Occupational Therapy in the Promotion of Health and Well-Being

The purpose of this statement is to describe occupational therapy’s contribution in the areas of health promotion and prevention. It is intended for internal and external audiences. The American Occupational Therapy Association (AOTA) supports and promotes involvement of occupational therapists and occupational therapy assistants in the development and provision of programs and services that promote health, well-being, and social participation of all people.

Health Promotion

It is important to frame the discussion of occupational therapy’s role in health promotion by first defining the term. The World Health Organization (WHO) provides the following definition in the Ottawa Charter for Health Promotion:

*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 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 lifestyles to well-being. (WHO, 1986, para. 2, italics added)

Trentham and Cockburn (2005) expand on this definition by stating that

*health promotion* is equally and essentially concerned with creating the conditions necessary for health at individual, structural, social, and environmental levels through an understanding of the determinants of health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, *social justice,* and equity. (p. 441, italics added)

Since 1980, the U.S. Department of Health and Human Services (HHS) has established health promotion and disease prevention objectives to facilitate and measure improvement in health (HHS, 1980, 1990, 2000, 2010). The vision of Healthy People 2020 is the realization of “a society in which all people live long, healthy lives” (HHS, 2010, p. 2). Healthy People 2020 has four major goals:

1. “Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.”
2. “Achieve health equity, eliminate disparities, and improve health of all groups.”
3. “Create social and physical environments that promote good health for all.”
4. “Promote quality of life, healthy development, and healthy behaviors across all life stages.” (p. 5)

Active engagement in life and overall health status and not just longevity is emphasized. From an individual perspective, a healthy life means the use of capacities and adaptations across the life span, allowing people to enter into satisfying relationships with others, to work, and to play. From a national

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1 Some italicized terms in this statement are defined in the glossary.
perspective, a healthy life means vital, creative, and productive citizens and residents contributing to flourishing communities and a thriving nation.

**Health Disparities**

It is important from a health promotion perspective to differentiate between the constructs of health and functional status. Many assessments of health status include items that measure function. As a result, these tools are negatively biased against persons with disabilities. It is possible to be physically and mentally healthy and have a high quality of life in spite of disability and functional limitations (Krahn, Fujiura, Drum, Cardinal, & Nosek, 2009). As noted earlier, one goal of Healthy People 2020 is to eliminate health disparities (HHS, 2010).

The term *health disparities* refers to population-specific differences in disease rates, health outcomes, and access to health care services. Addressing health disparities is consistent with the occupational therapy profession’s official document on nondiscrimination and inclusion, which states, “Inclusion requires that we ensure not only that everyone is treated fairly and equitably but also that all individuals have the same opportunities to participate in the naturally occurring activities of society” (AOTA, 2009b, p. 819).

Persons with disabilities may be the largest population experiencing health disparities. “The differences in health status between people with disabilities and without disabilities are increasingly recognized as preventable and therefore unacceptable” (Krahn, Putnam, Drum, & Powers, 2006, p. 18). Persons with disabilities are at risk for developing secondary conditions that are physical and mental as well as social health problems that are the direct or indirect consequence of the disability. The five most frequent secondary conditions identified in a study by Kinne, Patrick, and Doyle (2004) are (1) chronic muscle and joint pain, (2) sleep disturbances, (3) extreme fatigue, (4) weight or eating problems, and (5) depression.

The prevalence of these conditions was 2 to 3 times higher among adults with disabilities than among adults without disabilities. In addition, persons with disabilities often have higher rates of diabetes, obesity, anxiety, social isolation, and unemployment (Drum, Krahn, Culley, & Hammond, 2005) and less satisfaction with care within the health system (Krahn et al., 2006) than their able-bodied counterparts. Secondary conditions, many of which are preventable, are often considered the primary cause of health disparities for this population.

Health promotion programs and services may target individuals, communities, and populations as well as policymakers. The focus of these programs is to

- Prevent or reduce the incidence of illness or disease, accidents, and injuries in the population;
- Reduce health disparities among racial and ethnic minorities and other underserved populations;
- Enhance mental health, resiliency, and quality of life;
- Prevent secondary conditions and improve the overall health and well-being of people with chronic conditions or disabilities and their caregivers; and
- Promote healthy living practices, social participation, *occupational justice*, and healthy communities, with respect for cross-cultural issues and concerns.

**Prevention Strategies**

A key purpose of health promotion is improved well-being, quality of life, and social participation for individuals and populations. Health management and maintenance for persons with or without disabilities requires the implementation of prevention strategies. Prevention is generally categorized into three levels: (1) primary, (2) secondary, and (3) tertiary.

*Primary prevention* is defined as education or health promotion efforts designed to prevent the onset and reduce the incidence of unhealthy conditions, diseases, or injuries. Primary prevention attempts to identify, reduce, or eliminate risk factors for disease and injury. For persons with disabilities, primary
Prevention may include modifying the physical and social environment to address the special needs resulting from the disability. Strategies for improving nutrition; increasing physical activities; smoking cessation; weight management; and screening for heart disease, diabetes, and cancer are important for persons with disabilities as well as the general population.

Secondary prevention typically includes screening, early detection, and intervention after disease has occurred; it is designed to prevent or disrupt the disabling process. For persons with disabilities, secondary prevention involves limiting the development of secondary conditions and their subsequent impact on function and quality of life.

Tertiary prevention refers to services designed to prevent the progression of a condition. Tertiary prevention for persons with disabilities should also include strategies to promote equal opportunity, full participation, independent living, and economic self-sufficiency (Patrick, Richardson, Starks, Rose, & Kinne, 1997).

**Population Health Approach**

Population health focuses on aggregates, or communities of people, and the many factors that influence their health. A population health approach strives to identify and reduce health disparities as well as enhance the overall health and well-being of a population (Finlayson & Edwards, 1997). In addition to providing occupational therapy interventions for individuals, occupational therapy practitioners can develop and implement occupation-based population health approaches to enhance occupational performance and participation, quality of life, and occupational justice.

**Health Promotion and Occupation**

Healthy People 2020 and the Ottawa Chapter of Health Promotion parallel occupational therapy’s belief that engagement in meaningful occupations supports health and leads to a productive and satisfying life. Wilcock (2006) stated that

> Following an occupation-focused health promotion approach to well-being embraces a belief that the potential range of what people can do, be, and strive to become is the primary concern and that health is a by-product. A varied and full occupational lifestyle will coincidentally maintain and improve health and well-being if it enables people to be creative and adventurous physically, mentally, and socially. (p. 315)

According to Christiansen (1999), “Health enables people to pursue the tasks of everyday living that provide them with the life meaning necessary for their well-being” (p. 547). Well-being is a state of flourishing that consists of the following elements: positive emotion, engagement or flow, meaning (i.e., a sense of belonging to or serving something larger than oneself), positive relationships, and accomplishment or achievement (Seligman, 2011).

Occupational therapy services are provided to clients of all age groups, infants through older adults, from a variety of socioeconomic, cultural, and ethnic backgrounds, who possess or who are at risk for impairments, activity limitations, or participation restrictions. According to AOTA (2008), occupational therapy practitioners recognize that health is supported when individuals are able to engage in occupations and activities that allow them to achieve the desired outcome of participation in their chosen environments. The essence of occupational therapy is “supporting health and participation in life through engagement in occupation” (p. 626). This focus on engagement in occupation is interwoven through the delivery of service, beginning with evaluation and continuing through the intervention phase. Health management and maintenance are included within the domain of occupational therapy as an instrumental activity of daily living; health promotion and prevention are identified as occupational therapy

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When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).
intervention approaches; and health and wellness, quality of life, and occupational justice are potential outcomes of occupational therapy services (AOTA, 2008).

*Occupations* are purposeful and meaningful daily activities that fill a person’s time and are typically categorized as self-care, work, play or leisure, and rest (AOTA, 1995; Meyer, 1922). A natural, balanced pattern of occupations is believed to be health enhancing and fulfills both the needs of the individual and the demands of the environment (Kielhofner, 2004; Meyer, 1922). This belief has been supported in studies with well elderly individuals in urban communities (Clark et al., 1997, 2001, 2012).

By engaging clients in everyday occupations, occupational therapy practitioners promote physical and mental health and facilitate well-being for persons with and without disabilities. Occupational therapy practitioners promote positive mental health through competency enhancement strategies, such as skill development, environmental supports, and task adaptations, and they prevent mental illness through risk reduction strategies, such as establishing healthy habits and routines and providing training in relaxation and coping techniques (AOTA, 2010).

Occupational imbalance, deprivation, and alienation are risk factors for health problems in and of themselves. They may also result from or lead to the development of other risk factors, which can in turn result in larger health and social problems. Causes are varied (e.g., unanticipated caregiving responsibilities, losses in employment or housing) and can lead to occupational imbalance, deprivation, and alienation, which can then lead to individual health problems such as stress, sleep disturbance, and depression (Wilcock, 2006).

Belle et al. (2006) demonstrated that caregivers of people with dementia experienced significant improvement in quality of life and a decrease in depression after intervention that included stress management; strategies for engaging in pleasant events; and teaching of healthy behaviors, communication skills, and problem-solving skills regarding behavior management of care recipients’ difficult behaviors. Elliott, Burgio, and DeCoster (2010) similarly found that a caregiver intervention enhances health and decreases depression, resulting in a decrease in perceived burden. Occupational therapy practitioners are in a prime position to recognize the occupation and health problems inherent with caregiving and offer interventions such as those described in the cited research as well as additional interventions from an occupation lens, such as task analysis and modification to minimize the physical and emotional stresses of caregiving.

**Role of Occupational Therapy in Health Promotion**

Occupational therapy practitioners have three critical roles in health promotion and prevention:

1. To promote healthy lifestyles;
2. To emphasize occupation as an essential element of health promotion strategies; and
3. To provide interventions, not only with individuals but also with populations.

It is important that occupational therapy practitioners promote a healthy lifestyle for all individuals and their families, including people with physical, mental, or cognitive impairments. An occupation-focused approach to prevention of illness and disability has been defined by Wilcock (2006) as

> the application of medical, behavioral, social, and occupational science to prevent physiological, psychological, social, and occupational illness; accidents; and disability; and to prolong quality of life for all people through advocacy and mediation and through occupation-focused programs aimed at enabling people to do, be, and become according to their natural health needs. (p. 282, italics added)

The roles of occupational therapy practitioners in evaluation and intervention in health promotion practice are based on the *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2009a). Occupational therapy practitioners possess the basic knowledge and skills to carry out health promotion interventions to prevent injury and maximize well-being. However, this area of practice is very broad, and practitioners need to continually expand their knowledge in health promotion to be effective and competent members of the team.
While recognizing the unique role of occupational therapy in health promotion and prevention, it is also important to acknowledge and respect the contributions of other health care professions in this arena. Occupational therapy practitioners should operate within their scope of practice and training and partner with other health promotion disciplines with specialized expertise such as in the areas of public health, health education, nutrition, and exercise science.

As in all other areas of practice, health promotion services should be based on the best available evidence. Law, Steinwender, and LeClair (1998) conducted an extensive review of the literature on the relationship between occupation and health. The longitudinal studies that were reviewed found that activity participation had a significant effect on perceived health. Maintenance of everyday activities, social interactions, and community mobility influenced self-reported quality of life.

A long-term benefit attributable to preventive occupational therapy was shown by Clark et al. (2001) when they reevaluated participants from the Well Elderly Study and found that 90% of therapeutic gain observed after intervention was retained at the 6-month follow-up. The Well Elderly Study was replicated through the Well Elderly Trial 2 with participants from a wider array of economic and ethnic backgrounds. Occupational therapy health promotion was once again found to be a cost-effective method to enhance health and well-being among older adults in an urban context (Clark et al., 2012).

**Interventions With Individuals**

The following are examples of occupation-based primary prevention intervention that target individuals:

- Musculoskeletal injury prevention and management programs;
- Anger management and conflict resolution training for parents, teachers, and school-aged youth to reduce the incidence of bullying and other violence;
- Parenting skills training to enhance family health and decrease potential for abuse;
- Fall prevention programs for community-dwelling seniors; and
- Ensuring health literacy for non–English-speaking populations.

Examples of secondary prevention carried out by occupational therapy practitioners may include:

- Education and training regarding eating habits, activity levels, and prevention of secondary disability subsequent to obesity;
- Education and training on stress management and adaptive coping strategies to enhance resilience for persons with mood disorders and posttraumatic stress disorder; and
- Osteoporosis prevention and management classes for individuals recently diagnosed with or at high risk for this condition.

Examples of occupation-based tertiary prevention intervention may include:

- Transitional or independent-living skills training for people who have mental illness and those with cognitive impairments;
- Leisure participation groups for older adults with dementia to prevent depression, enhance socialization, and improve quality of life;
- Social participation activities at a drop-in center for adults with severe mental illness; and
- Stroke support groups for survivors and caregivers.

Occupational therapy practitioners have an opportunity to complement existing health promotion efforts by adding the contribution of occupation to programs developed by experts in health education, nutrition, exercise, and so forth. For example, when working with a person with a lower extremity amputation due to diabetes, the occupational therapy practitioner may focus on the occupation of meal
preparation using foods and preparation methods recommended in the nutritionist’s health promotion program. This focus enables achievement of the occupational therapy goal of functional independence in the kitchen and reinforces the importance of proper nutrition for the prevention of further disability (Scaffa, 2001).

**Interventions With Populations**

To be effective, health promotion efforts cannot focus only on intervention at the individual level. Because of the inextricable and reciprocal links between people and their environments, larger groups, organizations, communities, and populations may also benefit from occupational therapy intervention (AOTA, 2008; Law, 1991; Wilcock, 2006).

Examples of interventions through the intermediary of organizations include:

- Consultation to businesses to promote well-being of workers through identification of problems and solutions for balance among work, leisure, and family life;
- Consultation to schools regarding implementation of Americans With Disabilities Act of 1990 (ADA; Pub. L. 101–336) requirements;
- Education for day care staff regarding normal growth and development, handling behavior problems, and identifying children at risk for developmental delays; and
- Promotion of ergonomically correct workstations in schools and offices.

Community or population-level interventions may include:

- Consulting with the local transportation authority regarding accessible public transportation;
- Consulting with contractors, architects, and city planners regarding accessibility and universal design;
- Implementing a community-wide screening program for depression at nursing homes, assisted living facilities, and senior centers for the purpose of developing group and individual prevention and intervention programs;
- Conducting needs assessments and implementing intervention strategies to reduce health disparities in communities with high rates of disease or injury, such as lifestyle management programs addressing hypertension, diabetes, and obesity;
- Addressing the health and occupation needs of the homeless population by eliminating barriers and enhancing opportunities for occupational engagement; and
- Training volunteers to function effectively in special needs shelters during disasters.

Governmental or policy-level interventions may include:

- Promoting policies that offer affordable, accessible health care to everyone, including people with disabilities;
- Promoting barrier-free environments for all ages, including aging in place and universal design;
- Supporting full inclusion of children with disabilities in schools and day care programs;
- Lobbying for public funds to support research and program development in areas related to improvement in quality of life for people at risk and those with disabilities; and
- Promoting policies that establish opportunities for rehabilitation in the community for people discharged from inpatient psychiatric programs.

**Opportunities for Occupational Therapy in Health Promotion**

Funding for health promotion programs can come from governmental agencies, foundations, nonprofit organizations, insurance companies, and large corporations, among others. In addition, fee for service is
an option. Typically, health promotion and prevention programs do not rely on a single source of funding (Brownson, 1998; Scaffa, 2001).

Changes in health care brought about by the 2010 Patient Protection and Affordable Care Act (ACA; Pub. L. 111–148) have already and will continue to have an impact on health promotion, prevention, and public health service provision. Although the ACA is designed to improve individual health by increasing access to health insurance and health care, several provisions relate directly to health promotion. Specifically, Title IV calls for

- Increasing funding for prevention and public health programs;
- Providing education and outreach related to health promotion and disease prevention;
- Reviewing evidence related to preventive services and the development of recommendations;
- Providing Medicare coverage of annual well care visits and the development of personalized prevention plans;
- Improving access to preventive services for eligible adults in Medicaid;
- Eliminating patient copays for prevention services;
- Dispersing incentives for prevention of chronic diseases in Medicaid;
- Evaluating outcomes of community-based prevention and wellness programs for Medicare beneficiaries;
- Removing barriers and improving access to health promotion services for individuals with disabilities;
- Providing grants for employer-based wellness programs; and
- Funding for childhood obesity demonstration project (Kaiser Family Foundation, 2011; Network for Public Health Law, 2011).

Occupational therapy practitioners can seize opportunities to participate in the provision of health promotion and prevention services under the ACA by becoming a member of the primary care team and the patient’s medical home. Failure to integrate occupational therapy into these arenas could severely limit the profession’s future growth.

Case Studies

The following case studies provide examples of the role of occupational therapy in health promotion and prevention of disease and injuries.

Primary Prevention—Working With a Family

A retired couple consult an occupational therapist about a home safety assessment for the purpose of remaining in their home as they age.

Assessment

The occupational therapist develops an occupational profile (AOTA, 2008) using a semistructured interview format. She gathers information about the couple’s goals, occupational history, health, occupational performance, and satisfaction level within the various performance areas, as well as social connectedness and overall life satisfaction.

Both spouses are healthy and able to perform daily tasks with a high level of satisfaction. They have a strong social support network and report being very satisfied with their lives. The occupational therapist also explores the health history of their parents and learns of a history of Alzheimer’s disease and diabetes. She assesses the environment (i.e., home, yard, neighborhood) for accessibility and safety using the
Safety Assessment of Function and the Environment for Rehabilitation (SAFER) tool (Oliver, Blathwayt, Brackley, & Tamaki, 1993).

The occupational therapist notes that the living area is on three levels (several steps have no railings); rooms and hallways are generally poorly lit; and the rooms have too much furniture, leaving narrow or obstructed passageways. The yard has uneven and poorly defined walkways. The couple lives in a residential neighborhood with a distance of 3 miles to shopping. No public transportation is available, even for people with mobility impairments.

**Intervention**

For immediate consideration, the occupational therapist recommends that the couple install railings near all stairs, increase the level of lighting, and decrease the amount of furniture. She works with them to find the best configuration of furniture placement to maximize safety when walking in a room. She recommends that they consider changing the landscape to include clearly defined and level walkways that will also accommodate wheeled mobility, should that ever be needed.

A second set of recommendations includes how to retrofit the house if mobility impairments preclude climbing stairs in the future. The therapist describes optimal placement of an elevator from the first to the second floor. There is not an easy placement of an elevator from the basement to the first floor, so the therapist describes how the occupations now performed in the basement (e.g., exercise, laundry, computer use) may be transferred to the other two floors. The therapist works with the couple on problem solving around transportation, should driving become difficult.

**Primary Prevention—Working With a Business**

A commercial bakery contacts an occupational therapist to assess the various workstations in the bakery and make recommendations for improvements. Management goals include increasing productivity and decreasing sick days and worker compensation claims.

**Assessment**

The occupational therapist observes the work performed at the various workstations and interviews the workers. He notes body mechanics, repetitive motions, machine design, layout of workstations with travel distances, weights lifted and number of lifts per time unit, work speed and load, noise, temperature, air quality, clothing comfort, and length and frequency of rest breaks. He also notes worker-to-worker interaction and interaction among workers, supervisors, and management. In general, the supervisors and management seem approachable and open to suggestions from the workers.

The occupational therapist identifies a high frequency of lifting and repetitive motion done by the workers. Workstations require a significant amount of static standing, which can contribute to many musculoskeletal problems. Travel distances are long, work speed is rapid, noise level is high in certain parts of the factory, and the temperature is uncomfortably warm.

**Intervention**

The occupational therapist recommends ergonomically designed workstations that can decrease the amount of static work, time standing, travel, or lifting and that can improve working positions. Because some jobs involve repetitive motions that may not be avoided, the therapist instructs the managers in the benefits of rest breaks and instructs the workers in stretching exercises. Each worker is also instructed in proper body mechanics at his or her workstation. The therapist works with the management to design a daily schedule that allows for an even workflow to decrease times of high stress. The therapist is asked to return every 6 months to reassess and instruct new employees.
Primary Prevention—Working With a School

An elementary school is planning a new playground, which must be accessible to every child in the school. An occupational therapist is consulted for input on design features that will make the playground aesthetically pleasing, fun, and challenging to use for children of all abilities.

Assessment

The occupational therapist surveys the area where the school is planning to locate the playground. He uses the guidelines for play areas developed by the U.S. Access Board (2007) to ensure minimum requirements are met. He then researches commercially available playground equipment to find equipment that will be fun and challenging to use for all populations in the school as well as encourage interaction among the children.

Intervention

The occupational therapist provides the school with a report detailing his recommendations for important features in the playground equipment and the layout of the playground. He is careful to identify all safety issues and suggests ways to make the playground as safe as possible. The report also includes recommendations for landscaping so that children using wheeled mobility can easily navigate around the playground. The therapist remains on the design team for consultation until the playground is completed.

Secondary Prevention—Working With a Local Governmental Agency

An occupational therapist working in home health has noticed that her elderly clients who no longer drive because of a variety of functional limitations have no other means of transportation to go grocery shopping, run errands, and visit friends. The therapist reviews the literature for evidence and locates the special issue of the American Journal of Occupational Therapy that includes several systematic reviews on the relationship between occupation and productive aging (Leland & Elliott, 2012), and she commits to taking action.

Assessment

To determine the need for alternative means of transportation, the occupational therapist conducts a needs assessment, gathering existing data from several sources, including state and local census data and information from community organizations that provide services to older adults.

Intervention

The occupational therapist contacts the county office on aging to discuss her findings and concerns. She conducts a brief presentation, including data she collected about the local community and evidence from the systematic reviews. A joint task force is formed with local senior centers to further study the transportation experience of elderly county residents and make recommendations. Cognizant of the need to balance the fiscal resources of the county with the needs of aging county residents, the task force develops a proposal for extending one bus route and including three additional stops on two other bus routes during the weekday non–rush hour time period. The proposal emphasizes the importance of transportation and social participation to the health and well-being of elders.

Tertiary Prevention—Working With a Group

A rehabilitation unit in a hospital decides to offer health promotion classes to former patients with chronic conditions. An occupational therapy assistant is chosen to lead a class for patients with chronic obstructive pulmonary disease.
Assessment

The occupational therapy assistant researches information on the disease, existing programs, and their content and outcomes. He researches optimal group size, length of each session, session frequency, and number of sessions.

Intervention

Using the assessment information, the supervising occupational therapist works with the occupational therapy assistant and a respiratory therapist to develop the health promotion class, including number of participants, length of session, and topics offered. It is decided that a maximum of 15 participants will meet monthly for 1½ hours for a total of 12 sessions. Topics include self-management, assertive communication, information-seeking, and problem-solving skills. The group will also function as a support group. The occupational therapist collects data to determine the effectiveness of the program in preventing secondary conditions associated with chronic obstructive pulmonary disease and promoting independent living and quality of life.

Summary

Through this statement, the AOTA described the role of occupational therapy in the promotion of health and well-being among individuals, families, communities, and populations. Three levels of prevention services were defined, and potential contributions by occupational therapy practitioners were detailed at each level.

The examples provided are just a few of the extensive, rich, and varied occupation-based approaches that can facilitate the achievement of the national goals outlined in Healthy People 2020. These approaches include, but are not limited to, the creation of health-promoting social and physical environments, improved quality of life, healthy development, and health equity for all.

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Appendix. Glossary of Health Promotion Terms

**Occupational alienation**—“Sense of isolation, powerlessness, frustration, loss of control, and estrangement from society or self as a result of engagement in occupation that does not satisfy inner needs” (Wilcock, 2006, p. 343).

**Occupational deprivation**—“Deprivation of occupational choice and diversity because of circumstances beyond the control of individuals or communities” (Wilcock, 2006, p. 343).

**Occupational imbalance**—“A lack of balance or disproportion of occupation resulting in decreased well-being” (Wilcock, 2006, p. 343).

**Occupational justice**—“The promotion of social and economic change to increase individual, community, and political awareness, resources, and equitable opportunities for diverse occupational opportunities that enable people to meet their potential and experience well-being” (Wilcock, 2006, p. 343).

**Occupational science**—“An interdisciplinary academic discipline in the social and behavioral sciences dedicated to the study of the form, the function, and the meaning of human occupations” (Zemke & Clark, 1996, p. vii).

**Social justice**—“The promotion of social and economic change to increase individual, community, and political awareness, resources, and opportunity for health and well-being” (Wilcock, 2006, p. 344).

**Well-being**—A state of flourishing that consists of the following elements: positive emotion, engagement or flow, meaning (a sense of belonging to or serving something larger than oneself), positive relationships and accomplishment or achievement (Seligman, 2011).