pediatric. I use a compare-and-contrast process to extract observable differences between or among the samples.

Stage II: Developing Themes: I use the five steps to inductively develop themes: (a) reducing the raw information, (b) identifying themes within subsamples, (c) comparing themes across subsamples, (d) creating theme, and (e) determining the reliability of themes.

a: Reducing the Raw Information: I reduce the raw information to a manageable size. Major outlines are selected based on the 10 central human capabilities headings.

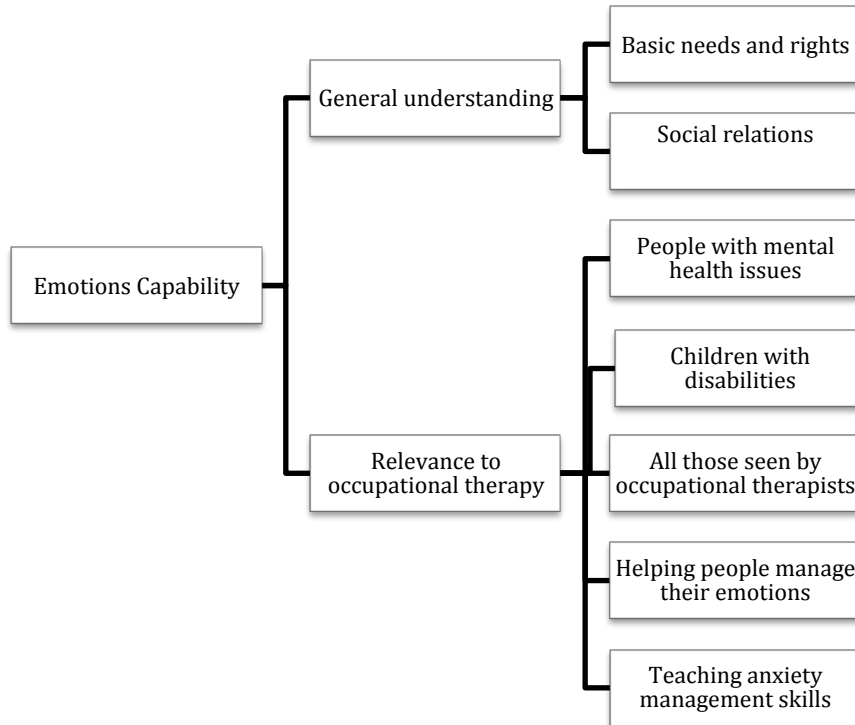
b: Identifying Theme : I carefully read the first cycle coding to identify emerging themes.

c: Comparing Theme across each sample: First, I examine the lists of themes and looks for themes from each list that may be related. They may appear as opposites or similar theme. Second, I begin to write and rewrite these potential differentiating themes. Then I return to each original transcript and read each carefully to see if each transcript include theme, making note of it in margin for later consideration as to its appropriateness.

d: Creating themes: The themes showing a distinction between occupational therapists in mental health (interviews 1,2,5) and occupational therapists in pediatric (interviews 3,4, 6) are then rewritten for maximum clarity. I will ask myself such questions as “Can I read any of the six samples and clearly see that this theme is present or absent? Is the theme presented with the fewest number of words or concepts possible? Have I reduced the number of theme as much as possible without losing meaning or confusing phenomena? If no clear differentiation appears in the responses to each question, it will be dropped from further analysis. I will present the themes with: a label, definition, description of indicators, description of exclusions, and examples.

e: Determining the reliability of themes: The final step is to determine *reliability* as a *percentage-based agreement* of the themes with the members of my supervisory committee.

Appendix E: The Thematic Map for the Emotions Capability



Appendix F: Example of How Themes within Subsamples Were Identified

Occupational therapists' General Views of Central Human Functional Capabilities (CHFCs)

| | OTs in Mental Health | | | OTs in Pediatrics | |
|---|--|--|--|---|--|
| Participant 1 | Participant 2 | Participant 5 | Participant 3 | Participant 4 | Participant 6 |
| 1) CHFCs reflect some occupational therapy approaches such as: | 1) CHFCs are important to OT in mental health | 1) CHFCs looks like: i- a human rights theory | 1) CHFCs fits well with OT | 1) CHFCs is interesting | 1) CHFCs considers actual health |
| i-Maslow's hierarchy of needs | 2) CHFCs looks more academic vs clinicians | ii-basic approach | i-having an individual's human rights fits well with OT | 2) CHFCs is relevant to OT | 2) OTs try to compensate for loss of function |
| ii-Human occupational Model | 3) Importance of life capability | iii-the person environment occupation model | | 3) CHFCs more relevant to adult | 3) Bodily health and bodily integrity relates to OT |
| iii-Canadian Model of Occupational Performance | 4) CHFCs model is applicable to OT as: | iv-the Canadian occupational performance model | 2) Familiar to OTs as: | i-more adopt with family values | 4) It is an interesting framework |
| iv-ICF | i- a framework for wellness | v-models in mental health | i- OT is a client centered practice | ii- the importance of CHFCs for caregivers | 5) Highlighting play as a key factor is very important |
| v-recovery philosophy | ii-a social justice model | vi-psychological models | ii-OT is function-based activities | | i-Play is much more complex than the way analysis in <i>Canadian Model of Occupational Performance</i> |
| 2) Familiar to OTs | iii-relates to COPM | vii-basic human rights model | | 4) CHFCs are more related to OT in mental health | 6) CHFCs are important to OT in mental health |
| 3) Play is a common example in both CHFCs and OT philosophy | iv-as aspects of the health determination | viii-the person environment occupation model | | | 7)CHFCs are as basic needs |
| 4) Relevant to OT as OTs try to: | v-as the context of environment | ix-a basic theory of human function and interaction | | | |
| i-understand clients' interests | vi-as basic needs and freedoms | 2) Uncertainty about how CHFCs might apply to practice | | | |
| ii-facilitate what they want to do | vii-very related to recovery (approach) | | | | |
| 5) Not new concepts to OTs as we currently work on them in mental health | viii-related in mental health | 3) CHFCs are more related in mental health | | | |
| 6)CHFCs framework is interesting | ix- CHFCs are kind of rights of people | | | | |
| 7) CHFCs is important | 5) CHFCs has a lot of potentially for OT | | | | |
| 8) Do not have a guide for action | i- propel OT profession forward | | | | |
| 8) CHFCs more make sense in advocacy and community practice | 6) More applicable for outpatients clients rather than acute clients | | | | |
| 9) Concern about how apply CHFCs to OTs' services | 7) Function is the main aim between OT approaches and models, and CHFCs | | | | |
| | 8) CHFCs gives you a broad perspective CHFCs bear more responsibility | | | | |
| | 9) CHFCs are relevant | | | | |
| | 10) CHFCs are helpful | | | | |

Appendix G: Online Survey

Exploration of the Capabilities Approach in Contemporary Occupational Therapy

Thank you for taking the time to complete this survey which should take about 20 minutes to complete. Its purpose is to understand the applicability of a human rights perspective, specifically Nussbaum's Capabilities Approach, to the practice of occupational therapy. The survey is based on preliminary work with 14 Occupational therapists and the issues they identified regarding the ten "Central Human Functional Capabilities" described in the Capabilities Approach. We very much appreciate your time and attention to completing this survey and contributing to this aspect of our practice. Your responses will help us evaluate the relevance of the Capabilities Approach to the practice of occupational therapy, and its potential applicability. THANK YOU.

SECTION 1: VIEWS AND OPINIONS

Please indicate the degree to which you agree or disagree with the statements within the ten key elements of the Capabilities Approach as related to the profession of occupational therapy and its current practices.

i. Life Capability: "Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living." Based on this definition, indicate your views and opinions in relation to the following items...

1- Life Capability is about...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| basic human rights | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| quality of life | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| longevity | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

2- Life Capability is relevant to occupational therapy practice as related to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| quality of life | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| working with people with mental health issues | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| working with seniors | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| acute care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| palliative care and end of life care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

Comments, thoughts:

ii. Bodily Health Capability: "Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter." Based on this definition, indicate your views and opinions in relation to the following items...

3- Bodily Health Capability is...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a basic human right | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| about health promotion | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| interconnected with the Life Capability | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

4- Bodily Health Capability is relevant to occupational therapy practice as related to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| promoting health and preventing diseases | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| feeding and/or eating | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| addressing physical health for those with mental illness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| advocating for adequate shelter and basic nutrition | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| addressing reproductive health | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

Comments, thoughts:

iii. Bodily Integrity Capability: "Being able to move freely from place to place; having one's bodily boundaries treated as sovereign, i.e. being able to be secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction." Based on this definition, indicate your views and opinions in relation to the following items...

5- Bodily Integrity Capability is about...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| basic human rights | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

6- Bodily Integrity Capability is relevant to occupational therapy practice as related to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|-------------------|----------|----------|-------|----------------|
|--|-------------------|----------|----------|-------|----------------|

- a client-centered approach ○ ○ ○ ○ ○
- a social justice perspective ○ ○ ○ ○ ○
- an advocacy perspective ○ ○ ○ ○ ○
- providing (emotional) trauma-
informed care ○ ○ ○ ○ ○
- addressing mobility issues ○ ○ ○ ○ ○
- referring clients to resources ○ ○ ○ ○ ○

Other, please specify...

Comments, thoughts:

iv. Senses, Imagination, and Thought Capability: "Being able to use the senses, to imagine, think, and reason – and to do these things in a “truly human” way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing self-expressive works and events of one’s own choice, religious, literary, musical, and so forth. Being able to use one’s mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to search for the ultimate meaning of life in one’s own way. Being able to have pleasurable experiences, and to avoid non-necessary pain." Based on this definition, indicate your views and opinions in relation to the following items..

7- Senses, Imagination, and Thought Capability is about...

- | | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|------------------------------------|-------------------|----------|----------|-------|----------------|
| expressing oneself in various ways | ○ | ○ | ○ | ○ | ○ |

Other, please specify...

8- Senses, Imagination, and Thought Capability is relevant to occupational therapy practice in relation to...

- | | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|----------------------------------|-------------------|----------|----------|-------|----------------|
| people with mental health issues | ○ | ○ | ○ | ○ | ○ |
| children with disabilities | ○ | ○ | ○ | ○ | ○ |
| self-expression | ○ | ○ | ○ | ○ | ○ |

Other, please specify...

Comments, thoughts:

v. **Emotions Capability:** "Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by overwhelming fear and anxiety, or by traumatic events of abuse or neglect." Based on this definition, indicate your views and opinions in relation to the following items...

9- Emotions Capability is about...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| basic needs and rights | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

10- Emotions Capability is relevant to occupational therapy practice with respect to the following populations...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| people with mental health issues | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| children with disabilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| all those seen by Occupational therapists | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

11- Emotions Capability is relevant to occupational therapy practice in relation to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------------------|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| finding support systems | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| helping people manage their emotions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| teaching anxiety management skills | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

Comments, thoughts:

vi. **Practical Reason Capability:** "Being able to form a conception of the good and to engage in critical reflection about the planning of one's life." Based on this definition, indicate your views and opinions in relation to the following items...

12- Practical Reason Capability is about...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---------------------------|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| making personal decisions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

13- Practical Reason Capability is relevant to occupational therapy practice...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| from a client-centered perspective | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| helping clients to make personal decisions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| providing educational and supportive strategies for caregivers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

Comments, thoughts:

vii. Affiliation Capability: "A. Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another and to have compassion for that situation: to have the capability for both justice and friendship. B. Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails, at a minimum, protections against discrimination on the basis of race, sex, sexual orientation, religion, caste, ethnicity, or national origin. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers." Based on this definition, indicate your views and opinions in relation to the following items...

14- Affiliation Capability is about...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| basic needs and rights | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| social relations | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

15- Affiliation Capability is relevant to occupational therapy practice with respect to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| helping clients to identify their interests | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| developing friendships and social network | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| advocating for their clients | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| developing social skills | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| working with clients with mental illness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... _____ | | | | |

Comments, thoughts:

viii. Other Species Capability: "Being able to live with concern for and in relation to animals, plants, and the world of nature." Based on this definition, indicate your views and opinions in relation to the following items...

16- Other Species Capability is about...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| people's relationship with the environment | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... | | | | |

17- Other Species Capability is relevant to occupational therapy practice...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| because relationship with animals affects health | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| because relationship with nature affects health | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| from a spirituality perspective | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| from a client-centered perspective | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| from an environmental perspective | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| not the main focus of occupational therapy practice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... | | | | |

Comments, thoughts:

ix. Play Capability: "Being able to laugh, to play, to enjoy recreational activities." Based on this definition, indicate your views and opinions in relation to the following items...

18- Play Capability...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------------|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| contributes to human happiness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| preserves quality of life | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| achieves a work/life balance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="checkbox"/> | Other, please specify... | | | | |

19- Play Capability is relevant to occupational therapy practice with respect to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| serving as a primary therapeutic approach in pediatric practice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| serving as a therapeutic approach when working with persons with mental health issues | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| its importance for everyone | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other, please specify... _____

Comments, thoughts:

x. Control over One's Environment Capability: "Political. Being to participate effectively in political choices that govern one's life; having the right political participation, protection of free speech and association. Material. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others, having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers." Based on this definition, indicate your views and opinions in relation to the following items with respect to...

20- Control over One's Environment Capability is...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| about decision making | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| a basic human right | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| about political opinions | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other, please specify... _____

21- Control over One's Environment Capability is relevant to occupational therapy practice with respect to...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| building skills | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| developing decision-making | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| helping clients gain and retain employment | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| advocating for their clients | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other, please specify... _____

Comments, thoughts:

YOUR overall views of the Central Human Functional Capabilities (1. Life; 2. Bodily health; 3. Bodily integrity; 4. Senses, imagination, thoughts; 5. Emotions; 6. Practical reason; 7. Affiliation; 8. Other species; 9. Play; 10. Control over one's environment.)

22- Which of the following reflect your general views about the 10 Central Human Functional Capabilities?

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| constitutes a new approach | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| encompasses a range of occupational therapy practices | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| is more theoretical than practical | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| is more related to mental health practice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| the construct of function is common to the "Central Human Functional Capabilities" as well as occupational therapy models | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| they overlap each other | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other, please specify...

23- Central Human Functional Capabilities is consistent with...

| | Strongly Disagree | Disagree | Not Sure | Agree | Strongly Agree |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| the Canadian Model of Occupational Performance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| the Human Occupational Model | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| the Person Environment Occupation Model | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| a client-centered approach | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| a recovery philosophy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| a framework for health and wellness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| a human rights model | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Maslow's hierarchy of needs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| a social justice model | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| an advocacy approach | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other, please specify...

Comments, thoughts:

SECTION 2: DEMOGRAPHIC INFORMATION

This section gathers general demographic information about your background and education.

24- Sex

- Female
- Male

25- Qualifying certification in occupational therapy

- Diploma
- Baccalaureate
- Master's
- Professional Master's
- Doctorate

26- Highest degree achieved

- Diploma
- Baccalaureate
- Master's
- Professional Master's
- Doctorate
- PhD

27- Place of graduation

- Canadian-educated
- Internationally-educated

28- Where do you work? Please check one:

- Alberta
- British Columbia
- Manitoba
- New Brunswick

- Newfoundland
- Labrador
- Nova Scotia
- Ontario
- Prince Edward Island
- Quebec
- Saskatchewan
- Northwest Territories
- Nunavut
- Yukon
- other

29- How many years have you been an occupational therapist?

- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- More than 30 years

30- Please indicate your type of employer (select all that apply)

- General Hospital
- Rehabilitation Hospital/Facility
- Mental Health Hospital/Facility
- Residential Care Facility
- Assisted Living Residence
- Community Health Center
- Group Professional Practice/Clinic
- Solo Professional Practice/Business
- Post-secondary Educational Institution

- School or School Board
- Association/Government/Para-Governmental
- Industry, Manufacturing and Commercial
- Consulative
- Other, please specify... _____

31- Please indicate your area(s) of practice (select all that apply)

- Mental Health
- Neurorehabilitation
- Musculoskeletal/Orthopedic
- Cardiovascular and Respiratory System
- General Physical Health
- Vocational Rehabilitation
- Palliative Care
- Health Promotion and Wellness
- Other Areas of Direct Service
- Service Administration
- Client Service Management
- Medical/Legal-Related Client Service Management
- Teaching
- Research
- Other, please specify... _____

32- Please indicate your position (select all that apply)

- Manager
- Professional Leader/Coordinator
- Direct Service Provider
- Educator
- Researcher
- Other, please specify... _____

33- Please indicate the clients with whom you work

- Children and Adolescents (0-18 years)
- Adult (19-64 years)
- Seniors (65 and older)
- Mixed
- None

Thank you for completing our survey!

Please indicate if you would like a summary of the results

- Yes
- No

Contact information:

Please use the following contact information: Email/ Mail Address:

Appendix H: Cover email

Dear...,

We are conducting a study that is looking at a framework regarding the human rights of persons with disabilities. An approach to conceptualizing a human rights perspective is called the Capabilities Approach. Described within the Capabilities Approach are 10 “central human functional capabilities”. These are:

1. Life: capability of physical survival
2. Bodily Health: capability to have good health
3. Bodily Integrity: capability to move freely from place to place
4. Senses, Imagination, and Thoughts: capability to use the senses, to imagine, to think
5. Emotions: capability to have attachments to things and persons outside ourselves
6. Practical Reason: capability to engage in critical reflection about the planning of one's life
7. Affiliation: capability to live with and show concern for others
8. Other Species: capability to live with, and have concern and connection for the world of nature and other species
9. Play: capability for being able to laugh, to play, and to enjoy leisure activities
10. Control over One's Environment: capability to exercise control over political environment and materials including land and goods ownership

We are most interested in your opinions and views about the applicability of these 10 central human functional capabilities *as they might be related to occupational therapy*. We invite you to complete the survey attached which will require between 20-30 minutes of your time. This survey is based on preliminary work with 14 Occupational therapists and the themes and issues they identified regarding these 10 central human functional capabilities. We appreciate the demands on your time, and your input is most important to the success of this work. In exchange, you will be eligible for a draw for a \$100 gift certificate.

Please find the link below. If you have any difficulty in opening it, please let us know at...anytime.

By clicking on the link below, I acknowledge I have read and fully understood the information above, and that I agree to participate in this survey. Please click on the link below to access the survey.

<http://fluidsurveys.com/surveys/tahereh/disability-and-human-rights-ii/>

Tahmineh Mousavi, PhD (Candidate), BSc (OT), University of British Columbia (UBC)
Dr. Elizabeth Dean, Department of Physical Therapy, UBC
Dr. Susan Forwell, Department of Occupational Science and Occupational Therapy, UBC
Dr. Shafik Dharamsi, Department of Family Practice, UBC

Appendix I: Participants' (n=14) Written Quotes about Life Capability

“Occupational therapists’ understandings of the Life Capability”

1. unable to answer due to lack of clarity around what normal is and lack of clarity around what would make life not worth living
2. OT is about quality of life in all aspects where function, independence and enjoyment has been compromised. It is interesting that mental health is at the top of the list but given our current practices, we often don't specifically address the mental health quality of life issues when working outside of a mental health service, however we know that mental health impacts on physical illness and recovery.
3. All individuals should be entitled to the highest level of care in order to achieve the highest quality of life possible regardless of all the criteria identified in the charter of human rights e.g. age, gender, illness/injury, etc.
4. Who determines when one's life is reduced to the point of not worth living and when? That point is of concern as it makes one think of the euthanasia argument.
5. Children with chronic health conditions such as cerebral palsy and spina bifida often live shortened lives. Life Capability is extremely relevant for this population.
6. I'm curious about the definition for...who judges "normal length", "prematurely", and "not worth living"?
7. Never heard of the term life capability prior to this survey
8. I am new to this model but it seems to me, according to the definition, that it has little to do with OT which is more about quality of life, however short or long.
9. I also think OT has to do with the potential for life capability in prevention of disability or occupational barriers due to environmental concerns (early learning), occupational barriers in adult life due to early barriers or lack of social opportunities for meaningful lifelong occupation
10. I have never heard the term "life capability". I only understand it with the definition attached and still it is difficult to apply context to.

“Relevance of the Life Capability to occupational therapy practice”

11. pediatrics, NICU (neonatal intensive care), oncology, etc
12. working with children with chronic health conditions
13. children
14. pediatrics/development, home care, long term care, chronic disease management

Appendix J: Participants' (n=9) Written Quotes about Bodily Health Capability

"Occupational therapists' understandings of the Bodily Health Capability"

1. it is not 100% clear what you mean by reproductive health, e.g., procreation?
2. addressing mental health issues for those with physical health problems

"Relevance of Bodily Health Capability to occupational therapy practice"

3. This thought need to be defined to include the individual choice to live at risk, ie. to have adequate shelter is often a choice. The definition of adequate shelter also has to be flexible.
4. I am uncomfortable with the conceptions of body and health described
5. What do they mean by bodily health, does that include mental health, neurology, ABI, developmental disability, recovery from physical trauma, car accidents, cancer, diabetes related amputations, etc? I am not fond of the definitions in the ten. They seem to be politically driven and I am not sure I want to fit OT into a system that does not quite fit. Why identify reproductive health to highlight more than endocrinological health for example as diabetes is an epidemic of greater proportions than infertility.
6. It seems this is further clarifying the previous Life Capability. My only concern is that disease and illness do occur and although prevention would be ideal, the treatment of all individuals regardless of health status to me is very important.
7. I find the inclusion of reproductive capability interesting...it reminds me of the isolation and sterilization used by the government of Canada (and other countries).
8. OT practice cannot encompass everything. I agree physical health for mentally ill, reproductive health and adequate shelter and nutrition are vital, but not at the top of the list of things an OT would advocate for - we do not have time. We barely have time for health promotion - we are not supported by administration for this - our resources are maxed by "putting out fires"
9. early prevention of disability or environmental effects of poverty, discrimination, lack of opportunity prevent individual bodily capability and ALSO cause a continued barrier within communities and generations.

Appendix K: Participants' (n=10) Written Quotes about Bodily Integrity Capability

"Occupational therapists' understandings of Bodily Integrity Capability"

1. respect for an individual's body
2. quality of life
3. I agree with the first part of the definition being about basic human rights, but I am not sure what it means about opportunities for sexual satisfaction and choice in matters of reproduction - I don't believe that abortion is a basic human right, for example, and I believe that sexual intimacy should be reserved for marriage, so I'm not sure how my beliefs fit with this definition.
4. accessibility

"Relevance of Bodily Health Capability to occupational therapy practice"

5. These labels and categories are too prescriptive for me to answer these question with any conviction
6. this relates to advocacy for universal access to services and healthcare to ensure that individuals can move physically from place to place (for example from province to province) and not to be disadvantaged by such movement
7. Again, I really don't like the definition here and find it a politically driven tool. I understand and respect the concept of bodily integrity being able to move about, however I would call that mobility. I believe that people should consent to treatment of any kind and should have choice. I believe there is a role in supporting victims of abuse and preventing abuse, but that is not a primary role for OT. I like the focus on capabilities, but I don't see this fitting. Have you reviewed the 10 Essential Capabilities for Mental Health Care Workers. That works well and is focused on health care.
8. OT may not have the expertise to provide trauma-informed care - would refer to another discipline with that expertise
9. The specifics of choice for reproduction places gender and sex within the definition.
10. In a holistic approach all these are.

Appendix L: Participants' (n=16) Written Quotes of Sense, Imagination, and Thought Capability

"Occupational therapists' understandings of Sense, Imagination, and Thought Capability"

1. "...but obviously it is much more than this egocentric definition you provide."
2. fulfilling occupational potential
3. It seems that it is not limited to expression but also perception
4. This defines humans from other creatures on earth, so is fundamental to our appreciation of previous rights.
5. "...client may be able to experience but not express."
6. according to the definition it is the right to expression not just expression

"Relevance of Sense, Imagination, and Thought Capability to occupational therapy practice"

7. adults with ABI, neurological impairment, people with physical health issues that impact on their senses, creativity and thought processes, dementia
8. people with physical issues
9. adults with disabilities could also be included in this list
10. I feel like I do not have enough information or understand enough about this category to make a selection
11. OT is already preoccupied with SELF-care, SELF expression and other Western constructs of the individual at the center of his/her universe. This is a very limited and limiting vision.
12. relevant to all populations --not sure if your questions mean only for these 3 populations (people with mh issues/children with disabilities/self expression?) or especially for these three categories
13. For OT this is a poor definition to tie to because it links 3 very distinct areas of practice and gives none of them proper attention: Sensory processing and regulation is a significant area of specialty for OT. Including senses, as defined above is not really about senses as OT describes and understands challenges related to senses. Again this is a political statement about access to education, freedom of speech, etc. This has all been said before and better in the Charter of Rights and Freedoms and other such political documents and well as the manifestos of political parties. Looking at the capabilities from an OT perspective, consider Senses: the capability to receive, interpret and utilize sensory information in order to function. Imagination is the ability to use creativity to find new and creative solutions to challenges and opportunities as they arise and thought capability is the ability to use the available cognitive resources with supports as necessary to create a good quality of life, in spite of damage due to accident, illness, injury or genetic changes.
14. Wow this whole thing is VERY theoretical & philosophical.
15. I am thinking this would relate also to adults with ABI or dementia who can experience in "one's own way"
16. Too large a definition, encompassing too many things - freedom of expression, sensory and cognitive abilities, right to education. I think this should be separated into different areas. Considering that a greater number of individuals identify themselves as non-religious or atheists, would this change the wording in your definition (i.e., religious exercise)?

Appendix M: Participants' (n=13) Written Quotes about Emotions Capability

"Occupational therapists' understanding of Emotions Capability"

1. it's a basic need but not sure if it's a right

"Relevance of Emotions Capability to occupational therapy practice"

2. Yes - but again, this is such a limited vision - what about giving to others, caring for others, being relied on by others.....?
3. not sure if this is OT practice, as there are other professionals with more training to address some of these issues - ie psychologists
4. response to physical illness, recovery
5. anxiety management skills would be only one possible intervention that would be used to facilitate health promotion and resilience
6. I seem to be on a theme here. I am concerned that the first on the list is attachment to things before attachment to people. There is also attachment to events, seasons, the environment etc. From an OT perspective we need appropriate, which means positive and also boundaried relationships with others, things, events, etc. I find it really disappointing that joy, happiness, fun, creativity and belong are not mentioned at all. It also assumes that people who have had trauma and or anxiety have emotionally blighted lives. For OT, I think it is important that we support people to experience a full range of emotions including silliness.
7. The idea of helping people "manage their emotions" is unclear to me. The word "manage" is slightly skewed in this context.
8. Additional OT Roles ~ Advocating at a policy level for prevention of harm (i.e., involved in child welfare from an occupational justice perspective); teaching children mindfulness as a self-awareness technique with to be in touch and accepting of their emotions and state
9. also related to assisting children with sensory processing difficulties
10. The list in #11 leaves out other types of work with mental health issues
11. teaching not only anxiety management skills, but other therapies like dialectical behavior therapy and chronic disease self-management.
12. Unfortunately, do not always have the time or expertise to teach anxiety management skills, except in a mental health setting
13. again, in a holistic practice all the Emotions Capability is interrelated to the client and client's support system or family and can't be separate whether a client is in acute care or long term mental illness in the community.

Appendix N: Participants' (n=9) Written Quotes about Practical Reason Capability

“Occupational therapists’ understandings of Practical Reason Capability”

1. understanding cognitive strengths and limitations
2. ensure that as clinicians they are reflective practitioners
3. capacity evaluations

“Relevance of Practical Reason Capability to occupational therapy practice”

4. Once again, I don't like the definition. "forming a concept of the good". I would prefer that it be about decision making. Sometimes a decision is not about good, it is about the lesser of two evils. I.e., do I take this cancer medication which will prolong life by two months with nasty side effects or do I die much sooner. Neither would be "the good". Abortion is a choice which is not about "the good" generally. OT does address executive function, or the ability to reason.
5. Engaging in critical reflection about the planning of one's life is a basic part of life and I'm not sure if it is relevant to occupational therapy practice. It is an entirely normal part of life and I'm not clear about the role of an occupational therapist in this context. Perhaps with head-injured clients this would be a significant role.
6. I have some difficulty with the word "good" and how that is defined or understood in a consistent way by all survey participants. helping clients to make personal decisions sounds like a professional boundary that could be crossed.
7. I perceive this as a skill rather than a basic human right, I also note that perhaps this is your opinion as you didn't ask that question?
8. This definition is not clear.
9. As long as the therapist is facilitating and not directing...

Appendix O: Participants' (n=12) Written Quotes about Affiliation Capability

“Occupational therapists’ understandings of Affiliation Capability”

1. occupational justice
2. I believe discrimination on the basis of economic status s one of the most obvious discriminations in our society today, and so should be included in your lists

“Relevance of Affiliation Capability to occupational therapy practice”

3. working with clients with physical disability, working with families from cultures that do not accept children with genetic or physical disabilities, working with people who will never be workers.
4. pediatrics
5. Within and OT realm this should likely include discrimination as a result of disability versus ability.
6. are you assuming capability is located within an individual or conferred? sorry, unable to respond
7. Definition issue again. I like the concept of affiliation but again the definition is a charter type of definition and is this time too narrow for OT. I think we need to go beyond minimum protections against a limited range of options, but rather tolerance and acceptance of the differences in people and that regardless of their affiliations they are all people. Generally in Canada we know enough not to discriminate against people due to color, race, etc. We need to go broader to look at discrimination based on weight, height, social strata, ability/disability, etc which for occupational therapists means a client cenetred approach. More simply, we are all entitled to have a friend and to have opportunities to be welcomed in work, school, neighborhoods, and communities of our choosing. I am not sure why work is separated out in the definition any more than other activities such as school, religious participation, participating in community center activities, etc.
8. social interactions are often times dependent upon physical accessibility to environments that allow for these interactions to flourish. I am not quite sure why the thinking or description has parceled out mental health as if it happens in isolation from physical health.
9. are the 2nd and fourth items as related to helping clients with these developmental tasks?
10. A and B should be separate issues. Two different constructs.
11. Parts A & B are quite different things - they should not be lumped together
12. if only we could all find such a supportive affiliation in occupation!

Appendix P: Participants' (n=15) Written Quotes about Other Species Capability

"Occupational therapists' understandings of Other Species Capability"

1. not just "relationship with" environment, but rather "relationship in harmony with" environment

"Relevance of Other Species Capability to occupational therapy practice"

2. I think this is not necessarily a growing area of practice, but rather a growing area of scholarship about occupation.
3. as before
4. Of course relationships with animals affects health, but this is not why this construct is relevant to OT.
5. It is a nice generic statement but it is not necessarily relevant to OT. For a client living on the 34th floor of an apartment with no pets or plants, who loves that urban lifestyle, that is a personal choice, to be respected.
6. also a medium for therapy
7. Not something that is usually addressed due to time constraints etc. With a client centered approach this could be a critical component of a person's wellbeing and enjoyment, and fulfillment of their life, and thus become a focus.
8. It may not be the main focus of OT, however our occupational relationship with other species can be integral to the client's role in the community/world, and impacts personal growth which impacts well-being.
9. If human relationships are important in the development of a sense of self, then so too are relationships to the environment, etc. in developing a fully engaged and interactive self within the environment that an individual exists.
10. - related to one narrow component of environment- re main focus of OT practice - depending on the client it may well be the main focus
11. While a client's relationship with the environment may not be the focus of occupational therapy, it may be an important component of strong programming by offering effective strategies and tools for a particular client (particularly one who is highly connected to animals, nature and the environment).
12. A lot of health is very unhealthy for some people
13. this is integral to the practice of occupational therapy and to human life
14. Although I agree this is not the main focus of practise, health indicators and advocacy for factors that underlie health (housing, nutrition, social/relationship stability and support) is a growing and important role for OT to become involved in on a professional basis and in the personal/political realm.
15. we need more relationships to the natural world in diverse ways.

Appendix Q: Participants' (n=9) Written Quotes about Play Capability

“Occupational therapists’ understandings of Play Capability”

1. I disagree that these last two points are true for everyone. This sounds very ethnocentric and prescriptive.
2. occupational justice

“Relevance of Play Capability to occupational therapy practice”

3. serving as a therapeutic approach in geriatrics, rehabilitation from accident, injury, illness
4. I believe this is of major importance for the geriatric population as well.
5. Interesting that you did not give us a choice about play in older adulthood
6. If therapy were more fun, there would be more compliance with recommendations. If one can have fun in spite of illness, etc. there is improved quality of life. A key issue for OT in any area of practice. It is not just about recreational activities though, it is about finding pleasure, excitement, pride, and joy in day to day activities as well.
7. Does this preserve or support quality of life?
8. This could be considered a basic human right.
9. recreational activity is that defined the same as leisure activity in this study

Appendix R: Participants' (n=10) Written Quotes of Control over One's Environment Capability

"Occupational therapists' understanding of Control over One's Environment Capability"

1. fundamental inclusion

"Relevance of control over One's Environment Capability to occupational therapy practice"

2. enabling people to form opinions, validating opinions, building confidence/self-esteem
3. advocating with clients/client groups
4. Building skills? I think this ought to be "building opportunities".
5. This one is not about OT at all really. It is a political statement about basic rights and freedoms. When I think of Control over one's environment I think of accessible work, school, leisure and housing. I think of assistive technologies and other supports.
6. WOW your definitions are long & convoluted
7. This definition should be explained or teased out more fully
8. Again the 3 parts are lumped together but are quite different and my answers would be different for each
9. not sure the definition is truly reflective of the title "One's Environment Capacity"
10. political environmental are tricky to work with to clients although awareness of the political influences would be a start for the client to understand their position in

Appendix S: Participants' (n=7) Written Quotes about the Central Human Functional Capabilities

“Occupational therapists’ understandings about the CHFCS”

1. Some of the thoughts fit with many OT frameworks but none of them fit with any one framework therefore I have answered the questions based on if the majority of thoughts match the framework

“Relevance of the CHFCS to occupational therapy practice”

2. Given the list of other possible frameworks that are useful, I am not sure of the value or relevance of this one. I do like the key topics, but feel that the definitions and content are politically driven, not health care driven. In some cases the understanding of terms even is not reflective of OT, (senses, for example). I like the capabilities approach though and would see benefit in having a capabilities model for OT.
3. your definitions were too convoluted to make sense of
4. The definitions are too abstract and/or multifocal, with no opportunity to separate them for discussion or application to specific cases.
5. Though this is a theoretical model, I think it just puts what we practice into words. It frames holistic practice.
6. I graduated in 1985 - never have been able to keep those theoretical models straight. I think OT is unique in looking at clients as a whole person within a complex system/environment and in being client-centered; trendy now, but I remember an OT instructor telling us in the 1980s the client was the most important person on the team
7. I think it is an interesting and comprehensive model worth exploring for OT application