

Representations of Disability within Occupational Therapy Literature
– A discourse analysis

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Preface

The past year working on my thesis has been a time of reflection and great personal growth. Apart from challenging my language skills, this thesis, and the two-year master program for that matter, has made me reflect over my role as an occupational therapist as well as my personal attitudes and beliefs. There is still much to learn and understand, but through this project I have gained a deeper understanding of myself, my profession and a much wider understanding of disability and society. Finishing this thesis has been a long and bumpy process, and I wish to thank the people who have kindly contributed.

I would like to thank my supervising professors, Borgunn Ytterhus and Eva Magnus, for taking the time to visit classrooms in order to present the project and giving me the chance to join a project that was exactly what I had been looking for. I would also like to thank them for guiding me through the process of writing this thesis. Your feedback, constructive criticism and encouragement have been deeply appreciated. Thank you.

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Abstract

The aim of this thesis is to explore what understandings of disability are evident in the literature used at Bachelor programs in Occupational Therapy in Norway. A therapist's understanding of disability can be assumed to affect how they work, consequently affecting disabled people as their clients. This, coupled with financial saving measures in the healthcare sector (such as utilising different professionals according to their expertise) makes it relevant to know what understanding of disability is present within a profession. Two research questions have been formulated to explore the understandings in the literature: *How is disability represented in occupational therapy literature used at Bachelor programs in Occupational Therapy in Norway?* and *Which is the dominant discourse concerning disability conveyed through course literature at Bachelor programs in Occupational Therapy in Norway?*

This thesis is a literature study and the method used to explore the subject is Fairclough's critical discourse analysis. Literature lists were collected from the five schools that offer Bachelor programs in occupational therapy in Norway. The most frequently used literature/chapters at all schools are included in the study.

Two understandings of disability were found in the texts; a traditional OT (occupational therapy) understanding and an understanding based on ICF. Three discourses were found, the medical, relational and individual, which all explain different aspects of the understandings. Within the traditional OT understanding, disability is understood as a problem, defined by the individual, with performing an activity or participating. It is caused by or in the interaction between the activity, the environment and the person. Within the ICF understanding disability is understood as resulting from the relationship between a person's possible impairment and their level of activity and participation. Disability is positively or negatively affected by the person's health, the environment and personal factors.

The traditional OT understanding is stronger within the analysed literature. The understandings cannot replace one another, and with support from other research, the conclusion is drawn that the understandings should complement and learn from each other while they continue to develop.

Sammendrag

Hensikten med denne masteroppgaven har vært å studere hvilke forståelser av funksjonshemming som finnes i litteraturen som brukes på Bachelorutdanninga i Ergoterapi i Norge. Det er rimelig å anta at en terapeuts forståelse av funksjonshemming vil påvirke hvordan hun jobber, hvilket igjen påvirker hennes klienter: funksjonshemmede personer. Dette samt at innsparingstiltak i helsesektoren (som å utnytte ulike profesjoners kompetanse bedre) gjør det relevant å vite hvilken forståelse av funksjonshemming en profesjon arbeider ut i fra. To forskningsspørsmål er blitt formulert: *Hvordan representeres funksjonshemming i litteratur brukt på Bachelor utdanninga i Ergoterapi i Norge og hvilken er den dominante diskursen om funksjonshemming som formidles gjennom pensumlitteratur på Bachelorutdanninga i Ergoterapi i Norge?*

Denne masteroppgaven er en litteraturstudie og metoden som er brukt er Fairclough's kritiske diskursanalyse. Pensumlister er samlet inn fra de fem skoler som tilbyr Bachelorutdanning i Ergoterapi. De hyppigest brukte bøkene/kapitlene på alle skoler er inkludert i studien.

To forståelser av funksjonshemming ble funnet i teksten: en tradisjonell OT (occupational therapy - ergoterapi) forståelse og en forståelse basert på ICF. Tre diskurser ble funnet: medisinsk, relasjonell og individuell, som alle forklarer ulike aspekter av forståelsene. Den tradisjonelle OT forståelsen ser funksjonshemming som et problem definert av individet i forhold til individets muligheter til å gjennomføre aktivitet og kunne delta. Denne muligheten dannes i interaksjon mellom aktivitet, miljø og individet. I ICFs forståelse er funksjonshemming forstått som et resultat av interaksjonen mellom en persons mulige funksjonsnedsettelse og dens nivå av aktivitet og deltagelse. Funksjonshemming blir positivt og negativt påvirket av personens helse, omkringliggende miljø og personlige faktorer.

Den tradisjonelle OT forståelsen dominerer i den analyserte litteraturen. Forståelsene kan ikke erstatte hverandre, og med støtte fra annen forskning, konkluderes det med at forståelsene burde komplettere hverandre og lære av hverandre når de fortsetter å utvikles.

1. Introduction

There are many ways of thinking about and understanding disability and disabled people. The layman on the street has rarely reflected over their understanding of disability and, when meeting a disabled person, any number of feelings can occur, including curiosity, pity, a need to help or a wish to avoid the person. Healthcare professionals, on the other hand, work with disabled people and have studied disability as part of their education. What is it they think about disability? It is known that professionals within the healthcare sector have a great deal of power over their clients (Swain, French & Cameron, 2003). Their understanding and way of thinking about disability will have a great impact on how they carry out their work, directly affecting disabled people who are their clients. One's understanding of disability is created and changed by what one is exposed to. For professionals, a central area where this exposure happens is at school, where they are trained in their chosen profession. Herein lies the focus for this study: What representations of disability are students exposed to?

The understandings students are exposed to are influenced by bigger social trends. Traditionally, disability has been seen as an individual medical condition, leading to politics focused on preventing and curing rather than adapting the environment or society (Barnes & Mercer, 2010; NOU 2001:22). To an extent, this view is still evident today. In the late 1960s, normalisation became the guiding principle within politics concerning disabled people (Askheim, 2003). Askheim (2003) states normalisation still influences politics, but is being challenged by the strong empowerment movement, focusing on the individual's right to influence services and decide how to live their life. This can be seen as a response to the criticism directed towards normalisation, that it tries to change people instead of trying to change and question what is said to be 'normal' (Barnes & Mercer, 2010).

On an international level, the United Nations has worked for changing attitudes towards people with disabilities for decades, striving for a view of disabled people as persons with rights who are able to make their own decisions and be active members of society (United Nations, 2011a). In Norway, the traditional, and much questioned and criticised, medical model of disability was officially replaced with the relational model of disability in Report no. 23 (1977-78) to the Storting, meaning disability is no longer understood as a result of a medical condition but as arising in the interaction between person and environment

(NOU 2001:22). However, changing the understanding on paper has not replaced the medical model in practice, meaning today the models coexist. Officially adapting the relational model has nonetheless led to more acknowledgement of the individual. This change is evident in the goal of politics concerning disabled people, which since 1981 has been full participation and equality (Sosial- og helsedirektoratet, 2006). In Report no. 34 (1996-97) to the Storting (St.meld. nr. 34 [1996-97]), empowerment (brukermedvirkning) is described as the most important tool for preserving basic values within politics for disabled people, making empowerment of clients a goal at the same time. Empowerment or "brukermedvirkning", is described as a democratic right, where individuals both participate in decisions concerning their own life and as representatives when it comes to developing services and interventions (NOU 2001:22).

Politics regulate society, and therefore a change of focus within politics will always have an effect on society. The Norwegian government has, since the 1990s, produced official 'plans of action' (handlingsplan) for how to improve the situation for disabled people, specifying what the values and goals are. The situation has improved; certain policies concerning removal of barriers in the society are in place (Sosial- og helsedirektoratet, 2006; St.meld. nr. 40 [2002-03]) and, in 2009 the Antidiscrimination Law was adopted (Diskriminerings- og tilgjengelighetsloven, 2009). Today, the rights of disabled people are viewed from a human rights perspective, looking at accessibility, dignity, participation and non-discrimination (Sosial- og helsedirektoratet, 2006), reflecting the focus on the person and not on the impairment. The United Nations presented the *Convention on the Rights of Persons with Disabilities* in 2006, further emphasising the rights of disabled people. Norway has signed but not ratified the convention (United Nations, 2011b). However, establishing policies and planning interventions does not guarantee that they will be implemented and have the desired effect. Despite goals of full participation and equality, reports show there is a gap between the aims and reality (see NOU 2001:22; Sosial- og helsedirektoratet, 2006). The gap is hard to close when disabled peoples' participation and equality is often not considered as very important in the planning, decision-making and intervention process (NOU 2001:22), when they are not considered when talking about diversity like other minorities and when no laws that prevent new barriers from being established have been made (Sosial- og helsedirektoratet, 2006).

One can see that politics have moved towards acknowledging the individual more and more. However, the healthcare system is still based on classifying people for administrating benefits, which implies following the medical model of disability (see St.meld. nr. 40 [2002-03]:9-10). Since there are multiple understandings of disability in politics and society, one would expect this to also be the case within the education system. Therefore, it is relevant to explore what these understandings are. The Coordination Reform (Samhandlingsreformen) is one of the new attempts to renew the healthcare sector. The goal is to provide proper treatment at the right time and place. Without going into the details of the reform, one point, which warrants the need for this particular study, is how municipalities have to acknowledge the spectre of different professions and manage to provide a coordinated service, utilising the different professional qualities (St.meld. nr. 47 [2008-09]). In order to utilise different professionals in the best way, they themselves first have to be aware of what they think, know and do and. And as Tøssebro (2009) points out, even though the question “what is disability” has been debated back and forth, it is something both politicians and researchers and, undoubtedly, also professionals and students, have to contemplate and take a stance on.

1.1 Research questions

This thesis is part of a project concerning representations of disability in course literature used in healthcare professional education in Norway. My fascination with attitudes and their origin led me to join this project. I have a Bachelor’s Degree in Occupational Therapy and, therefore, it was natural that this was the education program I would focus on. The aim of this study is to explore what understandings of disability appear in the occupational therapy literature. In order to explore this, two research questions have been formulated:

- How is disability represented in occupational therapy literature used at Bachelor programs in occupational therapy in Norway?
- Which is the dominant discourse concerning disability conveyed through course literature at Bachelor programs in occupational therapy in Norway?

The theoretical base for this project is social constructivism. This implies that questioning knowledge that is taken for granted is central and that knowledge is considered to be dependent on the time and context in which it is situated (Burr, 1995; Gergen, 1985; Phillips

& Jørgensen, 2002). Structuralism and post-structuralism are also central ideas when they describe language as a system and words as receiving meaning through how they are used in relation to other words and, furthermore, how this meaning can always change (Burr, 1995; Phillips & Jørgensen, 2002). To answer the research questions a qualitative approach has been chosen. The project has an explorative design, which, according to NEM (Den nasjonale forskningsetiske komité for medisin og helsefag) (2010), is commonly used in qualitative research projects. This means choices are made continuously and are not set at the beginning of the project. The method, critical discourse analysis, was set by the time I joined the project. There are many ways of conducting a discourse analysis, and, in this case, Fairclough's critical discourse analysis has been the primary guide. This is a literature study based on the most frequently used occupational therapy relevant literature at Bachelor Degree programs in occupational therapy in Norway. This degree is offered at five schools: Bergen University College, Oslo and Akershus University College of Applied Sciences, Sør-Trøndelag University College, University of Tromsø and Diakonhjemmet University College. The programs are 180 credits, taking three years to complete. The analysed literature are the most frequently used books/chapters: *Basisbøg i ergoterapi: aktivitet og deltagelse i hverdagslivet* (Foundational book in occupational therapy: activity and participation in everyday life) by Borg, Runge, Tjørnov, Brandt & Madsen (2007) and *Model of human occupation: Theory and application* by Kielhofner (2008a).

1.2 Reader's guide

Chapter 2 will present the theoretical base for this study. That means different models of disability are presented as well as disability studies as an academic discipline and occupational therapy as a profession. Relevant terms that will be used throughout the study are also clarified here. Chapter 3 focuses on previous research concerning how concepts and understandings within disability studies and occupational therapy conflict or match and how the disciplines possibly could learn from each other. The chapter is based on nine published articles by various authors. The method is presented in chapter 4, as well as the scientific base consisting of social constructivism, structuralism and post-structuralism. The data collection and selection process and the analysis are explained in detail. At the end of the chapter the reliability and validity is discussed and ethical considerations are presented. A clear divide has been made between the results, presented in chapter 5, and the discussion,

presented in chapter 6. In the discussion, the results, which are the different understandings of disability and the discourses they consist of, are reflected upon in relation to bigger social trends. The 7th and final chapter contains a conclusion of the results, ideas on further research and some final critical reflections on the research process.

2. Theoretical base

In order to understand research and situate and discuss the findings one needs to have knowledge about the subject and related theories. Therefore, this chapter will give insight into relevant theories and explain operational definitions.

The chapter will start with a look at how society has gone from expecting everyone to contribute despite considering the reason for disability to be punishment from God or a work of evil, to medically classifying, treating and excluding disabled people in today's industrialized Western society. The "modern" ways of viewing disability have not excluded religious ways of thinking in the Western world and globally the religious or superstitious understandings are still dominant. However, this study is situated in a Norwegian context, a Western industrialized society, and therefore the focus is on the new models of understanding disability. Models discussed further are the medical model, the social model, the relational model and The International Classification of Functioning, Disability and Health (ICF). Operational definitions relevant for the study are defined; impairment and disability and disabled people vs. people with disabilities. Disability studies as an academic discipline is mentioned throughout the text and will be presented here. Lastly, occupational therapy as a profession is presented. This is a profession not everybody is familiar with and there are many misunderstandings about what knowledge and possibilities the profession possesses. The profession is defined, its core concepts are presented in addition to the domains they work within and the processes used in therapy.

2.1 Models of disability

Historically, before the Industrial Revolution in Western society, religion had a big impact on how people with impairments were treated (Barnes & Mercer, 2010). This is still the case in a large part of the world today. The birth of an "abnormal" child was seen as punishment or as a work of evil. Practices such as infanticide occurred and "abnormal" people were widely devalued. At the same time religion preached you should take care of the sick. The disabled often survived on begging or with care from the family while they were expected to contribute as much as their impairments allowed. This changed in the Western world during the industrialisation of society with more demanding and complex work tasks leading to

disabled people not being able to contribute in the same way. Oliver (1990) describes this as the time when disability became an individual pathology. Focus was directed to the body and people were excluded and therefore controlled. There was a wish to protect the civilised society from the growing number of poor and disabled and, as a response, they were separated from the “normal” people by diagnosing and sending them to institutions (Barnes & Mercer, 2010). The diagnosing was done by the medical profession, which gained authority while focusing on the body and on treatments based on scientific knowledge (Barnes & Mercer, 2010; Oliver, 1990). This focus on the body and separation between “normal” and “abnormal” is the basis for how disability became to be seen as an individual problem by social scientists (Oliver, 1990).

The medical model of disability

The medical or individual model of disability has been widely accepted in the industrialised world since the late 19th century (Barnes & Mercer, 2010). Disability is seen as an individual problem caused by functional limitations of the body. It is based on medical diagnosis, treatment and cure. The approach disregards the experience of illness, influence of culture and surrounding environment (Barnes & Mercer, 2010; Oliver, 1990; Swain et al., 2003). Physical impairments draw attention to nature as something uncontrollable and signal a disorder that humans then want to correct or cure. The need to correct and cure, and the many stereotypes and ideas of disabled people needing special or extra care and help, strengthens the medical model (Swain et al., 2003). Much criticism has been directed towards the medical model. Oliver (1990) states disability has become medicalised even if many of the disorders have no biochemical cause and no medical treatments exist. According to Shakespeare (2010), people in favour of the social model of disability reject the medical model, but not medical prevention, rehabilitation and possible cures. Oliver (1990) conveys the same by saying the medical profession is necessary when working with, for example, diagnosing and treating impairments and traumas. But a problem arises and criticism is aimed at how medical profession today also has considerable power in cases where medical expertise is not necessary. Examples of this given by Oliver include prescribing wheelchairs, determining who is entitled to financial benefits and evaluating work potential. He also points to the fact that professions that might be more suitable for these tasks, such as physio- and occupational therapy, often work under doctors or within a discourse highly influenced by the medical

model. The mechanical way of measuring effects of impairment based on the medical model, necessary for distributing welfare benefits and social services, has also been heavily criticised (Barnes & Mercer, 2010). Swain et al. (2003) highlight the view of disability based on the medical model is constructed and inflicted on disabled people by non-disabled people, and that both disabled and non-disabled people criticise the model. The criticism of the model has been acknowledged and there have been a number of attempts at reclassifying impairment and disability. A change came in 1980 with the World Health Organization's (WHO) International Classification of Impairments, Disabilities and Handicaps (ICIDH). Barnes & Mercer (2010) note this is the first model that includes "social handicaps", defined as problems with fulfilling a "normal role". However this model sees disablement as a linear process, meaning impairment is the cause for "disablement" and "handicap" while the environment is thought of as neutral, not playing a role in or offering an explanation to what "social handicaps" are. This, in turn, undermines the importance of policy reforms and legislation in favour of disabled people. Society was not content with this ICIDH model and disabled activists continued to protest and, likewise, the medical profession came to the realisation of how social factors and relationships influence impairment and illness (Barnes & Mercer, 2010). This eventually led to a new model; a social model of disability.

The social model of disability

The environmental turn, when the perspective shifted from strictly medical to more social, gave rise to many different models of thinking about disability (Tøssebro, 2004). One of the strongest and best-known models today is the social model, which has had a significant impact on the field. Many organisations of disabled people were protesting against the medical model, and in the 1970s The Union of the Physically Impaired Against Segregation (UPIAS) set the foundation for the social model of disability (Shakespeare, 2010). According to Shakespeare (2010) and Gustavsson Holmström (2005), disabled activists protested against the individualistic and medicalised view of disability and, instead, focused on social oppression, cultural discourse and barriers in the environment as causes of disability. The fundamental principles of UPIAS describes the view of the social model of disability:

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. (UPIAS, 1975 in Shakespeare, 2010:267).

The social model distinguishes between *impairment* (a dysfunction or limitation of a body part, organ or mechanism; it is individual and private) and *disability* (a disadvantage, restriction or exclusion caused by society; it is structural and public). Impairment is not considered to be a cause of disability (Barnes & Mercer, 2010; Gustavsson Holmström, 2005; Shakespeare, 2010). Shakespeare (2010) outlines the views within the model and its goals: solutions to social oppression are seen as removal of barriers, anti-discrimination legislation and independent living. Non-disabled people or organisations are often seen as the cause or as contributing to the oppression. Also, according to advocates for the social model, it is disabled people themselves that should be conducting research and coming up with solutions on the field since they have the best insight.

The social model has highlighted the role the environment and society has in creating disability, providing an alternative to looking at and understanding disability as an individual deficit (Gustavsson Holmström, 2005; Shakespeare, 2010). It has also functioned as a base for disabled people to organise themselves politically and helped them build a positive collective identity. According to Shakespeare (2010), the fact that the model is easy to understand and has a clear agenda for social change has also contributed to it being politically effective. According to him, the model's way of thinking about disability is both a source of strengths and weaknesses. Shakespeare sees a problem in the authors being predominantly white, heterosexual men with physical impairments, which has led to the model being formulated from this point of view. The model does not take into account the various other impairments and disabilities that exist and result in different challenges than if you are a wheelchair user. When stating that impairment is not a cause for disability the model neglects the effect and importance impairment has in many people's lives (Barnes & Mercer, 2010; Shakespeare, 2010). Individuals facing degenerative conditions, premature death and pain cannot disregard the effects of the impairment, while people with a static condition might be able to (Shakespeare, 2010). Both Barnes & Mercer (2010) and Shakespeare (2010) write that the social model is striving for a utopia that cannot be reached. All social barriers cannot be successfully removed and changed to fit the needs of all people with impairments and

disabilities since they all have individual needs that conflict with each other. An example is how a kerb helps blind people to navigate streets while being an obstacle for wheelchair users. Another criticism worth noting is how there is not only one social model but several, and that this social model originally developed by UPIAS can be found at the stronger end of the spectrum (Gustavsson Holmström, 2005; Shakespeare, 2010; Tøssebro, 2004). Academically, the model is difficult to use according to Shakespeare (2010) because, in practice, it is not always easy to differentiate between impacts of impairment and barriers. When disability is defined as oppression a situation arises where you cannot research if one truly is oppressed, but only to what extent they are oppressed. He concludes that a social view on the subject is indispensable, but in his opinion the social model of disability has now become a barrier itself to further progress. He states it is “unhelpful in understanding the complex interplay of individual and environmental factors in the lives of disabled people” (Shakespeare, 2010:272). He calls for new models with a more complex understanding, which, for example, could be built on the International Classification of Functioning, Disability and Health (ICF) developed by WHO.

The ICF model of disability

The first WHO model, ICIDH, was criticised on conceptual and practical grounds, for example, for having a medical understanding of consequences and for focusing on consequences in the environment, not on consequences of the environment (Barnes & Mercer, 2010; Tøssebro, 2009). The revised version, known as ICF, was finished in 2001 (Barnes & Mercer, 2010). The model is also called the biopsychosocial model of disability and is a mix of the social and medical models (WHO, 2001). ICF is described as a classification of components of health (WHO, 2001), meaning the focus is on what constitutes health. Components relevant for human functioning and health are body functions/structures, activity and participation. These are further affected by the contextual factors, which are environmental and personal. The components can be used to indicate aspects of health, that is, how a person functions, or to describe disability which is problems with any of the components like impairment, activity limitation or restriction of participation (WHO, 2001). More specifically disability is defined as “the outcome or result of a complex relationship between an individual’s health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives.” (WHO, 2001:17). The

level or extent of functioning or disability is determined by the contextual factors and their interaction with the individual and their health condition. Functioning and disability are both viewed as interactive and evolutionary processes. This implies that components and contextual factors all influence each other, and a change in one component or factor will influence the others (WHO, 2001). Barnes & Mercer (2010) state biophysiological conditions are to be classified, measured and treated according to the scientific medical model when using ICF. This means, as WHO (2001) points out, that ICF should be used together with the International Classification of Disease, ICD-10, which determines the medical aspect and provides a diagnoses. However, when using ICF, it is still vital to recognise that health consists of biological, individual and social factors and that humans function on different levels: body or body parts, as a whole person and as a person in a societal context (Barnes & Mercer, 2010). ICF has not escaped criticism. Barnes & Mercer (2010) present a few of these points for which it has been criticised: associating impairment as a deviation from the norm, not discussing cross-level relationships, being grounded in Western concepts and traditions and, finally, for not providing a coherent theory of social action and, therefore, a new understanding of disability.

The relational model of disability

Another social model of disability is used in the Nordic countries, called the relational model. This model is at the weaker end of the spectrum of the social models and highlights the interaction between person and environment (Tøssebro, 2004). The base for this model is the general idea in the Scandinavian welfare states about full participation and equal opportunities (Gustavsson Holmström, 2005). In the relational model disability is defined as a mismatch between the person and environment, or as a gap between demands and functioning (Barnes & Mercer, 2010; Tøssebro, 2004). Barnes & Mercer and Tøssebro describe disability as contextual and relative, meaning a person is not disabled in all situations or all the time. Working within this model the aim is to modify the environment to accommodate people with different needs and impairments (Barnes & Mercer, 2010). A consequence of this model identified by Gustavsson Holmström (2005) is that disabled people become hard to identify since they become disabled in different situations and at different times.

The last described relational model is the fundamental model in Norway (St.meld. nr. 40 [2002-03]). Terms such as impairment and disability are understood according to the model. Having chosen this model as the framework for understanding disability influences how policies and practices concerning disabled people are formulated and what is prioritised. Occupational therapy is shaped as a field through these nationwide policies and ways of thinking. This also concerns schools that offer occupational therapy programs. One aim of this thesis is to research what model or way of thinking about disability is evident in the literature used at occupational therapy programs in Norway. Is it compatible with the relational model or is disability understood in some other way?

2.2 Operational definitions

The language we use has an effect on how we perceive and think about the world around us. Therefore, it is important to reflect over relevant words and expressions at an early stage and clarify this to the reader. In this thesis the relevant words to define are impairment and disability and disabled people vs. people with disabilities. Activity problem as a term is finally presented as it comes up multiple times in the reading of occupational therapy literature and in the results chapter.

Through time disabled people have been called a number of different things, but as times change so do the meaning of the words; they lose their technical meaning and become negative and abusive (Barnes & Mercer, 2010). The term *disability* (funksjonshemming) was intended to replace the term *handicap* when it appeared for the first time in official Norwegian documents in 1967 (NOU 2001:22). The word disabled was used in a medical sense while the medical model was dominant. Over time, and with a growing criticism of the medical model and the emergence of the social model with its wish to hold the society responsible for disabling people, the meaning of the word has changed (NOU 2001:22). There is a discussion in today's society on what terminology should be used. Many authors and organisations separate between disability and impairment. This distinction is also stated in official Norwegian documents. The term *impairment* (redusert funksjonsevne, funksjonsnedsettelse) is used to describe a loss, damage or deviance of a body part or a psychological, physiological or biological function while *disabled* (funksjonshemmet) is used to describe people whose practical daily life is significantly restricted because of the gap or mismatch

between the person's abilities and the demands by the environment or society (NOU 2001:22; St.meld. nr. 40 [2002-03]). Note that this definition is in line with the relational model of disability described earlier. This distinction between words will be used in this thesis except in cases where it is not possible, for example when referring to other sources in quotes.

There is an ongoing debate on what terminology is best, *disabled people* or *people with disabilities*. What standpoint one chooses depends on how you view disability. *Disabled people* is used to underline that disability is an essential part of the individual, while the term *people with disabilities* puts the focus on the individual and defines disability as only one aspect of the person (Gustavsson Holmström, 2005). Using the term *disabled people* is a political statement and therefore preferred in the disability movement (Hammell, 2006). Barnes & Mercer (2010:11) state they choose not to talk about *people with disabilities* because it "blurs the conceptual division between impairment and disability and implies that impairment defines an individual's identity". *People with disabilities* on the other hand is, according to Gustavsson Holmström (2005) and Hammell (2006), still used by many liberal professionals, academics and people with disabilities in many countries. As stated, the discussion is widely spread and ongoing but will not be explained in detail in this thesis. I have chosen to talk about *disabled people* throughout this study except when necessary while referring to other texts.

Finally, a few words on the term *activity problem* (sometimes occupational problem), which is widely used in occupational therapy literature. While talking about problems can give a negative impression, activity problems are central within the discipline because the core constructs are that humans have a need for occupation and that occupation is the source for meaning in life (Kielhofner, 2004). Since these are the foundations of the discipline, focus is directed to problems concerning this. However, it is acknowledged that problems arise from multiple factors in a complex situation. When the focus is on activity problems, Kielhofner (2004) states it is not enough to look at only impairment. Instead, one has to acknowledge the environment and the whole life of the person. The framework of occupational therapy practice also highlights the many factors influencing activity, for example, activity demands, client factors and context and environment (American Occupational Therapy Association [AOTA], 2008). The perspective is holistic and acknowledges both objective and subjective aspects of performing (AOTA, 2008).

To clarify, the term *activity problem* or *people with activity problems* will, in this study, be used to name the problems people receiving occupational therapy have in common and as a synonym to disabled people. It is acknowledged that problems are not simple, but arise from multiple factors and that it can affect the person's quality of life.

2.3 Disability studies

Disability studies as an academic discipline is mentioned throughout this study and what it deals with will be described to enlighten readers new to the subject. Disability studies is a fairly new academic discipline. In the 1970s disabled activists started re-interpreting and challenging current views of disability, giving rise to the social model of disability and the field of disability studies (Barnes, 2004). The first course in disability studies in the UK was offered in 1975 at the Open University, giving rise to a small body of literature with an analytical perspective on disability (Barnes, 2004; Hammell, 2006). The body of literature has kept growing and the international journal *Disability and Society*, established in 1986, adds to the field (Swain et al., 2003). Disability studies is promoted mainly by disabled activists and academics. It is an interdisciplinary and diverse field, drawing on for example sociology, anthropology, politics and history (Swain et al., 2003). The establishment of the field is by many disability activists, the core group of disability scholars, seen as a way of gaining power for disabled people (Linton, 1998).

Disability studies strive to explain disability. It focuses on disabled people's lifestyles and tries to shift the paradigm from the traditional medical view of preventing and treating to a social, political and cultural paradigm of understanding disability (Swain et al., 2003). The field rejects all explanations of disability as located within the person. Linton (1998) describes how the field sees disability as a social phenomenon and how it examines disability from a social, political and cultural standpoint. Linton claims it adds a critical dimension to how one thinks about, for example, independence, health and physical appearance and other aspects that are present in every aspect of life.

2.4 What is Occupational Therapy?

The aim of this study is to uncover how disability is represented and mentioned in occupational therapy literature and curriculums in Norway and what dominant discourse on disability these sources convey. Therefore, to understand the results and discussion, it is important to have knowledge of the field of occupational therapy. This following section will give a short introduction to the history of occupational therapy and what concepts and thoughts guide the profession today.

A brief history of Occupational Therapy

Kielhofner (2004) describes the knowledge of occupational therapy, how it has developed over time and how it consists of layers; a core paradigm, conceptual practice models and related knowledge. The paradigm is the most stable part and consists of core constructs, focal viewpoints and values. Since occupational therapy was founded in 1917 the paradigm has shifted two times and, as a result, there are three different paradigms worth mentioning.

Kielhofner (2004) describes the first *paradigm of occupation* that prevailed within occupational therapy from its founding until the 1940s. This paradigm views occupation as an essential part of life and health and focuses on the environment and mind rather than body and impairment. Occupation was seen as a therapeutic tool and a way of achieving dignity for the individual. According to Kielhofner (2004), the critique from medicine in the late 1950s calling for a more theoretical base for occupational therapy practice led to the emergence of a new *mechanistic paradigm*. There was a strong need to be acknowledged by the medical community as an effective medical service. Therefore, the attention within the paradigm shifted to performance capacity being determined by inner mechanisms (musculoskeletal, neurological and psychological). New methods were established for working with musculoskeletal dysfunction, adaptive devices appeared and compensatory techniques were developed. This paradigm diverted the profession from its basic idea, occupation as important to health, and failed to address the full range of problems disabled people faced. The professional identity crisis in the 1970s called for a return to the central focus of holism, occupation and human motivation for occupation. The third paradigm, *the contemporary paradigm*, was fully developed by the beginning of the 21st century (Kielhofner, 2004). This

is a more holistic paradigm combined with the knowledge of reducing impairment. This paradigm is predominate today and will be further discussed below.

Occupational Therapy today

The World Federation of Occupational Therapists (WFOT) released a statement on Occupational Therapy, where the profession is defined as:

... a client-centred 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. (WFOT, 2010:4).

To understand the statement and the core of occupational therapy one has to understand the term *occupation*. It is used to describe everyday activities and consists of the domains play/leisure, activities of daily living (ADL) and work (AOTA, 2008; Kielhofner, 2004). Occupations are complex, multidimensional and central to individuals' identity and sense of competence. They are also of special meaning and value to the individual. Kielhofner (2004) states that the drive for occupation is an urge to do things and discover, to use capacities and to experience being competent, something that every human desires. The term *activity* can sometimes be used instead, even though the definition of this term is a goal-directed human action (AOTA, 2008). Occupation can therefore be seen as something wider than the more focused term, activity.

Today the profession is guided by the contemporary paradigm. This paradigm is the basis for how the profession views its clients, the world and how they define their professional role. Kielhofner (2004) describes the paradigm as consisting of three core ideas or assumptions. First, humans are assumed to have an occupational nature, meaning people have a basic need for occupation and that occupation is a source of meaning. Second, denied access to occupation can lead to suffering and a reduced quality of life. Occupations are vital in improving the health status of the individual. Therefore, occupational problems and challenges are the focus of occupational therapy service. Third, the core of therapy is occupation-based practice. Occupations are used as therapy in different ways to achieve

goals. AOTA (2008) and Townsend (1993) mention these same core concepts, while Townsend also adds client-centred practice and the goal of therapy being enabling rather than treating. The goal of occupational therapy, as stated by Kielhofner (2004), is to provide opportunities and environmental resources to individuals and enable them to reshape their performance and lives into new patterns for participating in everyday life. This idea is also supported by AOTA (2008:626), which promotes “supporting health and participation in life through engagement in occupation”. Being meaningfully occupied is considered to be fundamental to well being (AOTA, 2008; Kielhofner, 2004).

Occupational therapists work with clients, which can be a person or family, an organisation, a business or a population (AOTA, 2008). The clients experience restrictions in participation in everyday occupations (Kielhofner, 2004). This restriction may be due to individual capacities, the occupation or the environment (WFOT, 2010). The domains of occupational therapy, that is what therapists work with, is further defined by AOTA (2008) and illustrated in Table 1.

Table 1. Domains of occupational therapy, not hierarchical (AOTA, 2008:628).

Areas of occupation	Client factors	Performance skills	Performance patterns	Context and environment	Activity demands
Activities of daily living (ADL)	Values, beliefs and spirituality	Sensory perceptual skills	Habits Routines	Cultural Personal	Objects used and their properties
Instrumental activities of daily living (IADL)	Body functions	Motor and practice skills	Roles Rituals	Physical Social	Space demands
Rest and sleep	Body structures	Emotional regulation skills		Temporal Virtual	Social demands
Education		Cognitive skills			Sequencing and timing
Work		Communication and social skills			Required body functions
Play					Required body structures
Leisure					
Social participation					

Occupational therapists have an established knowledge and expertise within these varied domains. Performing an occupation is considered to be affected by the client, the context and environment and the clients other occupations (AOTA, 2008). According to Townsend (1993) occupational therapy foundations are similar and compatible with those of social justice and, therefore, occupation can be viewed within the frame of social justice. Townsend

defines social justice as the concept and practice of ensuring social equality with a fundamental recognition that people have the power to act.

Occupational therapy's vision is to promote social justice by enabling people to participate as valued members of society despite diverse or limited occupational potential. The profession promotes social justice through practical approaches which enable people to develop their occupational potential. (Townsend, 1993:176).

This thinking has led to the term occupational justice, which concerns the ethical, moral and civic factors that support or hinder health-promoting engagement in occupation (AOTA, 2008).

How do occupational therapists work with all of these domains? The process of occupational therapy is described in the framework by AOTA (2008). The process includes evaluation, intervention and outcome monitoring. The client and therapist are equally involved in the entire process and, with a core defined as occupation, the aim of therapy naturally becomes more about enabling rather than treating (Townsend, 1993). Kielhofner (2004) identifies four ways to use occupation as therapy: providing opportunities to engage in occupation, modifying environments, providing technical devices and counselling or problem solving. The client is expected to participate actively in the therapy process with the realisation that their actions and investment in the therapy will determine its effectiveness (Kielhofner, 2004). This requires therapists to work client-centred, a core concept within the profession. There are many definitions of client-centred practice and they all have elements in common: collaboration and partnership, respect for the client, facilitating choice and involving the client during the whole process (Sumsion & Law, 2006). Sumsion & Law (2006) have identified five aspects of client-centred practice: power, listening and communicating, partnership, choice and hope. Power can be seen as the most important element to understand in order to work client-centred. One has to be aware of the power professionals have over clients and how the healthcare system today is organised in a way that does not empower clients. Sumsion & Law (2006) state power has an effect on the fulfilment of goals and that if one wishes to work client-centred, then addressing the power balance and shifting it towards the client is fundamental. One also has to have "... a profound respect for and understanding of the client's perspectives, desires and needs as well as the client's right to make choices and exercise decision about the therapeutic process" (Kielhofner, 2004:70). Outcomes of therapy

should support health and participation in life through engagement in occupation (AOTA, 2008). Outcomes of therapy are measured in terms of participation, perception of success, observable outcomes, satisfaction with care and participation in occupation and the potential improvement in occupational performance (AOTA, 2008; WFOT, 2010). Viewing outcomes in this way reflects enabling as the goal rather than treating. This means that even if the therapist can see little visible change, but the client perceives the therapy to have helped, then one can assume to have reached the goal. It is also important to note that occupational therapists view the clients' independence in a broader way than many others. A client is independent if they perform the activity by themselves, in an adapted/modified environment, with various devices, with alternative strategies or if they oversee others completing the activity (AOTA, 2008). This means the goal of independence can be reached in a number of ways and might not look like something the average man on the street would associate with being independent.

Occupational therapy is articulated differently in different countries. As stated earlier this study takes its starting point in the Norwegian context of occupational therapy. The Norwegian Occupational Therapy Association (Ergoterapeutene - Norsk Ergoterapeutforbund) states: "Occupational therapists contribute to finding solutions when a gap between health and demands of everyday life arise." (Ergoterapeutene - Norsk Ergoterapeutforbund, 2012a). Furthermore, occupational therapists are stated to have a different approach than other healthcare workers to activity and function. They are more focused on solutions than problems, which is why they start by asking the client what it is that is important in their life. The focus is on training and adapting everyday activities, and the goal is to make everyday life possible (Ergoterapeutene - Norsk Ergoterapeutforbund, 2012a).

The Norwegian Occupational Therapy Association has defined what the main areas of competence are and what challenges occupational therapists will face in the future (Ergoterapeutene - Norsk Ergoterapeutforbund, 2012b). These main areas of competence are: promoting participation and inclusion in everyday life, developing the individual's coping skills, adapting activities, modifying environments, solution oriented practice, knowledge based practice and collaboration oriented practice. According to the association, challenges in the Norwegian welfare society that also affect occupational therapists are: demographics

(aging population), challenges in health (for example mental illness, heart disease, diabetes or cancer), children's health and childhood, health among migrants and social differences and inequalities. These are factors that differ from country to country and shape the profession.

3. Previous research

Disabled people have reported various negative experiences concerning the services they receive (McCormack & Collins, 2010). The way a disabled person is met and understood by a professional can be very influential to how the disabled person views themselves (for instance at the onset of impairment) and, in other cases, in conflict with their own view of themselves (Kielhofner, 2005). Since the therapist can have an affect on the disabled person it is important to reflect over what this affect can be and if something can be done differently.

This chapter, based on nine published articles, will explore differences in understanding disability from an occupational therapy perspective and a perspective based on Western models of disability evident in disability studies. It is debated whether occupational therapy should consider what disability studies brings to the discussion and if this should be implemented into the understanding of disability within occupational therapy. The studies show there are different opinions as to whether the disciplines are compatible in their way of thinking about disability. Regardless of what author's think about the matter, there seems to be a common understanding between them that occupational therapy could and should consider what disability studies have to offer in order to develop occupational therapy as a discipline and profession. Two practical studies; by Block et al. (2005) and Gitlow & Flecky (2005), have been conducted on how ideas from disability studies can be implemented into occupational therapy curriculum. The results are presented at the end of this chapter.

Do the ways of defining disability conflict?

As will be presented below, some writers say there are no contradictions between the views of disability within occupational therapy and the views within disability studies, while other writers say the two disciplines are not compatible in their ways of thinking.

According to Craddock (1996b), many writers claim that there are no contradictions between the perspectives of the disability movement and the philosophy of occupational therapy and, therefore, the social model of disability is adoptable into the philosophy of occupational therapy. Block et al. (2005) claim the biggest difference is that occupational therapy focuses on individualised treatment while disability studies focus on community development and

social change through disability rights and independent living. Block et al. state that the occupational therapist approach in comparison to other rehabilitation models is less focused on physiology and more on environmental and social context. Basing their statement on comparison of the definitions of the two disciplines, Block et al. (2005) support the view that there is nothing between the two viewpoints that fundamentally conflict. McCormack & Collins (2010) think the views are theoretically compatible and give a practical example of how the two disciplines can be combined without conflict; they connect five core elements of client-centred occupational therapy with theoretical concepts in disability studies.

However, McCormack & Collins (2010) acknowledge the situation today as one where the two disciplines do not have a compatible view of disability, as most textbooks within occupational therapy confirm the medical model of disability. A number of other scholars also describe how occupational therapy still operates from a medical model point of view, where the disability is located within the individual (Craddock, 1996a; Hubbard, 2004; Kielhofner, 2005; Phelan, 2011). Since one of the major goals of the disability movement is the rejection of the medical model and the adaptation of the social or socio-political model of disability (Craddock, 1996a; McCormack & Collins, 2010), this becomes an irreconcilable difference between the two disciplines.

Being guided by the medical model leads to an individualisation of disability by occupational therapists, with focus on interventions for curing the individual's deficit rather than focusing on a broader societal approach for enablement and social inclusion (McCormack & Collins, 2010). In accordance with the medical model occupational therapists have the right to diagnose and assess, a power they have been unwilling to give up even when it comes to medically stable conditions, which has been heavily criticised by disability scholars (Craddock, 1996a). The disability movement has criticised traditional rehabilitation perspectives for having negative consequences for disabled people because it can imply that impairment and disability is a negative, undesirable state as well as a social and economic burden (Kielhofner, 2005). Client-centred practice (a central concept in occupational therapy) has also been criticised. Hubbard (2004:186) has a clear statement on the subject: "The assumption that the client-centred model is compatible with the socio-political model is false." Phelan (2011) is of the same opinion and states disability in client-centred thinking is located within the individual, with the individual at the centre of the model, while in the

disability studies perspective, the disability is located within society and, therefore, they call for society to be accountable. It is worth noting that both Block et al. (2005) and Phelan (2011) define the individual at the centre within occupational therapy and client-centred practice, but that Block et al. does not consider this as something negative while Phelan does. Phelan argues institutionalised structures, such as the historically privileged position as a professional and the thought of “overcoming” disability typical to rehabilitation, might prevent the therapist from working according to a client-centred model. Block et al. (2005) found evidence of this, discovering that the students’ understandings of disabled people were sometimes limited within a patient-professional framework, and that students thought empowerment and independence were best achieved in a therapeutic setting, not by self-advocacy.

No matter what scholars think about differences between how the disciplines view and define disability, they support the idea of implementing disability studies knowledge and perspectives into occupational therapy. It is also important to remember, as Craddock (1996b) points out, that people within the disability movement advocate the social model of disability for people with stable disabilities, and that in cases of progressive and terminal conditions both a medical and social model are needed.

Taking advantage of what disability studies can offer

Occupational therapists embrace an occupational therapy worldview of culture, consisting of a specific language of concepts, patterns of professional behaviour, a common body of knowledge and norms for producing knowledge (Trentham, Cockburn, Cameron, & Iwama, 2007). This culture is influenced by the different models or paradigms of disability which all reflect different views on disability (Hubbard, 2004). As mentioned earlier, the medical model of disability has a strong hold on occupational therapy. Scholars have called for a need to examine the language used about disabled people and a need to reflect over the norms that guide what is normal and how these have been created (Phelan, 2011; Craddock, 1996a).

Hubbard (2004) says disabled people, as the “patients” of occupational therapists, are demanding to be heard, to decide and define themselves and to be allowed a positive identity.

To enable this and to help the fact stated before, that clients of occupational therapy are not always happy with the services they receive, one can turn to disability studies.

Kielhofner (2005) and McCormack & Collins (2010) argue occupational therapy should take advantage of disability studies to broaden their perspective and to gain a greater reflexivity and understanding of disability. McCormack & Collins also state embracing disability studies can help occupational therapists to ensure a practice that is sensitive to disabled people's opinions. Phelan (2011) adds to this point of view by saying it can help in reviewing assumptions within the discipline and generate new knowledge concerning current practice, the disciplinary language, key-concepts and beliefs within occupational therapy. She also highlights how occupational therapy can enhance its status as a socially responsible discipline by bringing disability studies into occupational therapy. Both Phelan (2011) and McCormack & Collins (2010) state it is crucial to have a practice that is sensitive to disabled peoples' experiences and views and that this can be reached through learning from disability studies. McCormack & Collins (2010) state this is fundamental in order to reach the goal of client-centred practice. Phelan (2011), on the other hand, goes further by saying there might even be a need to rethink the concept of client-centred practice and include a broader focus on social structures as promoted by disability studies.

Much of the literature seems to be positive towards occupational therapy incorporating philosophies and ideas from the disability movement. Disability studies have, according to Kielhofner (2005), had an impact on the rehabilitation paradigm. Today, most concepts of disability also consider the environment as a dimension and contributing factor to disability. Kielhofner points out that this is also the case for occupational therapy. The discipline has tried to correct many of the failures of rehabilitation, such as recognising barriers in the environment and taking an increased interest in phenomenological and narrative accounts of impairment. But, a problem is that the focus on environment still tends to be on the immediate physical barriers or social factors and not on broad political and economic barriers, a theme that Phelan (2011) also mentions when discussing a need for a broader focus in occupational therapy.

Craddock (1996a) says perspectives from disability studies have led to debates in occupational therapy literature and a new understanding of how the individual relates to the

world, influenced a paradigm shift towards a more holistic approach in occupational therapy and clarified what it is an occupational therapist does. However, as the author points out in part two of the article (1996b), holism is not the same as adapting the social model of disability. Adopting the social model would “require us to relinquish the authority that we have drawn from our identification with the scientific authority of medicine, and the associated right to prescribe intervention” (Craddock, 1996b:76).

The implementation of disability studies into occupational therapy could happen via changes in the curriculum. Disability studies want to change curriculums to instead see disabilities as human variation, a political category, an oppressed minority and a cultural group (Hubbard, 2004). This means that focus would be on, for example, autonomy, dignity and competence. According to Phelan (2011) the predominance of the medical model of disability and the lack of influence from other perspectives might be the cause for assumptions about disability not being questioned. Hubbard (2004) says it is important for students to be aware of these different models that, through the curricula, shape the way they view disabled people and make decisions as educated professionals. She poses the question whether the curriculum today is up to the task of preparing students, tomorrow’s clinicians, for the many different tasks and situations they will encounter while working with disabled people. Phelan (2011) refers to what Linton (1998:141) states:

If rehabilitation professionals believe in self-determination for disabled people, they should practice what they teach by adhering to an active affirmative action program in their own departments; by adopting the books and essays of disabled people into their curricula; and by demanding that disabled people have an active voice in conference planning and on the platform at conferences.

Phelan agrees with Linton’s statement that rethinking ideas about disability should begin with knowledge from people with first-hand experience. Block et al. (2005), Hubbard (2004) and Kielhofner (2005) all bring forth the possibility of doing this through the occupational therapy curriculum and claim that this will also help students be better prepared and aware of disability experiences and their roles as advocates.

Implementing disability studies into the curriculum

One study made on the subject of occupational therapy education is by Gitlow & Flecky (2005), who used service learning to incorporate disability studies into occupational therapy education. Service learning is a good method, giving the students a chance to pair up with disabled people and challenge notions of disabilities while simultaneously giving students a chance to reflect on their own attitudes and assumptions. Evaluation of the course showed positive result of students learning experiences concerning: 1) the social construction of disability, 2) the role as an advocate for persons with disabilities, 3) awareness of disabled peoples personal meaning of accessibility, 4) viewing the environment in a new way, 5) experiences with connections to service learning, 6) definitions of partnership and 7) community tensions. The course led to the majority of the students feeling more comfortable when dealing with persons from diverse cultures and the importance of adapting the physical and social environment. To summarise, the authors state:

By combing concepts from disability studies and occupational therapy within the context of service learning, students have reported learning about disability as a social rather than impairment-based concept. In addition, partnership with persons with disabilities and the community has enriched student learning about disability and the role of occupational therapy in the community. (Gitlow & Flecky, 2005:551)

Block et al. (2005) have also carried out a study concerning education; they explored how occupational therapy students respond to a course in disability studies focusing on institutionalisation, deinstitutionalisation and community life. Teaching methods used were reading, guest speakers, movies and a site visit to an independent living centre (ILC). The course was reported to have given the students a deeper and new understanding of how disabled people have been, and still to some degree are, treated by healthcare professionals, how gender affects being disabled and that disability is not always physiological but can be caused by the environment and social prejudice. The site visit opened the students' eyes to the benefits with the peer mentoring approach used. Students were also confronted with the dilemma of individual rights versus clinical judgement, a dilemma close to the one posed by Kielhofner (2005) and mentioned by Craddock (1996b): Who should decide if occupational therapy has something to contribute, the profession or the disabled people?

Trentham et al. (2006) have examined transcultural competence and occupational therapy, examining inclusiveness of diverse lived experiences and the ability to work with clients from different cultures than one's own. This also applies to working with disabled people within a disability culture. Trentham et al. as well as Kielhofner (2005), highlight that students and professionals need the opportunity to analyse their own beliefs and values, especially when belonging to the dominant cultural group, for example, being non-disabled. Their concrete examples on how to include this in the curricula are seminars, lectures, panel discussion, case-based scenarios and fieldwork with specific groups. According to Trentham et al., this should be incorporated through the whole curriculum and should always be a part of the discussion because no occupation and experience can be separated from the cultural meaning surrounding it.

Disability scholars point out that rehabilitation practitioners unintentionally can act in an unhelpful or even harmful way and studies have showed that entry-level therapist assessment is dominated by determining the extent of limitation while the goal is usually impairment reduction (Kielhofner, 2005). This criticism and result cannot be disregarded by occupational therapists. According to Block et al. (2005), not all occupational therapists are aware of the criticism disability studies direct at rehabilitation approaches and can, in turn, react with hostility when faced with this criticism. The authors emphasise that both sides need to do their part; occupational therapists need to build bridges and disability studies scholars should facilitate for more discussion and collaboration. In Craddock's article (1996b) there are suggestions made by various writers on new roles that could be included in occupational therapists' work. For instance, working with employers and public services as advisors or experts on policies and laws concerning disabled people or working as a consultant or advocate within the independent living paradigm. Block et al. (2005) say voices of disabled people must be heard more in occupational therapy and that the next step can be to incorporate disability studies into occupational therapy education and practice. This would strengthen occupational therapy practice and could function as a medium for social change within the disability studies framework. Hubbard (2004) states that every healthcare student should attend a course in disability studies and that there should be a dialogue between the disciplines about body, impairment and technology. Additionally, healthcare curricula should be supportive of disability studies programs. But, it is also important to remember, as Hubbard (2004) and Craddock (1996b) state, one cannot expect a single model to be suitable

in all situations. Whichever model is used should be based on the individual's needs and the specific situation. Then, the social model of disability could function as an option in the range of intervention models within occupational therapy.

4. Method

The aim of this literature study is to explore representations of disability in occupational therapy literature used at universities and colleges in Norway. The method chosen to explore this is *critical discourse analysis*. In this chapter the scientific base for the study, social constructivism, structuralism and post-structuralism, and the method chosen, critical discourse analysis, will be presented. The data collection and analysis procedure will be described and the chapter is concluded with a few thoughts on reliability and validity as well as ethical reflections relevant for this study.

4.1 Scientific base

The aim of this study is to identify discourses that construct the understanding of disability within occupational therapy literature. Focusing on literature means focusing on language and what picture it constructs. The method chosen to explore this is critical discourse analysis. Phillips & Jørgensen (2002:4) state: “in discourse analysis, theory and method are intertwined and researchers must accept the basic philosophical premises in order to use discourse analysis as their method of empirical study.” Discourse analysis has roots in structuralist and post-structuralist linguistics and social constructionism (Phillips & Jørgensen, 2002). Naturally, these theories will be the starting point for this study and will be explained in this chapter.

Social constructivism

Social constructivism is concerned with the process of how people describe, explain or account for the world and themselves in which they live (Gergen, 1985). Berger & Luckmann (1966) define reality and knowledge as socially constructed and relative, describing knowledge as “... developed, transmitted and maintained in social situations...” (1966:15). They state social constructivism is not interested in validity or invalidity of knowledge, but in what passes for knowledge. The authors describe reality as ordinary peoples’ everyday life taken for granted, originating, maintained and made real from their thoughts and actions.

According to Burr (1995), Berger and Luckmann's book, *The Social Construction of Reality* (1966), is one of the major influential books on this subject. Burr (1995) describes how Berger and Luckmann explain how people's social practices construct the world around them while, at the same time, the world appears fixed and predetermined to them. This happens by people acting in the world and making acts and ideas available for others to share, which, in time, gives the act or idea a life of its own; it exists. Future generations are born into a world where this act or idea is a natural part, a given, and therefore it becomes a part of their understanding of the world.

There is no single definition of social constructivism but there are four common key premises that are central (Burr, 1995). These will be described below based on Burr (1995:2-5), Gergen (1985:266-269) and Phillips & Jørgensen (2002:4-6).

The first premise is a critical stance towards knowledge that is taken for granted and assumed. This means one opposes the traditional view that science can reflect or map reality directly without considering the context. Humans are thought to comprehend the world through categories. These are not necessarily derived from real observable divisions but might also be products of how humans have constructed the world. An example is how the two categories of humans, men and women, are observed. There are undoubtedly observable differences in this case. However, social constructivism would question whether the categories are based only on this difference and why the differences have been given so much importance that identity as a whole has been built on it. Another example are emotions; are they biological or dependant on how they have been constructed? This needs to be questioned and, therefore, one should always be suspicious of assumptions of the world.

The second premise is the understanding of the world as historically and culturally specific. How someone understands the world is dependent on where and when in time they live. It is situated in history and interaction with others and, consequently, one's worldview and identity could have been completely different under different circumstances. It is also subject to change when the conditions change. This also makes it impossible to say that "our understanding" is better than that of others. It is an anti-essentialist view; saying people are not equipped with fixed characteristics or essences and that the world is not predetermined or

set by external conditions. This understanding of the world affects institutions such as politics, economics and social and moral codes, which certainly vary with time and culture.

The third premise is that knowledge and understanding is sustained by social process. This means an understanding or knowledge is not valid or held over time because of its empirical validity, but through ever-changing social processes such as communication, negotiation and conflict. Knowledge is, according to social constructivism, produced between people in their interactions. These interactions, especially language, are of interest to social constructivists. Depending on how social relationships develop understandings can be suggested, acknowledged and abandoned over time. For example, what is moral in a relationship is decided through social interaction when actions are defined as, for instance, envy, anger or flirtation. When actions are defined and given meaning they become a label used for social control. Through interactions people compete to define and construct what is true and false. What is considered to be the “truth” is what people currently accept as understandings of the world, not objective observations of the world.

The last premise is the idea that there is a link between knowledge and social action. The social construction of knowledge and truth has consequences for social action, meaning, depending on how one views the world, certain actions are natural and others are unthinkable. Descriptions and constructions of the world create patterns of social action, some that are desired and some that are not. An example is how one defines alcoholism: is it something a person is responsible for or not? The definition, in turn, determines how the person is treated and expected to act.

Summarising these four points, a social constructivist is someone who is sceptical about assumed knowledge, does not think reality can be observed as objective truth and acknowledges that knowledge is constructed in social process depending on time and place, which means everything could always be different.

According to Phillips & Jørgensen (2002), social constructivism has received criticism concerning the idea of knowledge and social identity as conditional and uncertain, which in turn leads to no regularity in social life. This criticism is, however, exaggerated according to

Phillips & Jørgensen, who say most social constructionists see social identities as quite inflexible in practice since specific situations are restrictive.

The ideas of social constructivism are central for discourse analysis and for this study. In order to examine how disability is represented in occupational therapy literature a critical gaze toward assumed knowledge in the texts is necessary. Finding explanatory statements, connections, contradictions and justifications for words used and ideas presented is crucial to understanding how knowledge is constructed. The focus in this study is not on linguistics but the bigger picture. Therefore, the context which representations of disability are set in is important in order to gain a full understanding of how they are constructed and how different contexts have different effects. Analysing what is stated as “true” knowledge about disability can also be done by looking for changing opinions on the subject and discovering how ideas or knowledge is reproduced and sustained. What is “true” limits and directs social action, something that can be seen in texts by how disabled people are expected to act and be treated.

Structuralism and post-structuralism

The starting point for discourse analysis is that our access to reality always is through language, something derived from structuralist and poststructuralist linguistic philosophy (Phillips & Jørgensen, 2002).

Structuralist linguistics were developed by Ferdinand de Saussure and set the base for how language is understood as a system (Phillips & Jørgensen, 2002). Burr (1995) and Phillips & Jørgensen (2002) both outline the basic idea of structuralist linguistics. Language is built of signs. These consist of two dimensions, form (the sound) and content (the meaning). The point de Saussure made is that signs do not contain meaning and do not automatically refer to anything real. Meaning is ascribed to them through social convention and it is dependent on their relationship to other words; by being different they gain a specific value. Structuralism states this link between the form and content of the word, that a specific sound signifies a specific object, is fixed. This link is arbitrary and, by constructing language, it has also divided our world into arbitrary categories. The final point the authors make is how de Saussure separated language (the structure) from parole (the situated use of language, considered to be highly random) and focused on analysing only language that was assumed to

be stable. However, by doing this, structuralism fails to address how the meaning of words can change over time and how words can carry numerous meanings (Burr, 1995).

Post-structuralism answers these questions by saying the meaning of signs and language are not fixed and stable, which is the point that separates the structuralist and post-structuralist ways of thinking (Burr, 1995; Phillips & Jørgensen, 2002). Phillips & Jørgensen (2002) state poststructuralists agree with structuralists that meaning is ascribed to words in the network of signs and not from relation to something real, but they do not view this meaning as stable and they do not agree on the sharp distinction between language and parole. Burr (1995) describes the post-structuralistic view of meaning in language as temporary, contestable and always open to questioning. It is thought of as a site for struggle and conflict, of power relations being acted out and challenged. Language is a social phenomenon occurring between people, and in this exchange the person and identity can be constructed. Summarising, in the post-structuralistic view, language is a social phenomenon occurring between people and is created, reproduced and changed through usage. Signs or words can be used to exercise and resist power relations and they are given meaning in relation to each other, depending on the context in which they are used.

4.2 Critical discourse analysis

Discourse analysis is not only one method but many different interdisciplinary approaches (Fairclough, 2003; Phillips & Jørgensen 2002). Therefore, it is relevant to specify that the chosen method for this study is critical discourse analysis as described by Norman Fairclough. This approach is described below. The choice of method for this study was dictated by the project. Critical discourse analysis was set as the method based on the project leaders' earlier experiences and fields of knowledge.

First, the term discourse must be understood. Fairclough (1992) and Phillips & Jørgensen (2002) state there is no consensus on a definition of discourse. Phillips & Jørgensen (2002:1) define it as "A particular way of talking about and understanding the world (or an aspect of the world)". This definition is further explained by Phillips & Schrøder (2005), who state discourses are culturally specific and that they regulate how other ways of explaining or understanding the world are met, making the other understandings less natural or completely

unthinkable. Fairclough (1992) has three ways of defining discourse, also described by Phillips & Jørgensen (2002) and Phillips & Schrøder (2005). These are discourse as extended samples of spoken dialogue or text, that is as a social practice, as spoken or written language in context (with focus on production, interpretation and context) and as language used in different but specific social situations. Fairclough (1992) describes discourses as reflecting and constructing social entities and relations. Central to Fairclough's view of discourse is its importance as a social practice, responsible for reproducing and changing knowledge, identities and social and power relations, while also being shaped by these social practices (Phillips & Jørgensen, 2002).

Within Fairclough's critical discourse analysis certain themes are central: division between discursive and non-discursive practice, intertextuality, order of discourse and the three dimensions of discourse and discourse analysis. Fairclough (2003:205) states, "Critical discourse analysis is the analysis of the dialectical relationships between discourse (including language but also other forms of semiotics, e.g. body language or visual images) and other elements of social practices". The division between discursive and non-discursive elements of social structure are, according to Phillips & Jørgensen (2002), typical for Fairclough's critical discourse analysis. The part of the social world that functions according to non-discursive practices requires different analytical strategies when they function according to a different logic. Discourses are in a dialectical relationship to other social practices and are constantly affecting each other. The investigation of change through studying intertextuality is also important (Phillips & Jørgensen, 2002). Fairclough (1992) describes intertextuality as the way texts are constructed by drawing on other texts in different ways, depending on social circumstances. He separates between manifest intertextuality (with other text present) and interdiscursivity (drawing on other styles and discourses). Phillips & Jørgensen (2002) state change happens through combining texts and discourses and, by investigating intertextuality, one can see if discourses are reproduced or confirmed. Order of discourse is defined by Fairclough (1992:9) as: "total configurations of discursive practices in particular institutions, or indeed in a whole society". This is explained by Phillips & Jørgensen (2002), who say it is the sum of genres and discourses used within a social domain, a system, reproduced by communication and changed through new ways of using language.

Fairclough describes language use as a communicative event consisting of three dimensions (Fairclough, 1992; Phillips & Jørgensen, 2002): text dimension, discursive practice and social practice. The analysis of text is about the linguistic and formal features of the text. The discursive practice looks at the production and consumption of the text, on interdiscursivity and intertextuality. The social practice places the communicative event in the social practice it belongs to and analyses it in context. On this level, non-discursive practices have an effect, and drawing on other disciplines is necessary in order to understand the wider social practices. The final result of the discourse analysis is reached when the text and discursive practice have been studied and analysed in relationship to the broad social practices (Phillips & Jørgensen, 2002). These three levels have guided the analysis done in this study. Most focus has been put on the discursive and social dimensions as these best answer the research questions. The analysis will be further explained below in “Procedure for analysis”.

4.3 Data collection and selection

The data for this study consists of literature used at occupational therapy programs in Norway. This degree is offered at five schools in Norway: Bergen University College (Høgskolen i Bergen, HiB), Oslo and Akershus University College of Applied Sciences (Høgskolen i Oslo og Akershus, HiOA), Sør-Trøndelag University College (Høgskolen i Sør-Trøndelag, HiST), University of Tromsø (Universitetet i Tromsø, UiT) and Diakonhjemmet University College (Diakonhjemmet Høgskole).

The data collection process began in May 2011. Student counsellors, advisors and secretaries at the five schools were contacted regarding access to literature lists and course descriptions used in the occupational therapy programs during the past five years. By fall 2011, all data was collected. It is worth noting that different amounts of data were collected from each school because all did not have the resources to compile data from five years back. This did not cause a problem because the timeframe for the project was limited and it was therefore decided to only include the newest course descriptions and literature lists. Additionally, the program offered at Bergen University College has a different structure than the rest. The program is based on problem-based learning (PBL), meaning the students find their own literature and the only existing literature list is for the introduction course. Other schools have set literature lists for all subjects containing mandatory and additional literature.

Consequently, the data collected and used in the sampling process for choosing what literature to analyse in this study is:

HiB: Literature list for introduction course for school year 2010–2011

HiO: Literature list and course descriptions from 2010 group 2010–2013

HiST: Literature list and course descriptions for group 2008–2011

UiT: Literature list for group 2010–2013 and course descriptions updated 2009

DHR: Literature list in use school year 2010–2011 and course descriptions updated 2010

The collected data differ between schools. Some schools have literature lists that follow specific student groups, while other schools set their literature lists from one school year to the next. This does not pose a problem because all literature lists collected are from the same time period. But, one can wonder how the lists are updated; is it done annually or as preparation for each separate course? However, this is not a theme in this study and has not been investigated further.

The amount of literature from all the lists was expected to be extensive. In order to reach a manageable and representative amount of data to analyse it was decided to include the most frequently used literature specific to occupational therapy. The reasoning for this being that texts used often can be assumed to be central and trusted. To select what literature to analyse, the course descriptions were read and courses not specific for occupational therapy (such as anatomy and methodological courses) were excluded. The literature lists for all included courses were compiled in one alphabetically ordered document, clearly showing which school and course the literature was used in and if only certain chapters were used. References to anthologies were rewritten so the editor became the reference and the author of the chapter appeared at the end of the reference. This was necessary because counting how many times a book was used was done based on the alphabetical ordering of the list. The compiled list was 49 pages long with many references appearing multiple times (Appendix 2). To further shorten the list and pin down what literature to analyse, only literature used at four or more schools was included (Appendix 1). From this list, containing 11 books/articles, the most relevant literature was selected for analysis based on a discussion with the supervising professors. Literature about general occupational therapy was included while literature focusing on a specific area of occupational therapy was excluded. From the

literature chosen only the most frequently used chapters (evident from the alphabetically ordered list) were included. The included books/chapters are:

- Borg, T. et al. (2007). *Basisbog i ergoterapi: aktivitet og deltagelse i hverdagslivet*. (Foundational book in occupational therapy: activity and participation in everyday life) (2nd ed.). København: Munksgaard. Chapters: 5-7,13,16,17,19.
- Kielhofner, G. (2008a). *Model of human occupation: Theory and application* (4th ed.). Philadelphia: Lippincott Williams & Wilkins. Chapters: 4-8, 11,13.

Finally, 356 pages from two books were included in the analysis. However, these pages included passages not relevant for the analysis where disability was not discussed and mentioned. Passages about practical aspects and guides to carrying out occupational therapy have been disregarded. Only passages of the text relevant for the understanding of disability have been analysed.

The book by Borg et al. was written in Denmark while the English book by Kielhofner was written in an American context. The Danish book is an introduction to the field of occupational therapy in a Danish context, written and structured like a textbook. The first edition was published in 2003. Kielhofner's book is a presentation of the Model of Human Occupation, which explains human behaviour. The model, based on the work of Kielhofner himself, was first published in 1980 (MOHO Clearinghouse, 2011). Kielhofner was the driving force behind the model until his death in 2010, although it has always been developed in collaboration with others.

4.4 Procedure for analysis

The analysis has been guided by nine questions formulated by Phillips & Schrøder (2005) based on Norman Fairclough's critical discourse analysis. These are divided according to the three dimensions of discourse described by Fairclough: discursive practice, text dimension and social practice. Most focus has been on the discursive and social practice as these most appropriately answer the research questions and as I am not familiar with linguistic analysis.

Discursive practice

- Which discourses does the author relate to and how are the discourses articulated together?
- What worldviews, identities and social relations are discursively constructed?
- What/Which order of discourse does the discourses belong to?

Text dimension

- Modality
- Transitivity
- Word choice

Social practice

- What is the relationship between the discursive practice and the order of discourse?
- Does the discursive practice reproduce the order of discourse?
- What are the partly non-discursive social and cultural conditions that shape the discursive practice?

The first step of the analysis was to read through all the included literature and further limit what was included, leaving out sections not mentioning disability. It had been decided not to analyse the pictures and illustrations, but to focus on the text alone because neither the supervisors nor I have competence in picture analysis. Sections where disability was mentioned were marked for further analysis and statements that were explanatory and representative were highlighted. When reading the text the goal was to answer the questions from the discursive practice and text dimensions. The questions are difficult to answer separately and doing so gives no extra value and, therefore, focus has been on explaining the whole dimension when presenting the results. However, the questions have been used as a guide of what to look for while analysing the text. While reading, a mind map was made for each discourse that appeared throughout the text. Statements and other characteristics in the text that were typical for that specific discourse were written down. This includes, for example, specific words used often, representative quotes and personal thoughts of how things were connected. The result, what discourses are evident concerning disability within occupational therapy literature, is presented in the results chapter. The social practice dimension was analysed last. Non-discursive practices that limit the discourses, for example laws and policies, have been noted when they have been mentioned in the text. However, analysing this dimension has meant connecting the discourses found to bigger societal tendencies and other relevant theories. These results are presented in the discussion chapter.

4.5 Reliability and validity

Reliability and validity are measured according to certain criteria, which are fairly easy to establish within quantitative research and within a positivistic tradition where an objective measurable reality is believed to exist (Denscombe, 2004; Phillips & Jørgensen, 2002). Qualitative approaches draw their strength from their flexibility, opening up new possibilities and opportunities to gain new knowledge, but this flexibility can be seen to threaten the traditional reliability and validity of a project (NEM, 2010). This is also stated by Kvale & Brinkmann (2009) who say problems validating qualitative research are due to the method's strengths (the characteristic ability to question and describe the social reality) and not necessarily because it is a weak method.

A dilemma concerning traditional reliability and validity arises for researchers within a social constructivist tradition. "If the researcher accepts the social constructionist premise that knowledge is always historically and culturally embedded, this also pertains to scientific knowledge, including the researcher's own results." (Phillips & Jørgensen, 2002:174). It is impossible to describe the results as true or real because, technically, there are no objective truths when everything is socially constructed. According to Denscombe (2004), many qualitative researchers do, however, still engage in the discussion of reliability and validity, but based on understandings of the concepts adapted for qualitative research. This project, using discourse analysis based on a social constructivist thinking as the method, will consider reliability and validity based on a qualitative understanding.

Reliability is traditionally a measurement of the research method, seeing if it produces results unaffected by accidental circumstances, such as who carries out the study or when it is done (Denscombe, 2004; Silverman, 2006). Within social constructivism it is acknowledged that researchers can read and understand texts differently (Burr, 1995). Creswell (2007) supports this, saying the researcher's background shapes their interpretation. This implies results automatically will vary depending on when the analysis is done, by whom and depending on what previous knowledge the researcher has gained from one occasion to another. These factors indicate low traditional reliability. Transparency as the criteria for reliability, as mentioned by Silverman (2006) and Phillips & Jørgensen (2006), is more relevant for this study. Silverman specifies two ways of ensuring reliability for qualitative work. First, the

research process should be transparent, with sufficient descriptions of the strategy and data analysis. Second, attention should be paid to “theoretical transparency”, which is being explicit about one’s theoretical base and how this directs one’s interpretations.

Validity is traditionally defined as the truthfulness, accuracy and strength of the result or representation of the phenomena set to study (Denscombe, 2004; Kvale & Brinkmann, 2009; Silverman, 2006). Denscombe (2004) describes validity as a guarantee for the reader that the research not is based on inadequate data or incorrect interpretations. Burr (1995:180) states it is hard to validate ones reading and understanding of a text within discourse analysis. According to her, the analysis cannot be said to reveal a “truth” and that other researcher’s results are equally valid. A more appropriate way to look at validity within the social sciences is presented by Kvale & Brinkmann (2009). They state validity should concern whether a method can be used to investigate what it is said to investigate. The focus is not on if the results are true, but on if one is investigating the “right” thing. This implies that validation occurs during the whole process and not only as a check for the results. Silverman (2006) lists three distinct criteria to acknowledge for ensuring validity in qualitative research. First, acknowledgement of the researchers impact on the setting, second, the researcher’s personal values and third, the status of truth of a respondent’s account.

Phillips & Jørgensen (2002) highlight there is no consensus on what criteria to use for reliability and validity checks within discourse analysis. However, they, as well as Gill (2000) and Silverman (2006), give some examples of how to enhance the quality of a project.

The analysis should be solid, which means the analysis should be based on different text and text features to gather enough understanding and “evidence” for one’s conclusion (Phillips & Jørgensen, 2002). The solidity is added to by using a constant comparative method (Silverman, 2006), which means comparing fragments and looking for potential different explanations. A deviant case analysis (mentioned by Gill, 2000 and Silverman, 2006), which in detail examines contradicting findings, also solidifies results. The analysis should be comprehensive, meaning one does not have to analyse everything in every possible way, but enough to fully answer all questions posed to the text (Phillips & Jørgensen, 2002). Silverman (2006) also talks about comprehensive data treatment, and states the findings should apply to every part of relevant data, implying no parts or contradicting findings can be

left out. Gill (2000) states the quality can be enhanced by checking how participants understand the responses and by investigating coherence; that is, checking if the results match with earlier studies and knowledge. According to Gill (2000), perhaps the most important way of securing the quality of the project is to let the readers evaluate the results or present their own interpretations. This can be connected to the transparency mentioned earlier, which is a prerequisite for scrutiny by others.

The reliability, or transparency, for this study has been acknowledged by describing the research process in detail, explaining how personal background knowledge might affect the results (see Ethical considerations, p. 52), how the analysis has been carried out and by referring to the original texts. By adhering to transparency as criteria the validity criteria listed by Silverman (2006) are fulfilled. The researcher's personal values and impact on the study are reflected upon, while the criteria on the truthfulness of respondents accounts does not apply in this study as there are no respondents. The validity, if the method is suitable to analyse the chosen theme, can be assessed when the criteria of transparency is fulfilled and the reader can judge if the method matches the goal and if the research question has been answered. The "most important" criteria, evaluation by the readers, is also connected to the transparency of the project. The evaluation is made easy when the included literature is available for anyone to read, allowing people to see the "evidence" for the conclusions in the original text and context. To add to the transparency references have been given to specific chapters in the included literature rather than the whole book, making it easier to trace the source. Silverman (2006) states textual sources, like the ones used in this study, are considered more reliable than observations. A risk factor, however, is the text not being authentic, which one quite certainly can say is not the case for this study of officially acknowledged books. The analysis has been solid and comprehensive when all different aspects of the included texts have been taken into consideration and the result and the representations of disability have been thoroughly analysed until no new understandings have appeared.

4.6 Ethical considerations

Ethics is about the relationship between people, about what can be said and done to others. We affect each other directly and indirectly, for example, through knowledge and assumptions conveyed by research, which, in turn, affects how people understand each other and themselves (Johannessen & Tufte, 2002). There is no “one rulebook” on ethics because every research project is different and demands special consideration (Denscombe, 2004; NESH - Den nasjonale forskningsetiske komité for samfunnsvitenskap og humaniora, 2006). However, there are ethical principles and guidelines intended for evaluating whether actions are right or wrong (Johannessen & Tufte, 2002). The researcher is always responsible for studies being conducted in a moral way, and although ethical guidelines are not laws, every principle has to be taken into consideration (Denscombe, 2004).

In the case of this thesis, a literature review with no contact with informants, no permits from ethical committees were required. The characteristics of the study made some ethical principles, for example anonymity and informed consent, irrelevant. However, there are still ethical considerations to be made. It is important to reflect over how the data is treated, how results are presented, what the potential effects of the study are and how the researcher has an effect on the study.

The way data was treated and results presented follow the same basic principles. Ethical guidelines as described by NESH (2006) concerning scientific honesty, plagiarism and a clear system of references to other texts have been followed. The included data is written by different authors and they have been analysed and presented equally. When interpreting the data, its specific context has been considered and explained to the reader to avoid misunderstandings. The data has not been altered and references to the original source are given. References are made to specific chapters in the two included books, not only to the books in general, so that contributing authors are acknowledged. The analysis and results are presented in a clear and open manner so the reader can understand decisions and critically assess the study. This is made easier when chapters and not the whole book are referred to.

Researches must acknowledge the effect their work can have on involved parties, especially negative effects (Denscombe, 2004; NESH, 2006). The data material has been collected from

universities in Norway, which offers programs in occupational therapy. The data is not specific to the schools and, even if they use partly different literature, an inclusion criterion for this study was that the literature be used by at least four of the five schools, not singling any school out. Hence, there is no risk of any of the schools being treated in a different way or being presented as inferior to the others. The results from the study can be used by the schools to reflect over current practices if they wish, but this is not a topic in this study. Another involved party that can be affected is the authors of the included literature. A written and published text lives its own life and can be expected to be used under different circumstances. In this case, the representation of disability was analysed by looking at how it was mentioned in the literature. The focus was not on specific authors' different views or personal opinions, but on the whole picture the literature created. The authors' texts have been treated equally, explained in context and referred to in a clear manner.

When doing qualitative research, being close to the field is vital (NEM, 2010). But, getting too close to the subject has negative consequences, causing one to lose their neutral standpoint and "go native", becoming too involved (NEM, 2010). A researcher has to reflect and recognize how their personal, cultural and historical experiences shape their interpretation and understanding at all stages (Creswell, 2007; NEM, 2010). It will direct their attention to certain things, restricting their ability to see other methods or results (Phillips & Jørgensen, 2002). Creswell (2007) discusses "positioning oneself" in the research by being aware of these factors. The researcher has to be specific and clarify how their opinions can affect choices underway and the interpretation of results, and be able to impartially discuss conflicting views (NESH, 2006). In cases where the researcher has personal knowledge of the field of study it is essential that they reflect over positive and negative effects this might have (NEM, 2010). NEM (2010) states that as long as this is done in an explicit way, having previous knowledge does not have any negative effects.

I have an existing knowledge base gained through a Bachelor's Degree in Occupational Therapy. This degree was fundamental when this subject was chosen for the thesis, as it was desired that the thesis be connected to occupational therapy. Phillips & Jørgensen (2002) say exploring familiar discourses pose a particular challenge; it is difficult to treat them as socially constructed systems that could have been different and not as taken-for-granted knowledge or a common-sense understanding. This has been a personal challenge as a

researcher. I have a certain view of occupational therapy and disabled people gained through school. However, studying society and disability during the past two years has led me to reflect over my assumptions and beliefs about disabled people and the role of society. This personal development has helped to distance myself from the occupational therapy concepts, even if this is impossible to do completely. A deeper understanding of the concepts was also why this project, focusing on interpreting literature, was chosen. It provides a chance to further reflect on the subject of what disability really is in occupational therapy. As stated by Phillips & Jørgensen (2002), the aim for the discourse analysis is not to find out what people really mean with what they say, but to explore patterns in and across statements and to identify social consequences of different representations of reality. What is said about disability and whether it is right or wrong, or what is really meant, has not been analysed in this thesis. Doing this would be impossible since it would mean judging my own understandings. Instead, the focus has been on what is said, different opinions and patterns and studying the social consequences by drawing on other theories.

5. Results

This chapter is dedicated to the presentation of the results from the critical discourse analysis conducted, more specifically the results from the discursive practice dimension and text dimension. The social practice dimension is dealt with in the discussion chapter. The discourses found represent different ways of viewing disability, and these are presented first in the chapter. Thereafter, the complete understandings of disability that appeared in the text are presented. Figure 2 (p. 57) illustrates both the discourses and the complete understandings of disability that has been found. The research questions that are answered are: *How is disability represented in occupational therapy literature?* and, *Within which discourse does the literature place disability?*

Two texts have been analysed, written by Borg et al. (2007) and Kielhofner (2008a). The book by Borg et al., *Basisbog i ergoterapi* (Foundational book in occupational therapy), was written in Denmark. It is a typical introductory textbook touching on all areas of occupational therapy, presenting different theories on the field. Kielhofner's book, *Model of human occupation*, was written in an American context. This book presents a specific theory to understanding human occupation and also touches on many fields within occupational therapy, but from a different angle where the aim is to explain and promote the single specific theory. In this chapter, when presenting the results, references are made to the specific included chapters instead of only the book. This is to stay true to all authors and make the scrutinisation of the research easier for the reader. However, as a result, it seems as though more than two books have been used even though this is not the case.

5.1 The discursive practice – finding discourses and understandings of disability

Three different discourses have been identified in the texts. The discourses are medical, individual and relational, as illustrated in Figure 1. They describe how the individual is viewed and affected by different factors. The view of the individual is important as it is at the centre of the complete understanding of disability. The discourses are intertwined and they all contribute to the understanding of the individual and of disability within occupational therapy. They all are a part of the occupational therapy order of discourse, which is the complete understanding of disability within the field.

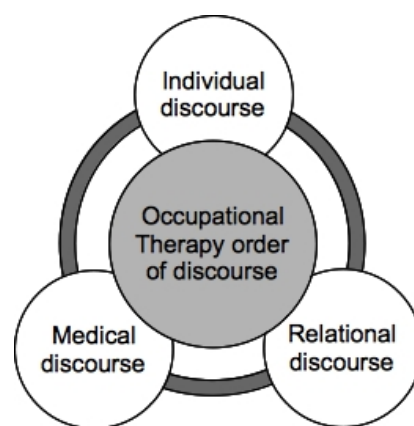


Figure 1. Interdiscursivity.

The individual discourse

The individual discourse describes how the person is understood within occupational therapy. Every person is thought to have a stable core (layer one in Figure 2, p. 57), which is the desire to be active and participate. The core and the meaning of activity and participation are seen as crucial for functioning and health (Dahl, Haugbølle, Jarl, Schjerning & Thanning, 2007). Dahl et al. (2007:126) state, “The goal of occupational therapy is to promote opportunities for activity and participation in everyday life.” Since activity and participation is the goal of all occupational therapy and, it is assumed to be something that applies to all people and situations. The core is also evident in Kielhofner’s text (2008a). The name, *Model of Human Occupation*, clearly states that human occupation is central. The concepts the model presents (volition, habituation and performance capacity) are ways of understanding how human occupation is motivated, organised and carried out. Activity and participation are

central in many examples given in the text (Kielhofner, 2008e:32-34; 2008c:51-52; Kielhofner et al., 2008:75-82) and impairments themselves are not necessarily seen as problems until they restrict activity and participation. The core can be seen as stable when facilitating activity and participation is always the goal of therapy, no matter what type of problem the person has.

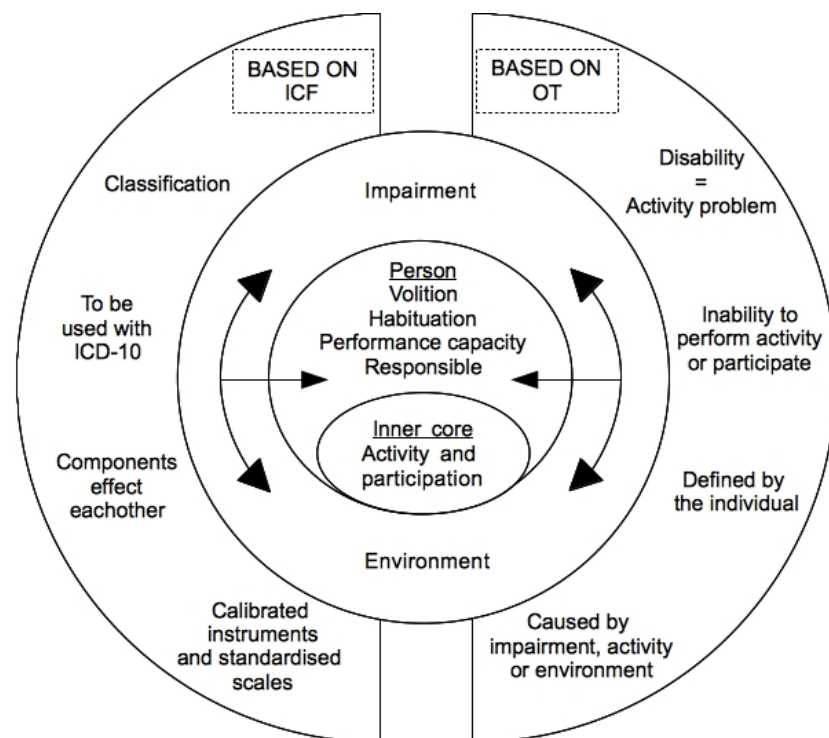


Figure 2. Representation of disability in occupational therapy literature, based on ICF and occupational therapy, OT.

Every person has an inner core and, on top of it, individual qualities that constitute the unique person. This is represented by the second layer in Figure 2. Within the individual discourse it is highlighted that people are responsible for themselves (see Fortmeier, Mathiasson & Schröder, 2007). Intervention in therapy is based on collaboration between therapist and client (Fortmeier et al., 2007), which is central because change cannot be accomplished, only facilitated, by the therapist. Instead the central mechanism behind achieving change is the client's actions, thoughts and feelings (Kielhofner & Forsyth, 2008b). Viewing the client as responsible is central for the idea of client-centred practice, where the person has the right to be involved in their case and have control over their own life as well as their health and

potential impairments (Dahl et al., 2007). Kielhofner & Forsyth state (2008a:171): "... all change in occupation is driven by clients' occupational engagement." By occupational engagement the author means doing, thinking and feeling as well as making a choice, being motivated and experiencing meaning. Kielhofner & Forsyth (2008a) describe contributors to change as, for example, making decisions, committing, exploring and identifying. A prerequisite for clients making choices and committing to something is that the client is viewed as responsible. If they are not viewed as responsible, their choosing will not be a step towards positive change. The other aspects of the person, mentioned in the second layer in Figure 2, are what Kielhofner (2008a) describes as individual qualities: volition, habituation and performance capacity. Volition directs action through what interests and values the person holds and through personal causation, that is, knowing one can make things happen (Kielhofner, 2008e). The concept of habituation explains human action as habits and roles that direct one's actions in specific contexts (Kielhofner, 2008c). The last concept, performance capacity, is the actual ability to do things (Kielhofner et al., 2008). These three concepts "... are fashioned and maintained, and altered by what people do and how they think and feel about their doing" (Kielhofner & Forsyth, 2008a:171). This means this part of the person is not static like the core, but changeable and, as explained in the next paragraph, affected by other factors.

The relational and medical discourses

At this stage the relational and medical discourses of understanding disability come into the picture. Within the relational discourse, disability is described as something changeable, consisting of and being affected by many factors. The medical discourse describes people and disabilities as something based on medical facts and impairments. It represents a more linear chain of events where effects of impairments are more predictable. The relational and medical aspect of disability is illustrated in the third layer of Figure 2. This layer consists of impairment and environment, which both affect the individual qualities discussed in the previous paragraph.

Impairments and the environment both affect each other. This is illustrated by Kielhofner, who states: "Environmental factors are also critical to whether and how impairments affect performance" (2008b:103) and "A disability may alter, but need not prevent, occupational

participation if adequate environmental supports are in place” (2008b:102). In some cases the environment is the cause for the impairment through, for example, an accident or being exposed to certain elements. In cases where the environment is not directly the cause, it still affects whether disabled people can perform activities and participate in society (Brandt & Jensen, 2007). The environmental impact, or whether or not the environment is available for the disabled person, is described by Brandt & Jensen (2007) and Kielhofner (2008d) as a relationship between the demands of the environment and the person’s characteristics and functional capacity. The environment can be both a resource and a constraint to action.

The environment and the impairment, while affecting each other, also affect the person (illustrated in Figure 2). How one is affected is highly personal, meaning even if two people have the same impairment or diagnosis it might affect them in different ways. Kielhofner (2008d:88) states: “Since persons have different capacities and beliefs in their own abilities, the same environment may engage and excite one person, bore another, and overwhelm a third.” This is typical for the relational dimension. One can say something might affect the person or have a certain influence but one can never be certain since there are many factors that all influence the person and situation simultaneously. As illustrated in Figure 2, the part of the person that is affected is the individual qualities, not the stable core. This means a person, no matter what the impairment or environment poses on the person, always has the wish to be active and participate in society in some way.

The personal characteristics that are affected are volition, habituation and performance capacity. Volition is influenced by biological and physical states that affect one’s capacity, interests and values through how one perceives the world and what possibilities and experiences one gets (Kielhofner, 2008e). This illustrates how impairment is separated from the person, viewing it as an influencing factor and not as automatically resulting in a predictable outcome. Volition is also affected through reflecting over and gaining experiences of doing: “At any point in time a person’s volition will reflect a unique personal history and circumstances that have shaped and continue to shape it.” (Kielhofner, 2008e:35). The aspect of habituation (habits and roles) is affected both by the impairment and the environment. Kielhofner (2008c) describes habits as part of life and how they may contribute to disability or compensate for it. Old habits are often severely disrupted by acquired impairment and changed capacities, while there always is a risk of learning dysfunctional

habits from the environment, especially if one is born with some form or impairment. Occupying roles is affected by being disabled (Kielhofner, 2008c). The impairments themselves can restrict role performance and, in the case of acquired impairments, there might arise a conflict between one's own expectations and ability to perform a role. A person may be barred from or not receive the opportunities to acquire or learn roles. Being cast into a sick or disabled role can be difficult to combine with one's own view of oneself, and can lead to a problem gaining a positive identity. Even if the impairment itself poses restrictions, Kielhofner (2008c) states the biggest obstacle to role performance are social barriers, ranging from poor attitudes to policies that exclude disabled people. The third personal characteristic that is presented in layer two in Figure 2 is performance capacity. Performance capacity has two aspects that can be affected: the objective physical and mental components and the subjective experiences (Kielhofner et al., 2008). The objective part is technically the same as impairment; both can be medically classified and observed. This is part of the medical discourse, where one focuses on the physical and measurable state of the body. The environment's effect on the objective components can easily be observed, like physical obstacles for wheelchair-users or high demands of efficiency for workers, which inhibits people with cognitive impairments. The subjective aspect is presented by Kielhofner et al. (2008:70) as the *lived-body concept*, which is knowing the world through one's particular body and how the experience affects one's performance. Disabled people are stated to have a particular way of experiencing their bodies (Kielhofner et al., 2008), sometimes depending on the specific impairment and sometimes on how they experience themselves in the environment surrounding them.

So far, the results have focused on presenting how people (disabled but also non-disabled) are viewed within occupational therapy literature. This is central since disabled people first and foremost are represented as people or individuals. There is a strong focus on the person. Who they are and what affects them is described in detail, especially by Kielhofner (2008a). People are thought of as a whole, where the separate parts, body, soul and active nature, interact with each other and the environment (Christensen Gammeltoft & Enemark Larsen, 2007). A disabled person is thought to have a desire to be active and having individual qualities that are affected by outer components such as impairment and environment. Impairment is not seen as part of the individual per se, but as a component that affects the person's individual qualities. The individual, relational and medical discourses all focus on

different aspects of who the person is, but are all intertwined and none of them explain the whole picture individually. This means that in occupational therapy a disabled person is not just seen as disabled, but first and foremost as an individual. This is illustrated by Dahl et al. (2007:139 [my translation]): “Diagnoses by themselves do not reveal any information on what problems peoples health conditions result in in everyday life”.

Understanding disability – the two outer halves in Figure 2.

As illustrated by the two outer halves in Figure 2 (p. 57), two separate ways of thinking about disability appeared in the occupational therapy literature. The right half represents a traditional occupational therapy (hereafter referred to as OT) way of looking at disability, based on the individual, medical and relational discourses. Disability, in this case, is referred to as an activity problem. The left half represents an understanding of disability based on the International Classification of Functioning, Disability and Health (ICF). The traditional OT understanding appears in both texts and is evident as a representation of disability both within the Danish and the American context. The understanding based on the ICF appears in the Danish book by Borg et al. and is not mentioned in the chapters by Kielhofner that are included in this analysis. To be fair to Kielhofner, he does discuss the ICF (in relation to his own model) in a part of the book that is not included in this study, meaning the ICF is also evident in the American context.

The two ways of understanding disability are illustrated in Figure 2 as having the same core, represented by the three inner layers, but differ on how they define and construct disability. Even though the core is described to be shared and similar or identical terms are used, the meanings of those terms differ depending on the model. This will be further explored in the discussion chapter, after the two different understandings have been presented in this chapter.

The traditional OT perspective

In the analysed occupational therapy literature the term *disabled* is not often used. Person, individual, client, user (brugere) and citizen (borgere) are more common. People are described as having a problem with activity or participation instead of being disabled. This is a matter of naming. The labels one chooses to use can be influenced by many factors and

change over time. A wish to profile the profession in order to assure its position in relation to other disciplines can be one influential factor behind what labels or names are used. This is a discussion in itself but is outside the scope of this study and will not be further elaborated on. In this study, people with activity problems are considered to represent the same people others choose to name disabled people.

Activity problems or disabilities arise when people are restricted from performing the everyday activities that are necessary and desired (Bendixen, Madsen & Tjørnov, 2007; Johanssen, Petersen, Sørensen & Voss, 2007). Activity occurs in the interaction between the person, the activity and the environment (Hare, Jacobsen & Mathiasson, 2007; Christensen Gammeltoft & Enemark Larsen, 2007). A problem can arise if any of these factors are affected. Aspects of the person that has an effect on activity and potential problems are what have been described earlier as the core and individual qualities. Bendixen et al. (2007), summarise the aspects as a person's status, skills and starting point on a physical, psychological and social level. The activity itself can create potential problems depending on its kind, content, demands and time requirements. The aspects of the environment that have an affect are described by Bendixen et al. (2007) as living conditions such as physical, social and cultural environment as well as economics and laws which set conditions and restrictions. Furthermore, it is not only the factors alone that cause a disability. The interaction, or lack thereof, is equally important (Bendixen et al., 2007). Bendixen et al. further state this interaction is what determines the quality of peoples' everyday lives. Disability can be measured or observed depending on these factors. There is a vital subjective dimension of disability within this traditional OT understanding. What constitutes a disability is defined by the person, as Johanssen et al. (2007:487 [my translation]) state, "... activity problems are individual and expressions of the person's subjective experiences of what is problematic in their everyday life." This means it is not the different components of performing that decides if there is a problem or not, but the whole picture, and whether or not the individual thinks it constitutes a problem in their life. A disability or activity problem can then be seen as a conflict between inner and outer conditions, that is, the person's capacities and the environments conditions (Bendixen et al., 2007).

Disabled people are thought to function or perform activities and participate on multiple levels (Dahl et al., 2007; Kielhofner, 2008b). Dahl et al. describe four levels: functioning,

executing, activity and performance and a level of development of awareness and personality. Kielhofner (2008b), on the other hand, describes three levels: occupational skill, performance and participation. The levels are formulated differently but have the same basic principles and build upon each other and, as illustrated by Kielhofner (2008b:104), “skills is embedded within performance, and the performance is embedded within participation.” All levels are important since they affect each other and the performance (Dahl et al., 2007). The levels of doing are affected in different ways. Skills (consisting of motor, process, communication and interaction skills) are clearly affected by impairments, while performance is highly influenced by habituation (the person’s habits and roles) and environment and how the two factors compensate for, or worsen, the effect of impairment (Kielhofner, 2008b). Kielhofner (2008b:102) states, concerning the highest level, that “a disability may alter, but need not prevent occupational participation if adequate environmental supports are in place.” People organise their activity performances according to a top-down perspective, adapting the performance to specific goals and contexts instead of focusing on underlying performance components (Dahl et al., 2007). This means, for example, that people prioritise maintaining roles instead of physical capacities that can be adapted and compensated for in a way that roles cannot. Kielhofner (2008b) states the highest level represents something with a social and personal significance, which motivates a person and explains why compromises are made to achieve this level.

Consequences of activity problems can be extensive; restrictions or lack of opportunity to perform activity and participate is believed to have consequences on health, development and quality of life (Bendixen et al., 2007). Problems caused by impairments or the environment restricting meaningful participation and performance of activities can result in a situation where one’s condition is in conflict with both society’s and one’s own values, possibly threatening one’s personal identity and self-worth (Hare et al., 2007; Kielhofner, 2008e:). Occupational identity (who one is and wishes to become) and occupational competence (sustaining a pattern of participation reflecting ones identity) are both affected by disability, but Kielhofner (2008b) describes the effect on a person’s competence as more significant than on identity. Explained in different words, disabled people know what they want to do but the effect of disability prevents them from acting in a way that supports these wishes. Occupational identity and competence make up occupational adaptation, that is, being who one wishes to be and sustaining this wish (Kielhofner, 2008b). Kielhofner (2008b) highlights

that this adaptation is problematic at one time or another in most people's lives and requires rebuilding one's occupational identity and competence.

There are many examples of how disability affects the person. Kielhofner (2008e) describes how disability threatens or alters the daily positive things that enliven one's existence, how disability can invalidate one's worldview, values and future and be the cause for emotional pain when one cannot perform like others. Habits and roles can become invalidated or impossible to carry out, such as in the case of an acquired disability, whereas children born with impairments often are not even given the same opportunities as others to learn and experience (Kielhofner, 2008c, 2008e). A disability can make it hard to maintain one's identity (Hare et al., 2007), and there is a risk of being cast into a sick or disabled role one might not be comfortable with (Kielhofner, 2008c). Still, Kielhofner (2008c) points out that by accepting the disability identity as part of the self it is easier to develop a positive identity. As stated earlier, the person is seen as responsible and is expected to take an active part in the therapy. To facilitate this, disabled people need support, information and guidance (Hare et al., 2007). They are the ones who should make decisions concerning their own case, part of this being if they wish to receive therapy or other services (Dahl et al., 2007).

This traditional OT understanding of disability is built on the individual, relational and medical discourses. The individual discourse has a strong position when the person affected decides what constitutes a problem. What is felt to be a problem is dependent on the person's core and individual qualities like volition, habituation and performance capacity. As described earlier, disability is stated to have a major effect on the individual. Kielhofner (2008d:93) states that volition, habituation and performance capacity are always influenced by doing and participating in the world. This statement connects the individual and relational discourses. The relational discourse, with its focus on the interaction between factors, is central in explaining how the problem arises, not as a predictable result from a certain factor but in a much more complex interaction between factors. The main discourses within traditional OT understanding of disability are the individual and relational. The medical discourse is evident in the text but it does not play a major role in describing how disability arises. The focus is not on the impairment itself and, as stated earlier, having some form of impairment does not constitute being disabled. However, note that this conclusion is based on analysed literature, meaning which discourses and understandings are dominant amongst occupational therapists in practice might be different.

The ICF perspective

The second way of representing disability within occupational therapy literature is based on ICF (left sphere in figure 2). Within ICF, function and disability are systematically described. The aspect of equal civil rights, regardless of impairment or disability, is central to the model (Dahl et al., 2007). ICF can be used both as a conceptual framework and a classification for functioning and disability (Dahl et al., 2007). The conceptual framework of ICF defines function and disability as consisting of the following components: bodily functions and structures, activity and participation (Bendixen et al., 2007; Dahl et al., 2007). These components are affected by health condition and contextual factors, which are environmental and personal. The components make up a dynamic and complex system, making it difficult to analyse and predict causal connections between the elements. The components and interactions are illustrated in Figure 3.

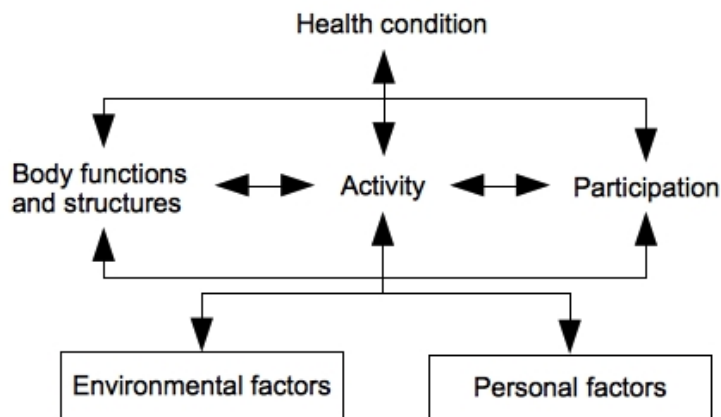


Figure 3. Components of the ICF (WHO, 2001:18).

The understanding of function and disability is based on the definition of the components, defined within the ICF framework and presented by Dahl et al. (2007). Body functions and structures refer to physical and psychological functions and to anatomy. If there is a significant loss or deviation of these functions/structures compared to the statistical norm, it constitutes impairment. An activity is defined as a task or action performed by a person, while participation is defined as a person's involvement in everyday life, representing functional ability on a societal level. Activity limitations are problems a person has with

performing an activity, ranging from mild to extensive. It is defined as a deviance from what a person without the problem could perform, both regarding how well and to what extent it is performed. Restrictions in participation are problems experienced with involvement in daily life. One is expected to be as involved as someone without the limitation in a society with the same culture. The environmental factors that affect function and disability are defined as products and technology, natural and created environments, support and contact, attitudes and services and policies. No personal factors are specified. Instead, WHO suggests they be interpreted in the specific cultural context (Dahl et al., 2007).

This means, if one complies with this conceptual framework of ICF, that disability arises in the relationship between a person's possible impairment and their level of activity and participation. Disability is positively or negatively affected by the person's health, the environment and personal factors (Bendixen et al., 2007). These factors are what determine how serious or extensive the disability is (Dahl et al., 2007).

So far ICF has been described as a conceptual framework. However, since ICF also is a classification of disability, it can be used not only to understand disability but also to classify and describe function and disability. The classification aims at providing a standardised and mutual conceptual framework for describing health and related concepts (Bendixen et al., 2007). Dahl et al. (2007) describe the system of classification. Every component has three levels of categories, each more detailed, specifying what is included in the component. For the classification the components *activity* and *participation* are fused together while, as mentioned before, personal factors have no classification and should be examined based on the surrounding culture. All components can be graded based on how they relate to the "normal distribution in the standard population" (Dahl et al., 2007:145), resulting in a quantification of disability. It is recommended that this quantification be used together with appropriate qualifying words. Dahl et al. (2007:145) further state "quantification can only happen with calibrated measurements and standards..." These standards are not available for all categories and, in that case, one is advised to use other validated measurements. The classification consists of over 1400 categories and, to facilitate the use of the classification in practice, *core-sets* are being developed, which are condition-specific lists with relevant components to investigate.

ICF is stated to be a biopsychosocial model of functioning, combining the traditional medical and social models of understanding disability (Dahl et al., 2007). That it is built on multiple models is evident when all three discourses found in the text can be related to the understanding of disability built upon ICF. In the conceptual framework of ICF, the medical discourse of disability is evident in the component of body function and structures that account for the physical, measurable part of the person. When it comes to ICF as a classification of function and disability, the medical model has a very strong position. The classification is categorised and how a function or functional state of a person is classified depends on how one performs compared to the “normal distribution in the standard population” (Dahl et al., 2007:145). It is stated that only calibrated measurements should be used, something that diminishes the subjective experience of the person. The core-sets mentioned earlier further medicalises the classification because they give the defining power of what and how to evaluate to the professionals (Dahl et al., 2007), something not desired by the international disability movement nor WHO. Also, WHO intends for ICF to be used together with the International Classification of Disease, ICD (Dahl et al., 2007). ICD is a medical classification and the use of it in combination with ICF can enforce the position of a medical understanding of disability. The relational discourse, which views disability as resulting from a relationship between multiple factors, is strong within ICF conceptual framework and understanding of disability. It is clearly stated in the text (Dahl et al., 2007:142 [my translation]): “All elements in the model are mutually influential...” and “... a change in one element in the model will affect the other elements in the model as well as the total function or disability.” They further state: “... the dynamic between the components is in reality far more complicated than the official illustration shows” (2007:142), meaning even if the interaction between components (see Figure 3) is fairly easy to illustrate, it is far more complex and, hence, outcomes are hard to estimate or explain. The relational discourse is not very evident in the classification system based on ICF, where the medical discourse is dominant. However, since more components than just the physical body are taken into consideration, it is acknowledged that function and disability is dependent on many factors. It is stated that all components interact, but it is not deliberate on how these interactions take place. Focus is directed to classifying specific components and not interactions. Finally, the individual discourse can be identified within the conceptual framework when personal factors are acknowledged as part of the context affecting disability. However, it is not further specified what these factors are. Dahl et al. (2007) give examples like sex, age, race, religion,

education, social status, economic situation and sexual orientation. It is difficult to say if not classifying these and leaving it to the therapist could have a negative effect on the components position compared to the others that are classified. On the other hand, the effect might also be positive when it allows aspects relevant for the person to be acknowledged. The core-sets that are part of the medical discourse counteract the individual discourse when defining power is given to the therapist, and the disabled person loses their say in what is examined and how. The individual discourse can, however, be seen as evident on a deeper level when activity and participation are things all individuals do in their own ways. But still, measuring activity and participation is done by comparing to the “normal” person without disability, which is typical for the medical discourse.

In the Danish text, ICF is described “primarily as a conceptual framework for understanding functional ability, for clarifying the occupational therapy area of responsibility but also as a classification with different usages within the healthcare system.” (Dahl et al., 2007:124 [my translation]). Dahl et al. (2007) state no one is required to use ICF in Denmark and that the framework has gained more attention than the classification, with focus put on implementing the framework in practice. The framework plays an important part in multidisciplinary work when it aids a common language and understanding of clients and problems, as well as making the division of tasks among workers and sectors clearer (Christensen Gammeltoft & Enemark Larsen, 2007; Dahl et al., 2007). In this sense, it also helps to clarify what the occupational therapist’s field of expertise is, both for therapists themselves, but also for other professions and clients. The classification based on ICF is described as mainly used for statistics concerning populations (Dahl et al., 2007). On a lower level, ICF can be used to classify a person’s functioning and disability in case of somatic injury or illness and to justify potential needs for social or health related services (Christensen Gammeltoft & Enemark Larsen, 2007). Another area of use is mentioned by Brandt & Jensen (2007), stating that ICF can be used when working with access to environments and assistive aids. Environments and assistive aids are defined as environmental factors in ICF, which is beneficial for occupational therapy when focus is directed to the aid or environment and not only to the person. However, since the relationship between components in ICF is not explained, Brandt & Jensen state the model is good in a general sense, but not comprehensive enough for understanding causal conditions when working with assistive technology and the environment.

In summary, two ways of understanding disability within occupational therapy literature have been presented, one based on traditional OT and another based on ICF. The similarities and differences between these representations and their practical consequences will be discussed in the next chapter.

Interdiscursivity – the mixture of discourses

After presenting how disability is represented in occupational therapy literature one can see how intertwined the discourses are. The individual discourse has a strong position in the occupational therapy order of discourse. Occupational therapy takes its starting point as the person's own conception of their present and future situation (Fortmeier et al., 2007). In chapters included from Kielhofner's book (2008a) the individual discourse is illustrated, supported and built on various examples from the field, placing experiences from the field as evidence for the discourse. For example, volition is illustrated with examples of four different people, their situation and problems and how their volition affects their choices and actions and performance capacity and the lived body are described through examples of women with strokes and neglect and how they learn to live with their new experience of their and how a man experiences his hand after a hand injury that required three of his fingers to be reattached. The relational discourse presents people as affected by and developed in a relationship between multiple factors, such as personal characteristics and individual qualities, the activity and the environment. This relational thinking is also evident in the biopsychosocial understanding of health and disability that ICF is based on and the complex interaction between the factors of functioning and disability (Dahl et al., 2007). The relational thinking explains why people are different since people are affected in different ways by different factors at different times in different environments. The medical discourse enters the picture when discussing impairments. As stated earlier, impairment affects what capacities are developed and what will be found important and enjoyable. Within occupational therapy there is an acknowledgement of impairment as a factor affecting both the individual and the performance of activities and participation (see Bendixen et al., 2007; Kielhofner, 2008e). The focus is not on the impairment and how it can be fixed, but on what effects it has on the person's activities and participation and how these effects can be minimized or avoided. In some cases, however, after assessing the effects and the cause, the focus can be on the impairment. An example is hand injuries, where "traditional" hand training can restore

function and thereby remove the effects on the activity of not being able to use the hand. In this way the medical discourse is part of the understanding of disability, even if it does not have as strong a position as the individual and relational discourse.

Intertextuality – the use of other texts

The two texts use other texts in different ways, which may be because they belong to different genres. The included chapters from Kielhofner's book (2008a) use many old sources. To illustrate this is the statement based on a source from 1985, which states there is no defined disability culture. Many people would surely contest this today. Old sources are not wrong but they reflect the situation as it was in an old context. Using them might not reflect the situation in a contemporary and accurate way. Kielhofner's book is the fourth edition, which might explain the old sources when updating every chapter thoroughly would almost equal writing a new book. Another reason might be that on some topics, no new reliable material has been produced to reflect the current situation, or simply that the sources are classical works that still are representative for today's context. The genre Kielhofner's book belongs to can be called a theoretical or academic genre. The intention of the text is to present his specific theory, and sources are used to support his statements and point of view. The theory can be seen as socially constructed, combining ideas and concepts to produce something that is viewed as knowledge and "theory" on the field of occupational therapy and human functioning. The references used in the text are chosen to illustrate and support this theory and examples given show the model's applicability in practice. Many references are made to texts produced within the discipline of occupational therapy, but also to texts on psychology, sociology, disability studies and ICF.

The book on the Model of Human Occupation is written in collaboration with many authors from around the globe and significant research has been done to develop instruments based on this model, as well as in practice, to support these ideas. The model has been continuously developed since the late 1970s (MOHO Clearinghouse, 2011). All of this has added to the strong position of the model and Kielhofner himself within occupational therapy today. It is important to be aware of the strong position Kielhofner has within the field when one uses the theory, as this otherwise can happen without questioning what one is doing and only reproducing and accepting the existing knowledge and understanding.

In contrast, the Danish text by Borg et al. (2007) is written in a textbook genre, aimed at students as an introduction to the field of occupational therapy. The text uses newer sources than the English text and they are used in a different way, presenting different aspects of theories and models. Many references are, not surprisingly, made to other occupational therapy literature from the US, UK, Canada, Australia and Scandinavia. The Scandinavian context the book is written in is evident, for example, through much of the literature referred to originating from Scandinavia as well as through Danish and other Scandinavian laws being referred to in order to set the context of the profession. Other literature referred to is, for example, on rehabilitation, disability studies and ICF. Sources are used in order to present different theories and ideas within the discipline of occupational therapy. This gives a nuanced and comprehensive picture of the field. On a number of occasions, the Danish text refers to the English text by Kielhofner that is included in this study as well as other texts written by Kielhofner. It is only in the chapter by Brandt & Jensen (2007) about technical aids and accessibility that Kielhofner's work is not referred to. Because the aim is to be an introduction for students there is also a very strong professional discourse evident in the text. However, this is not discussed as it is outside the scope for this study.

A conclusion based on how other literature is used is that the discourses and understandings, to a fair degree, are reproduced and upheld. There is a focus within the traditional OT understanding on other occupational therapy literature, which, in the long run, contributes to preserving existing knowledge and understanding. One can wonder, however, what effect ICF has on occupational therapy practice and understandings in the long run, when it clearly uses some of the same concepts as the discipline and provides a common understanding of concepts for interdisciplinary work. In the analysed texts, ICF is explained on its own but put into an occupational therapy context when it comes to how it is used. As stated earlier, the ICF framework is used more than the classification in practice today, something that might change in the future if ICF further gains popularity and becomes a tool for distributing benefits. Already it is stated by Christensen Gammeltoft & Enemark Larsen (2007) that occupational therapy assessments should uncover all relevant information within all ICF components in order to understand the patient's functioning. Then, the focus is on demands of ICF and not only on what occupational therapy practice highlights.

5.2 The text dimension – how words are used

The focus for this study is the discursive and social dimensions. This decision is based on the amount of included material, the timeframe and also because these two dimensions better answer the research question (see p. 13). However, the text dimension has been acknowledged when it comes to what words are chosen when discussing disabled people and which words are typically used within the two ways of representing disability based on traditional OT and ICF.

In these occupational therapy texts different names and terms are used to describe disabled people: client, patient, brukere (user/client), borgere (citizen), individual, person, disabled people or people with disabilities. Borgere (citizen) is the commonly used term in the Danish text, explained by Fortmeier et al. (2007), who state it is the most contemporary Danish term to use. When describing human functioning and general principles, person or individual is used in English: “each person has unique volitional thoughts and feelings” (Kielhofner, 2008e:35) and “habits play an especially important role when persons face the challenges of a disability” (Kielhofner, 2008c:57). Otherwise, client or brukere (user), or sometimes patient, is used when referring to a person receiving occupational therapy both in the Danish and English text. For example, when Kielhofner & Forsyth (2008a, 2008b) describe the therapeutic reasoning and how clients achieve change, they use the term client throughout the chapters. Another way of naming disabled people in the text is by their first names in examples. These examples are given and then referred to when describing the theory. Kielhofner starts many chapters with illustrative cases and gives even more detailed examples when describing *the lived body* concept (Kielhofner, Tham, Baz & Hutson, 2008). The Danish book also has examples, see Dahl et al. (2007) and Christensen Gammeltoft & Enemark Larsen (2007). Referring to a citizen, person or individual can be thought to reflect the view of the person as a responsible individual with equal rights. It can also be an attempt to put emphasis on the shifted power balance one is trying to achieve, for example, through client-centred work, where the person’s perspective and ideas are highly valued.

The language used often shows a clear division between the individual and their qualities and disability or impairment. Headlines are most frequently divided according to this, such as *Values and impairment* or *Roles and disability* in Kielhofner’s book (2008a). The phrasing

people with disabilities or *person with chronic illness* is more commonly used than *disabled people* or *wheelchair user* both in the Danish and English text. This reflects the same division between person and impairment. There is no apparent structure for when ‘people with disabilities’ or ‘disabled people’ are used in either one of the texts. It is also never clarified what is meant by the words impairment and disability, if they have a special meaning or if they are used interchangeably. However, it is important to note that this might have been done in other chapters that were not included in the analysis.

The two understandings of disability, based on traditional OT and ICF, use different textual features and words when discussing disability. This is connected to what they choose to highlight; the individual discourse is much stronger within the traditional OT understanding while the medical discourse has a stronger position within the ICF understanding. When the ICF framework and classification is discussed in the text by Borg et al. (2007) words like *classification*, *standard* and *norm* are used. This is typical for the medical discourse, and is naturally not a big part of the traditional OT perspective where the individual discourse is more dominant and words like *person*, *unique* and *subjective* are more common. An example of this is how Kielhofner & Forsyth 2008b use words like *enable*, *modify*, *understand*, *respect* and *support* when they describe the therapeutic process. This reflects the position of the person, not as a patient where the therapist has all the power, but as more equal in the relationship with focus on the client as an individual.

To illustrate the difference, Kielhofner & Forsyth (2008b) describe clients as unique individuals and their thinking, doing and feeling as the mechanism behind change. Fortmeier et al. (2007:166) describe values and basic assumptions within occupational therapy as, among others, client-centred practice, the client’s perspective, the active participation of the client and empowerment. In comparison, when talking about the classification based on ICF, disability can be quantified with a generic scale, systematically described and defined compared to the normal distribution in the standard population (Dahl et al., 2007). These are examples of how words used do not match and even contradict each other. Using the term classification based on a norm is not compatible with an individual focus. Furthermore, there is a difference between defining disability as a problem with an activity that is important to the individual (see Bendixen et al., 2007), and as combination of impairment, activity limitations and participation restrictions affected by personal and environmental factors (see

Dahl et al., 2007). Personal factors are included in ICF as a contextual factor influencing functioning and disability, but, nonetheless, what constitutes disability is decided compared to the standard population and what one is expected to manage and does not take into account any subjective aspects of the problem.

Finally, a few words on modality, that is, how the author commit or distance themselves from the statements, using words like *must*, *may*, *can* or *should* (Fairclough, 1992; Phillips & Jørgensen, 2002). As mentioned earlier the texts are written in different genres, which can affect the modality of the language. Kielhofner's text is certain and clear in its way of presenting the message. This can be because he has a clear agenda with what he is saying and only one point of view to present. The Danish book, on the other hand, is written as a textbook and is more of an introduction, so the authors have taken it upon themselves to present many theories and viewpoints. Therefore, they cannot state everything as certain, because the field is more complicated and dynamic than that. In general, the language is more certain when discussing the core of the individual (the drive for activity and participation) than when discussing the individual and environment and what affects them. This is to be expected as the core of the person is a fundamental value within the discipline and it would not hold up if one were uncertain or unclear about this. In contrast, when talking about the individual, how they become unique and how the environment influences the individual, impairment and action, the language is more uncertain and open to interpretation. This can be because the interactions are very complex and relational depending on many different variables. Therefore, it is impossible to certainly say that all people react to something in a specific and predictable way.

6. Discussion

The research questions: *How is disability represented in occupational therapy literature?* and, *Within which discourse does the literature place disability?*, have been answered in the previous chapter. Now, the results will be taken a step further by connecting them to the social world surrounding them, called the social practice in Fairclough's critical discourse analysis. When examining the social practice dimension the focus is on non-discursive practices that affect the discourses and assessing, to what extent, discourses and the understandings they create are reproduced or challenged (Phillips & Schröder, 2005).

First, non-discursive practices affecting the understandings of disability that have appeared in the analysed occupational therapy literature will be presented. Thereafter, consequences of the non-discursive practices and of the different understandings of disability will be discussed in a theoretical and practical perspective. The chapter is concluded with thoughts on further research and final, critical reflections on the thesis.

6.1 Non-discursive practices restricting discourses and understandings of disability

A non-discursive practice is something that works according to a different logic than discourses, for example economics, physics and biology (Phillips & Jørgensen, 2002). Together with the discourses they produce the social practice, represented by the third layer in Fairclough's model (presented in chapter 4). Phillips & Jørgensen (2002) state it is hard to separate discursive and non-discursive practices or analyse the dialectical relationship between them. In this study, some conditions with a clear influence on the understanding of disability did not seem to belong to any particular discourse. They have been regarded as non-discursive practices influencing the total understanding of disability. These non-discursive practices have consequences, which will be described later in connection to theoretical and practical consequences.

The understanding of disability is strongly influenced by the non-discursive practice of laws and policies, especially the ones that regulate the healthcare sector. The context plays a great role when the healthcare sector is regulated in different ways in the US and in Scandinavian welfare states. The focus in this study is on the Scandinavian context. In the Danish context,

the healthcare system bases its organisation of examination and treatment on illness, and the basis for receiving help is a diagnosis (Dahl et al., 2007). This system is evident throughout the Danish text, and is also applicable to the Norwegian context. In Norway, the National Insurance Scheme (folketrygden) ensures financial security by compensating for certain expenses brought on by, for example, unemployment, disease, injury or disability (Folketrygdloven § 1, 1997). The aim is to aid people in helping themselves, giving them the opportunity to provide for themselves and manage on their own as much as possible. The National Insurance Scheme evens out the income and living conditions between a person's different life stages and between groups of people in society (Folketrygdloven, 1997 § 1). However, it also creates the need to classify and diagnose people in order to decide who is entitled to benefits (Hedlund, 2009).

Another non-discursive practice that affects what is included in the occupational therapy curriculum in Norway is the set structural frame (rammeplan) of occupational therapy education (see Forskrift til rammeplan for ergoterapi, 2005). According to this framework, the education (totally 180 credits) has to contain 30 credits of medical subjects, divided into anatomy and physiology and "disease studies" (sjukdomslære) and disability. The education also has to contain 75 credits of professional occupational therapy subjects. These are divided into the areas of health promotion and prevention, rehabilitation, habilitation and treatment. Out of the 75 credits of occupational therapy specific subjects, the structural frame dictates 33 credits should consist of rehabilitative work. This is more than twice as many credits compared to the other areas which occupational therapists work within. This is, however, what the framework dictates and is what the schools offering the programs must adhere to. These non-discursive practices exist together with the discursive practices, affecting each other as they develop. For instance, the set structural frame dictates what education programs have to contain, which determines what students are taught. Simultaneously, values and interests in society also affect what is believed to be the "right" way of thinking, which affects what people strive for and what they demand of politics. This will lead to the set structural framework developing, and again affecting what students are taught.

6.2 Theoretical consequences of different understandings of disability

What are the theoretical consequences of understanding disability from a traditional OT point of view or based on ICF? The understandings have been presented in the previous chapter, but one also has to understand the similarities and differences between them to see if they contradict or support one another. This is vital in order to explore if one understanding has a stronger position than the other, if there is movement towards one understanding and if the situation is stable or conflict-ridden.

There are similarities between the understanding of disability based on traditional OT and ICF. McLaughlin Gray (2001) states the classification system of the ICIDH-2 (the draft version of ICF [WHO, 2001]) is compatible with essential occupational therapy principles. This is also reflected by Kramer, Bowyer & Kielhofner (2008:520), saying there are many similarities between the model of human occupation, close to the traditional OT understanding, and the ICF. One similarity is that activity and participation in both cases is recognised as a central outcome, significant to health, and determined by individual characteristics and the environment (Kramer et al., 2008; McLaughlin Gray, 2001). This is also supported by McIntyre & Tempest (2007), who find this similarity to be the reason why the ICF is compatible to essential rehabilitation principles. Other similarities between the traditional OT and ICF perspectives are that both recognise that a person's health condition can alter participation and that the influence among factors is dynamic and nonlinear (Kramer et al., 2008). McLaughlin Gray (2001) states recovery within both perspectives is viewed as not only remedying impairments, but as restoring abilities and participation in everyday activities, which is a step towards focusing on capacities and possibilities instead of deficits. She also notes that both perspectives focus on the complex nature of health and factors affecting it. When it comes to the included literature in the study, one can see that ICF and the traditional OT understandings are compatible since they are described side by side in the Danish textbook included in this study. Dahl et al. (2007) explicitly describe the ICF as an important contribution to the understanding and development of the occupational therapy area of responsibility. Another study by Stamm, Alarcos, Machold, Smolen & Stucki (2006:17) also comes to the conclusion that there are "strong conceptual connections between the ICF and occupational therapy models, which encourage occupational therapists to use the ICF in their practice."

However, there are points where the traditional OT and ICF understandings of disability differ from each other. Some differences have been described in relation to the text dimension earlier and regarding the different use of discourses. To summarise, the relational discourse where disability arises as a result of many factors, like impairment, environment and person, is strong within both representations, while the medical discourse is stronger within the ICF understanding and the individual discourse is stronger within the traditional OT understanding.

The traditional OT and ICF understanding of disability uses many of the same words and terms. As stated by McLaughlin Gray (2001:25), many occupational therapists that encounter the concepts of ICF say: “this is about occupation!” However, concepts do not always have the same meaning, as will be discussed below. As a reminder, the concepts from the different understandings are shown in Figure 4.

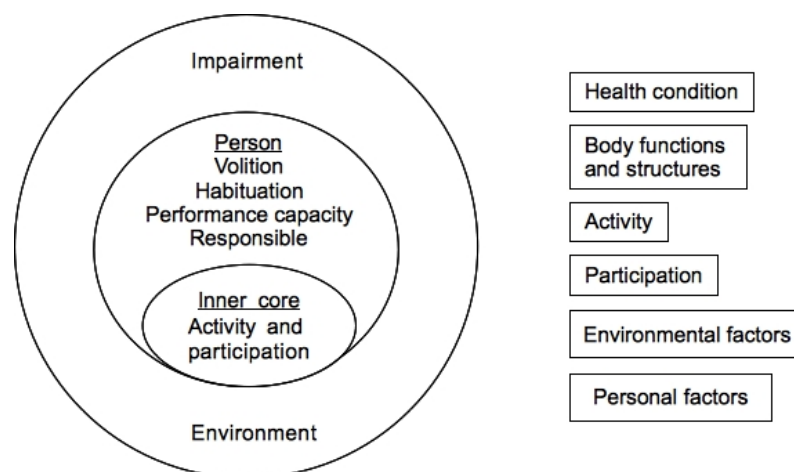


Figure 4. Comparing traditional OT and ICF concepts.

Starting with the outer layer and comparing the meaning of impairment, health condition and body structures and functions, it is clear that they cover the same physical dimension of components of disability. Kielhofner (2008d) defines components of the environment as physical, social, cultural, economic and political, while within ICF the environment is defined as physical, social and attitudinal (WHO, 2001). This shows the environmental

component has the same meaning in both understandings, a conclusion that is further supported by findings from a study conducted by Stamm et al. (2006).

The next layer of the circle in Figure 4, illustrating the person, includes volition, habituation, performance capacity and responsibility. These factors can easily be interpreted as reflecting the personal factor within ICF. Within the traditional OT understanding of disability the individual discourse has a major influence as described earlier, and how a person “works” is extensively explained. Within ICF, personal factors are defined as “the particular background of an individual’s life and living, and comprise features of the individual that are not part of a health condition or health states” (WHO, 2001:17). Personal factors are not classified but examples are given: gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, social background, education, profession, past and current experiences (past life events and concurrent events), overall behaviour pattern and character style, individual psychological assets and other characteristics (WHO, 2001:17). Since the personal factor within ICF is not classified one cannot say the understandings are contradicting. However, according to Stamm et al. (2006), making a connection between person and personal factors is not correct. In their study, they only connect volition to the personal factor in ICF, while performance capacity is connected to the ICF category of body functions and body structures. Habituation is, according to Stamm et al. (2006), not possible to classify to any concepts or categories within ICF. But, there are different opinions on how the traditional OT concepts of the person connect to ICF. Kramer et al. (2008) connect volition to the category motivation under mental functions and body functions in ICF. They further connect habituation to two concepts, as orientation to time under mental functions and body functions, and as carrying out daily routines under general tasks and demands classified within activity and participation. The personal quality called “responsibility” within the traditional OT understanding is different from the other components of the person. It does not explain how the person “works” but is a way of looking at people and stating what is expected of people within occupational therapy. Responsibility is a concept that is not directly mentioned within ICF, which is not surprising since it is not a model concerned with working with people on a practical level.

At the centre of the illustration of the traditional OT understanding (the circle in Figure 4) the inner core of the person is found. Here, the terms used are identical: *activity* and

participation. Activity is defined by WHO (2001:14) as “the execution of a task or act by an individual”, which, according to Dahl et al. (2007), is a much more narrow understanding of the term than within occupational therapy. They emphasise that the quality of the execution, the meaning of the activity to the person and the sociocultural context the activity is executed within is not acknowledged in the ICF understanding of activity. This illustrates how different meanings can be and the importance of not assuming certain terms have the same meaning when working with different models. The narrow understanding of activity within ICF can be aided, according to Stamm et al. (2006), by sticking to the occupational therapy understanding. This deeper understanding can also be beneficial for a multi-professional team, providing a common way of understanding the meaning and importance of activity to the person. Participation, the second concept, is, according to Dahl et al. (2007), used in a wider sense within ICF, covering an aspect of citizenship, than within occupational therapy. Participation within ICF has also been studied by Hemmingsson & Jonsson (2005). They criticise the way participation is conceptualised within ICF, how it acknowledges only the observed performance and not the subjective experience of meaning. When focusing on what people do, what people want to do is overlooked. This is problematic when the two are not always the same thing, which is another point of criticism of participation within ICF. It does not emphasise people’s opportunities to influence and make decisions about their lives. Hemmingsson & Jonsson (2005) criticise the limited dimensions of participation that are captured, which does not for example acknowledge that environments can have both a facilitating and barricading effect simultaneously for the same person. Haglund & Henriksson (2003) bring forth another problem concerning activity and participation. It is not distinguished between single actions, like lifting, and more complicated and demanding activities, like furnishing your home. This means, according to Haglund & Henriksson (2003), that the ICF classification does not always provide detailed enough explanations, which are needed within occupational therapy intervention. A final criticism is put forth by Dahl (2002). The lack of a clear way of coding activity and participation (which are defined separately but merged in the classification) threatens the quality of data collected with the classification. Dahl (2002) says without a common agreement as to whether it should be *activity and participation* or *activity or participation*, users are now making their own distinctions.

It is not only how well conceptual understandings of terms align that has to be examined. Stamm et al. (2006) state knowing how the ICF categories connect to occupational therapy concepts is vital if one wants to use the ICF classification when assessing clients. This is also highlighted by Haglund & Henriksson (2003). With the growing status of the ICF, therapists might be compelled to use the classification when justifying needs for benefits or communicating with other professionals, which means understanding the differences and similarities between the concepts is very important. Kramer et al. (2008) state that concepts from the model of human occupation are aligned, even if not perfectly, with ICF concepts and domains in different ways and on different levels of specificity. Stamm et al. (2006) further deliberate on this and state the majority of concepts can be linked to ICF. However, as has been presented, different opinions are evident on the subject of how well the concepts match, and, therefore, it is impossible to say what is right.

To conclude, ICF gives occupational therapists a chance to explain the complexity of interaction between individual, environment and function to other professionals (McIntyre & Tempest, 2007). However, McIntyre & Tempest (2007:1477) say the major problems with using ICF are “the lack of recognition of the personal factors and subjective dimension to health and disablement”. Geyh et al. (2011) have studied the personal factor within ICF, and concluded there is a need for standardisation of what personal factors are since they have the potential to enhance the understanding of functioning, disability and health and strengthen the position of the individual within ICF. Occupational therapy and occupational science has, according to McLaughlin Gray (2001) and Stamm et al. (2006), the potential to contribute to this understanding of subjectivity, complexity of activity and overall understanding of personal factors. However, even though there are similarities between the traditional OT perspective and ICF, it is not surprising that many authors, like Haglund & Henriksson (2003), Hemmingsson & Jonsson (2003), McLaughlin Gray (2001) and Stamm et al. (2006), state that using both ICF and occupational therapy models and understandings is best since there are still important differences.

After concluding what similarities and differences there are between the perspectives that have appeared in the text, it is important to place them in a bigger context. The official understanding of disability in Norway is defined as relational (Hedlund, 2009:55; St.meld. nr. 40 [2002-03]). This means disability is understood as a mismatch between the person's

capacities and the requirements of the environment (Kassah & Kassah, 2009; Tøssebro, 2004). This Nordic relational understanding is also evident in the Danish context and confirmed in the Act on Social Service (Lov om social service) (Fortmeier et al., 2007). If one compares the understanding of disability based on traditional OT concepts with this relational model of disability, there are similarities between the two. Fortmeier et al. (2007) state the relational model of disability is compatible with occupational therapy values, where the individual's possibilities for activity and participation are seen in relation to the environment. Within the Nordic relational model, disability is viewed as relative depending on the context (Kassah & Kassah, 2009). This resonates well with the relational discourse that is part of the traditional OT understanding of disability. Both understandings focus on modifying environmental conditions and individual capacities to minimise the disability (see Barnes & Mercer, 2010; Dahl et al., 2007; Christensen Gammeltoft & Enemark Larsen, 2007). Additionally, within occupational therapy there is a strong focus on the activity (see Dahl et al., 2007), which is not directly mentioned in the relational model of disability. However, the focus does not conflict with anything in the relational model, and one can even imagine that, in many cases, the activity one needs to perform is the link between the environment and the person, implying it is acknowledged within the relational model of disability as well. The relational model aims for equality and participation (Gustavsson Holmström, 2005), something that also reflects with occupational therapy values, even though the focus is generally on the individual. Disability within both perspectives is, however, not predictable and highly individual when it is dependent on the situation and the person (Gustavsson Holmström, 2005; Bendixen et al., 2007). Since there are no clear rules to who is disabled there is a risk for ambiguities, which, in turn, enables people or policymakers to free themselves from responsibility (Hedlund, 2009). Therefore, neither the relational model nor the representation of disability based on traditional OT concepts are suitable understandings for research, planning or evaluating policies for the disabled, where there is a need to quantify disability (St.meld. nr. 40 [2002-03]:9-10). The need to clearly define people is also evident within research, as stated by Tøssebro & Kittelsaa (2004). The starting point for research concerning disabled people is often declared as relational, accounting for the environment, but when the sample has to be defined one turns to biomedicine, which then affects the rest of the research. The relational definition of disability simply does not work for research when it is impossible to define who should be included in the sample (Tøssebro & Kittelsaa, 2004). The result is that the medical understanding of

disability is used within the healthcare sector when it provides clear diagnoses and defined characteristics to look for in the individual instead of something nonspecific that changes with the situation, which does not provide the basis for granting benefits or function as inclusion criteria in research (St.meld. nr. 40 [2002-03]).

This traditional OT understanding can also be compared to the social model of disability (presented in chapter 2). This is partly what has been described in the chapter 3 about previous research. These understandings differ on certain vital points. Within the social model of disability, disability is defined as created by the environment (Barnes & Mercer, 2010; Gustavsson Holmström, 2005) while within the traditional OT understanding it is created by multiple factors: the person's capacity, the activity and the environment (Bendixen et al., 2007). The impairment is also given different importance. Within the traditional OT perspective impairment is seen as affecting the individual's qualities (see Kielhofner 2008c, 2008e) and performance (see Kielhofner, 2008b), while within the social model impairment is acknowledged as a condition but not as a factor influencing disability (Barnes & Mercer, 2010). When these differences exist it is not surprising that interventions within the two perspectives vary. Within the social model intervention is focused on political action and social change (Barnes & Mercer, 2010), and within the traditional OT perspective focus is on creating possibilities for activity and participation (Dahl et al., 2007). Based on the literature study performed, there seems to be a divide between the traditional OT understanding and the social model of disability. This conclusion is also supported by arguments presented in the previous research chapter. For example, the results from this study support what Kielhofner (2005) and Phelan (2011) have said (see chapter 3 for details) about the focus within occupational therapy being on the individual and their immediate surroundings and less on societal structures and barriers. These themes were hardly discussed in the analysed included literature.

6.3 Practical consequences of different understandings of disability

What are the practical consequences of the non-discursive practices and of the understandings of disability that have appeared in the text? Practical consequences can be hard to define in this case when literature and theory is the base for conclusions and no input from the field has been gathered. However, structural rules determine what is accepted and

expected at a workplace, which impact how therapists can carry out their work. One can also assume that what understanding the therapist has of disabled people will affect how they work and how clients are met and treated.

One of the non-discursive practices influencing how disability is understood is the organisation of the healthcare system. As described earlier, the welfare system today is based on the medical perspective. The medical understanding of disability implies disability is the person's special needs, which is suitable for the administrative purposes and the needs of the welfare state (Kassah & Kassah, 2009). The medical understanding and the medical profession have a strong position within society today, especially when it comes to the division of benefits (Hedlund, 2009; Kassah & Kassah, 2009). Hedlund (2009) states a medical classification or diagnosis, acknowledged in ICD-10, is commonly required in order to qualify for benefits. An example is disability pension, which, in order to receive, one must fill a list of requirements. Two of the requirements are that the disease, injury or disability is permanent and the reason for the person not being able to earn an income and that the person has undergone appropriate medical treatment and sufficient efforts have been made to improve ones ability to earn an income (NAV, 2012b). The same rules apply for receiving the basic benefit (grunnstønad), granted to cover extra recurring costs due to disease, injury, congenital defects and disabilities that are permanent (NAV, 2012a). However, there are cases where a diagnosis is not needed. For example, to utilise the Working Environment Act (arbeidsmiljøloven) concerning accessible workplaces, the worker has to insist the act is relevant in their case (Hedlund, 2009), with no requirement for a diagnosis. The same applies to the Antidiscrimination Law in Norway, where focus is on the discriminatory action and not on if a person is "disabled enough" to be covered by the law (Hedlund, 2009).

This strong power position of medicine makes it difficult for other understandings or ways of thinking to gain a foothold, even though Hedlund (2009) states there is a change happening within certain areas of welfare services for disabled people. An example of this is how in Denmark today, occupational therapists can act independently and treat clients without referrals from doctors, except in cases of interventions after hospitalisation (Christiansen Gammeltoft & Enemark Larsen, 2007). But, since occupational therapists work within the healthcare sector, in an environment that demands diagnoses and categorising of whether people are deserving of benefits or not, there is an impending risk of being influenced by the

medical thinking even though occupational therapists have their own understanding of disability. As Dahl et al. (2007) state, a diagnosis is the basis for intervention within occupational therapy because they work within the healthcare sector. This is the case even though occupational therapy theory does not focus on diagnoses and labels. This dilemma is reflected in the situation disabled people often face, described by Hedlund (2009). At times they need to prove themselves as active and capable, reflecting what occupational therapy sees, while in other situations they need to be passive and severely affected by disability in order to receive benefits, that is, conform to the demands of the medical understanding. Kielhofner (2008e) also describes this dilemma; experiencing oneself as self-efficient is not only negatively affected by the impairment itself, but is made more difficult by the many “quirks” of the welfare system. It is not only the requirement for diagnosis that has an effect. The welfare system has an impact on disabled persons when services and support are often arranged and provided in specialised settings (Kielhofner, 2008d). This is well intended, but can have a negative effect when a shortage of resources and organisational guides and demands can result in less than optimal settings or conditions. These specialised social groups do not offer normal opportunities for roles and activities and can have a great effect on a person’s occupational life (Kielhofner, 2008d).

Based on this study, it is impossible to say what understanding of disability occupational therapists gain during their education. That would require another type of study. However, in this study, the assumption is that students, to some degree, will adopt the understandings of disability found in the texts, as the literature included in this study is the most frequently used in all educations. If attitudes predict action, individuals’ understandings of disability is also assumed to have an effect on how one carries out ones job.

Kielhofner & Forsyth (2008b) describe how a therapist with an understanding of disability, based on traditional OT concepts, should work. As illustrated in Figure 2 (p. 57), the individual is at the centre of understanding disability, which is reflected by therapy starting with getting to know the client, understanding the individual and collaborating with them (Kielhofner & Forsyth, 2008b). Diagnoses do not play a big part here, instead focus is on asking questions and understanding the client’s position, including strengths and challenges. The understanding of the client is the basis for setting goals and determining the means to reach them. Kielhofner & Forsyth (2008b) describe that change only can occur through the

clients occupational engagement (that is what they do, think and feel), which reflects viewing the person as responsible for themselves. Therapy facilitates and supports this engagement. When it comes to reaching the goals of therapy, Kielhofner & Forsyth (2008b:151) state: “Since goals are formulated in collaboration with clients, examining the extent to which goals have been attained allows a determination of how much the client’s desires were achieved.” Throughout this process it is evident that the client is put in the centre and seen as responsible. They participate in deciding what the problems are, what the goal should be, the means of reaching them and if goals were achieved. There are influences of the medical thinking present in the description of the therapeutic process. For example, one way of gathering information is through structured assessments, which are also used to determine whether there has been an improvement during therapy (Kielhofner & Forsyth, 2008b). Even though these instruments are standardised and can reflect a medical way of assessing and judging, occupational therapy ideas are strong within them when they are developed based on Model of Human Occupation and other similar occupational therapy specific understandings. Using the structured assessments also contributes to evidence-based practice, which is the goal within occupational therapy.

If one compares this way of working to a therapeutic process carried out by a person who has an understanding of disability based on ICF, there are differences. First, the ICF does not explicitly tell you how to work with clients. It is merely a conceptual framework and classification. However, one can contemplate what the consequences would be. The classification is extensive, with over 1400 categories (WHO, 2001:23). In order to fully utilise the classification, one has to understand these categories and how to use them. It is easy to fall back on using core-sets developed for specific diagnoses, listing which categories to check based on what diagnosis one has. However, McIntyre & Tempest (2007) note the main challenge with using these core-sets is that personal factors and the subjective dimension are not recognised. This means if one uses only these core-sets there is a risk of overlooking the individual dimension, which, within the traditional OT understanding, is of great importance. As discussed earlier, the meaning of ICF concepts that are similar or identical to traditional OT concepts are not always the same. This implies one has to be aware of the differences in order not to draw false conclusions and avoid misunderstandings. Kramer et al. (2008) and Stamm et al. (2006) encourage occupational therapists to use ICF in their work, but that they should not forget their own conceptual models. Using both models

and being aware of the differences is also supported by Haglund & Henriksson (2003) and Hemmingsson & Jonsson (2005). When combining the models the therapist can start out with a traditional OT understanding of disability and use ICF to, for example, ease communication with other professionals or base conclusions about needs for benefits on these categories that perhaps are better known among service providers and other professions than occupational therapy specific concepts.

These are not the only understandings of disability present within the field of occupational therapy either. There are other frames of reference to describe activity and participation, for example one developed in Canada (Canadian Model of Occupational Performance) and one in Australia (Occupational Performance Model) (Bendixen et al., 2007). Besides these, other frames of references are in use to describe prerequisites for activity and participation. Examples of these are biomechanics, empowerment, recovery, stress and flow (Bendixen et al., 2007). The included literature in this study is a very limited selection, and it is impossible to say what other understandings of disability might appear elsewhere in the literature used. However, when going through the literature lists at the beginning of the research process, an understanding I, as a researcher with a degree in occupational therapy, was expecting to find did not appear. This was the Canadian Model of Occupational Performance, which I have been taught as an equal to Kielhofner's Model of Human Occupation. Kielhofner's model, developed in the United States, is widely used within the occupational therapy educations in Norway. Literature connected to this model appeared about twenty times on the compiled literature list. The two models are equal in the sense that both discuss how the person functions and is affected by different factors. The Canadian model, on the other hand, only appeared about ten times on the compiled literature list, and is not used at as many schools as Kielhofner's theory. However, this is only what I have noted when looking at the compiled list. It is possible that the Canadian model appears as part of other books, as it does in the Danish book by Borg et al. (2007). Still, Kielhofner's theory has a much stronger position as it is more widely used. Whether this is true or not, and whether the schools are aware of this is not known. Nevertheless, this illustrates how students' understanding of disability is easily shaped, depending on which books are chosen for each course. Because book choice has a big impact, the question of who is in charge of revising literature lists and how often this is done becomes highly relevant. However, this has not been a subject for this study.

As a conclusion to what understanding of disabled people students adopt, taking into consideration that this is only speculation based on theory and not talking with students themselves, one can assume the traditional OT understanding would be the dominant understanding. This understanding is far more evident in the analysed literature, and further supported by the wish to be a unique profession. Concepts and understandings are always changing and developing. This happens with a set goal and within a historical and cultural context (Bendixen et al., 2007). Therefore, it is important to be aware of what is going on within one's own and related fields and be a part of the development, noted by Haglund & Henriksson (2003), who say acknowledging development within ICF helps build bridges instead of isolating occupational therapy as a profession.

Moving on to consequences of the set structural framework as a non-discursive practice, the framework puts much emphasis on rehabilitation as an area of work for occupational therapists. This has practical consequences through dictating what the students will study and learn. Rehabilitation focuses on restoring previous function, the personal dimension of impairment and, more recently, not only the medical aspects, but also the social dimensions of disability such as equality and antidiscrimination (Hammell, 2006; Kassah & Kassah, 2009). However, rehabilitation easily connects with medical subjects, and, as these two together account for 63 credits in an educational program (60 credits is one years workload), there is a risk of students gaining a medicalised understanding of disability, influencing how they work with disabled people.

One has to ask why rehabilitation is prioritised more than other areas of work, like health promotion and preventive work. Kassah & Kassah (2009) state traditional rehabilitation is under immense pressure with demands for better and cheaper services while political institutions are abandoning the medical perspective within rehabilitation and focusing more on disabled peoples' needs and wishes. With this shift in mind, focusing on health promotion and preventive work might make more sense in the long run. However, the strong position rehabilitative work still holds might be because of its connection to medicine. Traditionally, the medical profession determined what moral and physical standards disabled people should "live up to" (Kassah & Kassah, 2009). Since the medical model still has a strong hold within the healthcare sector, so does rehabilitation. Even though schools have to obey this set structural frame, it is not further specified what the different modules are supposed to

contain. This study has not focused on how the set structural frame is implemented and, therefore, one cannot know if rehabilitation is strongly connected to medicine or if a more modern understanding of the concept is prevailing and what potential effect this might have on students' understandings of disability.

7. Conclusion and further research

As stated in the beginning of the previous chapter, is one understanding stronger than the other and is this relationship stable or are there conflicts? Unfortunately, there are no definite answers. ICF is internationally recognised as a tool for classification within different sectors and disciplines (WHO, 2001). Occupational therapy, on the other hand, is also internationally recognised, but is a specialised discipline. As has been described, ICF has a strong medical influence, which gives it credibility in today's society where diagnoses are the basis for organising health- and social care. However, occupational therapy acknowledges the subjective dimension, the person, which WHO also recognises as central in understanding health and disability (Geyh et al., 2011). As has been described above, many authors state that combining the understandings and being aware of differences is the best way to work. One also has to consider that both ICF and occupational therapy are under constant development. This can imply learning from each other and developing together is a good way forward. Haglund & Henriksson (2003) highlight this exact point; it is of great importance that occupational therapists become involved in the ICF model and not isolate themselves with their own concepts and understandings, as this benefits no one in the long run.

When conducting this literature study a few areas needing more investigation have come to light. For instance, the literature included in this study is quite limited. A greater understanding could be gained through analysing different literature from the literature lists used at schools in Norway. This has the potential to further confirm and explain or contest the findings presented in this study. Another interesting aspect could be to take a longitudinal approach and analyse how understandings that appear in the literature change over time and in relation to changes within the field of disability. Furthermore, the sole focus for this study has been literature, which gives no grounds to say what the common understanding of disability is among therapists in the field. A qualitative study focusing on this could compare understandings among therapists in the field with theoretical understandings. As mentioned earlier, it is unclear why literature representing the Canadian model, widely known within occupational therapy, appears to have a much weaker position than the theory of Kielhofner. This could be investigated by looking closer at these two theories and how they are used at the schools.

7.1 Final critical reflections

This has been a long process with much reading and translating. My language skills have surely been tested, reading four languages; Norwegian, Danish, Swedish and English, as well as writing in English. However, this has been a period of great personal reflection and growth.

Reading Danish has been challenging and more time consuming than expected. There is a risk that I have misunderstood some Danish concepts, although I think the risk is minimal when I have actively used dictionaries and found patterns among findings. The amount of literature included was quite large, about 350 pages. A smaller sample of literature would have allowed a deeper analysis of the textual dimension and the possibility to more strictly follow Fairclough's method of critical discourse analysis with all the different aspects it analyses. For this study the method has instead been used on a more general level as a guide. These choices have been made based on the focus of the study; to map out what is said about disability in the occupational therapy literature. In order to reach this goal, a larger sample of text is needed, and doing detailed textual analysis would not yield as interesting results as looking at the bigger picture found in the texts. The included literature is from two separate genres, as discussed earlier. This has made analysing challenging when the focus of the books are very different, with one aimed at introducing many viewpoints and theories on the subject while the other focuses on a specific theory. It has been a challenge to find the common theme in both texts and find the common factors both texts embrace when their focuses are so different.

The names of understandings and discourses are all coined by myself and there is a risk of them not being clear enough and easily mixed up with already established concepts, for example relational discourse and relational model of disability. To avoid this, efforts have been made to clarify the names given and use them consistently. For people with knowledge of occupational therapy, the traditional OT understanding might appear very similar to Kielhofner's Model of Human Occupation. Kielhofner's theory has indeed had a very strong influence on this study and the traditional OT understanding is, to a great degree, the same as Kielhofner's theory. This was, however, unavoidable when his book was one of the most frequently used at schools offering occupational therapy programs in Norway, and this was

set as the inclusion criteria. However, the traditional OT understanding is not solely based on the Model of Human Occupation when the Danish book by Borg et al. (2007) presents many perspectives and often does not refer to Kielhofner when discussing what occupational therapy is. The name “traditional OT understanding” was chosen for the reason that it is not only based on Kielhofner, but also ideas from Danish authors, even if these might be inspired by and similar to what Kielhofner is saying.

After reflecting on the whole process, I can conclude that I have followed the method as described in the method literature step by step when analysing the included texts, emphasising parts but not changing the method. I have grown immensely during this process and I hope the results have yielded something that students, occupational therapists and people working within occupational therapy education programs can reflect over. Finally, the set structural frames regulating the educational programs and their place in society is being debated, and only the future will tell if their removal or new form will have an impact on the understandings of disability and challenges these bring.

Bibliography

- American Occupational Therapy Association (AOTA). (2008). Occupational therapy practice framework: Domain and process 2nd edition. *American Journal of Occupational Therapy*, 62(6), 625–683.
- Askheim, O. P. (2003). *Fra normalisering til empowerment: Ideologier og praksis i arbeid med funksjonshemmede*. Oslo: Gyllendal Akademisk.
- Barnes, C. (2004). Disability, disability studies and the academy. In J. Swain, S. French, C. Barnes, & C. Thomas, (Eds.), *Disabling barriers: Enabling environments* (2nd ed.) (pp. 28–33). London: Sage Publications.
- Barnes, C. & Mercer, G. (2010). *Exploring disability* (2nd ed.). Cambridge: Polity Press.
- Bendixen, H. J., Madsen, A. J., & Tjørnov, J. (2007). Begreper og referencerammer i ergoterapi. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp. 190–238). København: Munksgaard.
- Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. London: Penguin Books.
- Block, P., Ricafrente-Biazon, M., Russo, A., Chu, K. Y., Sud, S., Koerner, L., ... Olowu, T. (2005). Introducing disability studies to occupational therapy students. *American Journal of Occupational Therapy*, 59(5), 554–560.
- Borg, T., Runge, U., Tjørnov, J., Brandt, Å., & Madsen, A. J. (Eds.). (2007). *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.). København: Munksgaard.
- Brandt, Å., & Jensen, L. (2007). At muliggøre aktivitet og deltagelse: Hjælpemidler og tigængelighed. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp. 576–612). København: Munksgaard.
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Christensen Gammeltoft, B., & Enemark Larsen, A. (2007). At muliggøre aktivitet og deltagelse hos voksne: Somatisk behandling og rehabilitering. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi- aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp. 513–546). København: Munksgaard.
- Craddock, J. (1996a). Responses of the occupational therapy profession to the perspective of the disability movement: Part 1. *British Journal of Occupational Therapy*, 59(1), 17-22.

- Craddock, J. (1996b). Responses of the occupational therapy profession to the perspective of the disability movement: Part 2. *British Journal of Occupational Therapy*, 59(2), 73-78.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks: Sage Publications. [Chapter 2: Philosophical, paradigm and interpretive frameworks, pp. 15–33.]
- Dahl, T. H. (2002). International classification of functioning, disability and health: An introduction and discussion of its potential impact on rehabilitation services and research. *Journal of Rehabilitation Medicine*, 34, 201–204.
- Dahl, T. H., Haugbølle, J., Jarl, B., Schjerning, J., & Thanning, G. (2007). Det ergoterapeutiske ansvarsområde: At muliggøre aktivitet og deltagelse i hverdagslivet. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp. 124–160). København: Munksgaard.
- Denscombe, M. (2004). *Forskningens grundregler: Samhällsforskarens handbok i tio punkter* (P. Larson, Trans.). Lund: Strudentlitteratur. (Original work published 2002).
- Diskriminerings- og tilgjengelighetsloven. (2009). *Lov 2008-06-20 nr 42: Lov om forbud mot diskriminering på grunn av nedsatt funksjonsevne*.
- Ergoterapeutene- Norsk Ergoterapeutforbund. (2012a). *Fakta om ergoterapi og ergoterapeuter*. Retrieved May 9th 2012 from:
<http://www.netf.no/Ergoterapeutene/om-ergoterapi/Fakta-om-ergoterapi>
- Ergoterapeutene- Norsk Ergoterapeutforbund. (2012b). *Kompetanser i ergoterapi: Ergoterapeuter gjør hverdagslivet mulig*. Retrieved January 19th 2012 from:
<http://www.netf.no/NETF/om-ergoterapi/Ergoterapeuters-kompetanse>
- Fairclough, N. (1992). *Discourse and social change*. Cambridge: Polity Press.
- Fairclough, N. (2003). *Analysing discourse: Textual analysis for social research*. New York: Routledge.
- Folktrygdeloven. (1997). *Lov 1997-02-28 nr 19: Lov om folketrygd*.
- Forskrift til rammeplan for ergoterapeut. (2005). *For 2005-12-01 nr 1374: Forskrift til rammeplan for ergoterapeututdanning*. Available at:
<http://www.lovdata.no/for/sf/kd/xd-20051201-1374.html>

- Fortmeier, S., Mathiasson, G., & Schröder, I. (2007). Etik, værdier og grundlæggende antagelser i ergoterapi. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp.161-189). København: Munksgaard.
- Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American psychologist*, 40(3), 266–275.
- Geyh, S., Peter, C., Müller, R., Bickenback, J. E., Kostanjsek, N., Üstün, B. T., ... Cieza, A. (2011). The personal factors of the international classification of functioning, disability and health in the literature: A systematic review and content analysis. *Disability and Rehabilitation*, 33(13–14), 1089–1102.
- Gill, R. (2000). Discourse analysis. In M. W. Bauer, & G. Gaskell (Eds.), *Qualitative researching with text, image and sound: A practical handbook* (pp. 172–190). London: Sage Publications.
- Gitlow, L., & Flecky, K. (2005). Integrating disability studies concepts into occupational therapy education using service learning. *American Journal of Occupational Therapy*, 59(5), 546–553.
- Gustavsson Holmström, M. (2005). Den sociala modellen. In B. Danemark (Ed.), *Sociologiska perspektiv på funktionshinder och handikapp* (pp. 59–81). Lund: Studentlitteratur.
- Haglund, L., & Henriksson, C. (2003). Concepts in occupational therapy in relation to the ICF. *Occupational Therapy International*, 10(4), 253–268.
- Hammell, K. W. (2006). *Perspectives on disability & rehabilitation: Contesting assumptions; Challenging practice*. Edinburgh: Churchill Livingstone Elsevier.
- Hare, H., Jacobsen, A., & Mathiasson, G. (2007). At muliggøre aktivitet og deltagelse: Arbejdsfstholdelse, erhvervsrettet rehabilitering og revalidering. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp.379–409). København: Munksgaard.
- Hedlund, M. (2009). Meningsbrytninger i begrepet “funktionshemming”. In J. Tøssebro (Ed.), *Funktionshemming - politikk, hverdagsliv og arbeidsliv* (pp. 55–67). Oslo: Univeristetsforlaget.
- Hemmingsson, H., & Jonsson, H. (2005). An occupational perspective on the concepts of participation in the international classification of functioning, disability and health: Some critical remarks. *American Journal of Occupational Therapy*, 59, 569–576.
- Hubbard, S. (2004). Disability Studies and health care curriculum: The great divide. *Journal of Allied Health*, 33(3), 184-188.

- Johannessen, A., & Tufte, P. A. (2002). *Introduksjon til samfunnsvitenskapelig metode*. Oslo: Abstrakt forlag. [Chapter 5: Forskerens etiske og juridiske ansvar, pp. 65–73.]
- Johanssen, K., Petersen, K., Sørensen, K., & Voss, A-L. (2007). At muliggjøre aktivitet og deltagelse hos voksne: Hospitals- og sosialpsykiatri. In T. Borg, U. Runge, J. Tjørnov, Å. Brandt, & A. J. Madsen (Eds.), *Basisbog i ergoterapi: Aktivitet og deltagelse i hverdagslivet* (2nd ed.) (pp.478–512). København: Munksgaard.
- Kassah, A. K., & Kassah, B. L. L. (2009). *Funksjonshemning – sentrale ideer, modeller og debatter*. Bergen: Fagbokforlaget.
- Kielhofner, G. (2004). *Conceptual foundations of occupational therapy*. (3rd ed.). Philadelphia: F. A. Davis Company.
- Kielhofner, G. (2005). Rethinking disability and what to do about it: Disability studies and its implications for occupational therapy. *American Journal of Occupational Therapy*, 59(5), 487–496.
- Kielhofner, G. (2008a). *Model of human occupation: Theory and application* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008b). Dimensions of doing. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 101–109). Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008c). Habituation: Patterns of daily occupation. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 51–67). Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008d). The environment and human occupation. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 85–100). Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008e). Volition. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 32–50). Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G., & Forsyth, K. (2008a). Occupational engagement: How clients achieve change. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 171–184). Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G., & Forsyth, K. (2008b). Therapeutic reasoning: Planning, implementing, and evaluating the outcomes of therapy. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 143–154). Philadelphia: Lippincott Williams & Wilkins.

- Kielhofner, G., Tham, K., Baz, T., & Hutson, J. (2008). Performance capacity and the lived body. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 68–84). Philadelphia: Lippincott Williams & Wilkins.
- Kramer, J., Bowyer, P., & Kielhofner, G. (2008). The model of human occupation and the ICF, and the occupational therapy practice framework: Connections to support best practice around the world. In G. Kielhofner, *Model of human occupation: Theory and application* (4th ed.) (pp. 519–531). Philadelphia: Lippincott Williams & Wilkins.
- Kvale, S., & Brinkmann, S. (2009). *Det kvalitative forskningsintervju*. (2nd ed.) Oslo: Gyldendal akademisk.
- Linton, S. (1998). *Claiming disability - knowledge and identity*. New York: New York University Press.
- McCormack, C., & Collins, B. (2010). Can disability studies contribute to client-centred occupational therapy practice? *British Journal of Occupational Therapy*, 73(7), 339-342.
- McIntyre, A., & Tempest, S. (2007). Two steps forward, one step back? A commentary on the disease-specific core sets of the international classification of functioning, disability and health (ICF). *Disability and Rehabilitation*, 29(18), 1475–1479.
- McLaughlin Gray, J. (2001). Discussion of the ICIFH-2 in relation to occupational therapy and occupational science. *Scandinavian Journal of Occupational Therapy*, 8, 19–30.
- MOHO Clearinghouse. (2011). *Introduction to MOHO*. Retrieved March 8th 2012 from: <http://www.uic.edu/depts/moho/intro.html>
- NAV. (2012a). *Grunnstønad*. Retrieved April 4th 2012 from: <http://www.nav.no/Helse/Grunn-+og+hjelpestønad/Grunnstønad>
- NAV. (2012b). *Uførepensjon*. Retrieved April 4th 2012 from: <http://www.nav.no/Arbeid/Jobb+og+helse/Uførepensjon>
- NEM – Den nasjonale forskningsetiske komité for medisin og helsefag. (2010). *Veiledning for forskningsetisk og vitenskapelig vurdering av kvalitative forskningsprosjekt innen medisin og helsefag*. Oslo: De nasjonale forskningsetiske komiteer.
- NESH – Den nasjonale forskningsetiske komité for samfunnsvitenskap og humaniora. (2006). *Forskningsetiske retningslinjer for samfunnsvitenskap, humaniora, juss og teologi*. Oslo: De nasjonale forskningsetiske komiteer.
- NOU 2001:22. *Fra bruker til borger - En strategi for nedbygging av funksjonshemmende barrierer*. Oslo: Sosial- og helsedepartementet.

- Oliver, M. (1990). *The politics of disablement*. New York: St. Martin's Press.
- Phelan, S. K. (2011). Constructions of disability: A call for critical reflexivity in occupational therapy. *Canadian Journal of Occupational Therapy*, 78, 164–172.
doi:10.2182/cjot.2011.78.3.4
- Phillips, L., & Jørgensen, M. W. (2002). *Discourse analysis as theory and method*. London: Sage publications.
- Phillips, L., & Schrøder, K. (2005). Diskursanalytisk tekstanalyse. I M. Järvinen, & N. Mik-Meyer (Eds.). *Kvalitative metoder i et interaktionistisk perspektiv: Interview, observationer og dokumenter* (pp. 275–302). Copenhagen: Hans Reitzels Forlag.
- Shakespeare, T. (2010). The social model of disability. In L. J. Davis (Ed.). *The disability studies reader*. (3rd ed.) (pp. 374–382). New York: Routledge.
- Silverman, D. (2006). *Interpreting qualitative data Methods for analyzing talk, text and interaction*. (3rd ed.). London: Sage Publications. [Chapter 8: Credible qualitative research, pp. 271–314.]
- Sosial- og helsedirektoratet. (2006). *Full deltakelse for alle: Utviklingstrekk 2001-2006. Del 1*.
- St.meld. nr. 34 (1996-97). *Resultater og erfaringer fra regjeringens handlingsplaner for funksjonshemmede og veien videre*. Oslo: Arbeidsdepartementet.
- St.meld. nr. 40. (2002-03). *Nedbygging av funksjonshemmende barrierer. Strategier, mål og tiltak i politikken for personer med nedsatt funksjonsevne*. Oslo: Sosialdepartementet.
- St.meld. nr. 47. (2008-09). *Samhandlingsreformen. Rett behandling- på rett sted- til rett tid*. Oslo: Helse og- omsorgsdepartementet.
- Stamm, T. A., Alarcos, C., Machold, K., Smolen, J. S., & Stucki, G. (2006). Exploration of the link between conceptual occupational therapy models and the International Classification of Functioning, Disability and Health. *Australian Occupational Therapy Journal*, 53, 9–17. doi:10.1111/j.1440-1630.2005.00513.x
- Sumsion, T., & Law, M. (2006). A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy*, 73(3), 153–162.
- Swain, J., French, S., & Cameron, C. (2003). *Controversial issues in a disabling society*. Buckingham: Open University Press.
- Townsend, E. (1993). Occupational therapy's social vision. *Canadian Journal of Occupational Therapy*, 60(4), 174–184.

- Trentham, B., Cockburn, L., Cameron, D., & Iwama, M. (2007). Diversity and inclusion within an occupational therapy curriculum. *Australian Occupational Therapy Journal*, 54, 49–57. doi:10.1111/j.1440-1630.2006.00605.x
- Tøssebro, J. (2004). Introduction to the special issue: Understanding disability. *Scandinavian Journal of Disability Research*, 6(1), 3–7.
- Tøssebro, J. (Red.). (2009). *Funksjonshemming – politikk, hverdagsliv og arbeidsliv*. Oslo: Universitetsforlaget. [Chapter: Introduction, pp. 11–20.]
- Tøssebro, J., & Kittelsaa, A. (2004). Studying the living conditions of disabled people: Approaches and problems. In J. Tøssebro & Kittelsaa, A. (Eds.). *Exploring the living condition of disabled people* (pp.17-43). Lund: Studentlitteratur.
- United Nations. (2011a). *Convention on the rights of persons with disabilities*. Retrieved: April 27th 2012 from: <http://www.un.org/disabilities/default.asp?navid=14&pid=150>
- United Nations. (2011b). *Convention and optional protocol signatures and ratifications*. Retrieved: April 30th 2012 from: <http://www.un.org/disabilities/countries.asp?id=166>
- World Federation of Occupational Therapists (WFOT). (2010). *Definitions of Occupational Therapy from Member Organizations*. Retrieved November 15th 2011 from: <http://www.wfot.org/ResourceCentre.aspx>
- World Health Organization (WHO). (2001). *International Classification of Functioning, Disability and Health: ICF*.

Appendix 1 – Literature used at four or more schools

- Borg, T. et al. (2007). *Basisbog i ergoterapi: aktivitet og deltagelse i hverdagslivet*. København: Munksgaard.
 - Also editions from 2003
- Bredland, E. L. et al. (2002). *Det handler om verdighet*. Oslo: Gyldendal.
- Case-Smith, J. (2010). *Occupational therapy for children*. Elsevier Mosby.
 - Also editions from 2005
- Creek, J. (Ed.). (2008). *Occupational therapy and mental health*. Churchill Livingstone Elsevier Science.
 - Also editions from 2002
- Crepeau et al. (2009). *Willard & Spackmans Occupational Therapy*. Philadelphia: Lippincott Williams & Wilkins.
 - Also editions from 2003
- Kielhofner, G. (2008). *Model of human occupation*. Philadelphia: Lippincott, Williams & Wilkins.
 - Also editions from 2002 and 1995
- Mæland, J. G. (2010) *Forebyggende helsearbeid i teori og praksis* (2nd ed.). Oslo: Universitetsforlaget.
 - Also editions from 2005
- Ness, N. E. (2002). Ergoterapifagets aktivitetsperspektiv. *Ergoteapeuten*, nr. 10(45), p. 1–24, appendix.
- Nyboe, L. & Hvalsøe, B. (Eds.). (2009). *Lærebog i psykiatri for ergoterapeuter og fysioterapeuter*. København: Munksgaard Danmark.
- Tuntland, H. (2006) *En innføring i ADL*. Høyskoleforlaget.
- Turner, A. et al. (2002). *Occupational therapy and physical dysfunction* (5th ed.). Churchill Livingstone.

Appendix 2 – Compiled literature list from all five schools

- Aas R. W., & Grotle, M. (2007). Clients using community occupational therapy services: Sociodemographic factors and the occurrence of diseases and disabilities. *Scandinavian Journal of Occupational Therapy*, 14, 150-159.
- Aas, J. E. (1998). Traumatisk skulderluksasjon. *Fysioterapeuten*, 2, 8-12.
- Abusdal, U. G. (1995). *Fibromyalgi? En bok om muskelsmerter*. Oslo: Tano.
- Adalberth, A. (2005). *Bløde verdier der gjør en forskel*. Forlaget Birmar.
- Alm Andreassen, T. (2007). Når brukerne ikke blir tatt på alvor. *Tidsskrift for velferdsforskning*, nr 1.
- Almvik, A., & Borge, L. (Red.). (2006). *Psykisk helsearbeid i nye sko*. Kap. 3. Bergen: Fagbokforlaget.
- Almvik, A., & Borge, L. (Red.). (2006). *Psykisk helsearbeid i nye sko*. Kap. 7. Bergen: Fagbokforlaget.
- Almvik, A., & Borge, L. (Red.). (2006). *Psykisk helsearbeid i nye sko*. Kap. 3, 5, 14. Bergen: Fagbokforlaget.
- Alsaker, S., & Josephsson, S. (2003). Negotiating occupational identities while living with chronic rheumatic disease. *Scandinavian Journal of Occupational Therapy*, 10, 167-176.
- Alsaker, S., & Josephsson, S. (2010). Occupation and meaning: Narrative in everyday activities of women with chronic rheumatic conditions. *OTJR - Occupation, Participation and Health*, 30(2).
- Alsaker, S., Jakobsen, K., Magnus, E., Bendixen, H. J., Kroksmark, U., & Nordell, K. (2006). Everyday occupations of Occupational Therapy and physiotherapy Students in Scandinavia. *Journal of Occupational Science*, 13(1), 17-26.
- Altenborg, U. (Red.). (2005). *Aktivitetsvidenskab i et nordisk perspektiv*. (s. 15-63). København: FADL's forlag.
- Alve, G. (2006). *Terapeturollen i samhandling. En studie av ergoterapeuters samhandlingsmåter i møte med pasienter*. Det medisinske fakultetet, UiO
- Alve, G. (2007). 'Plukker du mye sopp' Samhandling mellom Hege og pasienten. *Ergoterapeuten*, nr 1, s. 8-9.
- Alve, G. (2007). Person og profesjon, *Ergoterapeuten*, nr 1, s.20-26.
- Alve, G. (2007). Person og profesjon. *Ergoterapeuten*, nr. 1, s. 20-26.
- Alve, G. (2007). Terapeturollen i samhandling. En studie av ergoterapeuters samhandlingsmåter i møte med pasienter. *Ergoterapeuter*, nr. 1, 16-19.
- Alve, G. (2007). Terapeutrollen i samhandling, *Ergoterapeuten*, nr 1, s. 16-19.
- Ambjørnsen, I. (1994). *Utsikt til paradiset*. Trondheim: J.W. Cappelens Forlag.

- Ambjørnsen, I. (1996). *Fugledansen*. Trondheim: J.W. Cappelens Forlag.
- Ambjørnsen, I. (1997). *Brødre i blodet*. Trondheim: J.W. Cappelens Forlag.
- Ambjørnsen, I. (1999). *Elsk meg i morgen*. Trondheim: J.W. Cappelens Forlag.
- Amdam, J., & Veggeland, N. (2004). *Teorier om samfunnsplanlegging*. Universitetsforlaget.
- Amstrup, K., & Poulsen, I. (2004). *Geriatrici. En tverrfaglig utfordring*. København: Munksgaard, Danmark.
- Andersen, E. S., Grude, K. V., & Haug, T. (2009). *Målerettet prosjektstyrning*. (5 utg). Oslo: NKI forlaget.
- Andersen, M. M., Hass, I., Quist Lauritzen, G., & Norling Schmidt R. (2003). *Ergoterapi og børn*. Kap 3. FADL.
- Andersen, M. M., Hass, I., Quist Lauritzen, G., & Norling Schmidt R. (2003). *Ergoterapi og børn*. Kap. 4. FADL.
- Andersen, M. M., Hass, I., Quist Lauritzen, G., & Norling Schmidt R. (2003). *Ergoterapi og børn*. Kap 1. FADL.
- Andersen, M. M., Hass, I., Quist Lauritzen, G., & Norling Schmidt, R. (Red.). (2003). *Ergoterapi og børn*. Kap. 7.
- Andersen, M. M., Lauritzen, G. Q., & Stokholm, G. (2010). *Ergoterapi og børn. Udvikling, aktivitet og deltagelse*. (2. utg.). København: Munksgaard.
- Andersen, M. M., Lauritzen, G. Q., & Stokholm, G. (2010). *Ergoterapi og børn. Udvikling, aktivitet og deltagelse*. (2. utg.). Kap. 2-6, 9-11. København: Munksgaard.
- Andersen, S. (2003). *Sundhed sidder mellem ørene. Det at leve med en kronisk sygdom*. Dansk parkinsonforening, Hornslet.
- Anderssen, S., Strømme (2001). Fysisk aktivitet og helse – anbefalinger. *Tidsskrift for den Norske Legeforening*, 121, 2037-41.
- Andersson, L. (2009). Metodisk bruk av aktivitet i ergoterapi. *Ergoterapeuten*, 1, 2009/52.
- Andersson, L. (2009). Metodisk bruk av aktivitet i ergoterapi. *Ergoterapeuten*, 1, s. 36-41.
- Andersson, L., & Öberg, P. (både 2006- og 2004-utgaven kan brukes). Diversity, health and ageing. In Daatland, S. O. & Biggs, S. (Eds.). *Ageing and Diversity. Multiple pathways and cultural migrations*. Pp. 45-60. Bristol: The Policy Press.
- Andresen, R. (2000). *Fellesskap og sammenhenger- yrkeshjelpere i grupper, nettverk og organisasjoner*. Kap. 10, 11. Oslo: Gyldendal Akademisk.
- Arbeids- og inkluderingsdepartementet. (2004). *Mangfold gjennom inkluderin og deltakelse. Ansvar og frihet*. St.meld. nr. 49 (2003-2004).
- Arbeids- og inkluderingsdepartementet. (2006). *Arbeid, velferd og inkludering*. St.meld. Nr. 9 (2006-2007). Kap. 1, 2.9, 3.10, 4.3, 5.9, 14.

- Arnadottir, G. (1990). *The Brain and Behavior*. The C.V. Mosby Company
- Artzen, C. (2009). "Jeg får ikke henden til å gjøre det de skal gjøre". *Å leve med apraksi etter hjerneslag*. Kap. 3. Forlaget aldring og helse, UiT, Tromsø.
- Askheim, O. P., & Starrin, B. (Eds.). (2007). Empowerment i teori og praksis. I O. P. Askheim, *Empowerment – ulike tilnæringer*. s. 21-33. Oslo: Gyldendal Akademisk.
- Askheim, Ole Petter (2003). *Fra normalisering til empowerment*. Kap. 7. Oslo: Gyldendal.
- Asmervik, S. (2009). *Universell utforming. Byer, hus, parker og transport for alle*. Kap. 1,2,3. Tapir Akademisk.
- Atkinson K., & Wells C. (2000). Creative Therapies, a psychodynamic approach within occupational therapy. p. 3-153. Stanley Thornes Publ.
- Awaad, T. (2003). Culture, Cultural Competency and Occupational Therapy: A Review of the Literature. *British Journal of Occupational Therapy*, 66(8), 356-362.
- Bacheloroppgave. (2007). "Livsglede for eldre" – lev livet, livet ut. Skrevet av en gruppe sykepleiestudenter ved ASP, HiST.
- Bade, S., & Eckert, J. (2008). Occupational therapists' critical value in work rehabilitation and ergonomics. *Work: Journal of prevention, assesment & rehabilitation*, 31(1). 101-111.
- Bang, S., Heap, K. (1999). Teori om grupperprosesser. I: Skjulte ressurser. Om veiledning i grupper. Kap. 13. Oslo: Universitetsforlaget.
- Barne- likestillings- og diskrimineringsdepartementet. *Lov om diskriminering og tilgjengelighet*.
- Barne- og familiedepartementet. (2003). *FNs konvensjon om barnets rettigheter*.
- Barne- og likestillingsdepartementet. (2008). *Konvensjon om rettighetene til mennesker med nedsatt funksjonsevne*.
- Barne- og likestillingsdepartementet. (2008). *Lov om forbud mot diskriminering på grunn av nedsatt funksjonsevne*.
- Barne- og likestillingsdepartementet. (2009). *Et helhetlig diskrimineringsvern. Diskrimineringslovutvalgets utredning om en samlet diskrimineringslov, grunnlovsværn og ratifikasjon av tilleggsprotokoll nr. 12 til EMK. NOU 2009:14*.
- Barne- og likestillingsdepartementet. (2009). *Norge universelt utformet 2025. Regjeringens handlingsplan for universell utforming og økt tilgjengelighet 2009-2013*.
- Bass-Haugen, J., Mathiowetz, V., & Flinn, N. (2008). Optimizing Motor Behavior Using the Occupational Therapy Task-Oriented Approach. I: M.V. Radomski & C. A. Trombly Latham *Occupational Therapy for Physical Dysfunction*. Kap. 22. Wolters Kluwer/ Lippincott Williams & Wilkins.
- Bathen, T. (2005). "Opposite Limb Activation" En aktuell treningsmetode ved neglect? *Ergoterapeuten*, 6, 48, s. 24-28.

- Bathen, T. (2005). "Opposite Limb Activation" En aktuell treningsmetode ved neglekt? *Ergoterapeuten nr. 6/05/48 s. 24-28.*
- Bendixen, H. J., Borg, T., Pedersen, E. F., & Altenborg, U. (Red.). (2005). *Aktivitetsvidenskab i et nordisk perspektiv*. Kap. 1-3. Copenhagen: FADL's forlag.
- Bendixen, H.J., Borg, T., Frydendal Pedersen, E. og Altenborg, U. (Red.). (2005). *Aktivitetsvitenskap i et nordisk perspektiv*. s. 223-238. København: FADL's Forlag.
- Bendixen, H.J., Borg, T., Pedersen, E.F., & Alenborg, U. (Red.). (2005). *AktivitetEdsvitenskap i et nordisk perspektiv*. s. 97-110. København: FADLs Forlag.
- Benum, B. et al. (2007). *Å bygge en arbeidsplass*. Gyldendal.
- Berg, B., & Lauritsen, K. (2009). *Eksil og livsløp*. s.9-18,170-198. Oslo: Universitetsforlaget.
- Berg, M. (2005). Pediatric Evaluation of Disability (PEDI)., *Ergoterapeuten nr 9*, s. 46-51.
- Berg, M. (2008). Norsk Validering av Pediatric Evaluation of Disability Inventory (PEDI). Kartlegging av barns ADL-ferdigheter. *Ergoterapeuten nr 8*, s. 32-37.
- Berg, M. m.fl. (2005). Validering av Pediatric Evaluation of Disability i Norge. *Ergoterapeuten nr 9*, s. 52-55.
- Berge, T., & Repål, A. (Red.). (2008). *Håndbok i kognitiv terapi*. Kap. 1, 2. Oslo: Gyldendal akademisk.
- Bernhoft-Osa, K. m.fl. (2005). Occupational Justice. Rett til aktivitet og deltakelse. *Ergoterapeuten, nr. 2*, s. 24-28.
- Berthoud, R., Blekesaune, M., & Hancock, R. (2009). Ageing, income and living standards: evidence from the British Household Panel Survey. *Ageing & Society*, 29(7): 1105-1122.
- Bjerkreim, T. (Red.). (2005). *Eldre i en brytningstid*, s. 62-69. Oslo: Gyldendal Akademisk.
- Bjerkreim, T. (Red.). (2005). *Eldre i en brytningstid*. s. 15-22. Oslo: Gyldendal Akademisk.
- Bjerkreim, T. (Red.). (2005). *Eldre i en brytningstid*. s. 71-83. Oslo: Gyldendal Akademisk.
- Bjørk, I. T., Bjerknes, M.S. (Red.). (2003). *Å lære i praksis- en veiviser for studenten*. Kap. 6. Oslo: Universitetsforlaget.
- Bjørneby, S., Topo, P., & Holthe, T. (1999). *Technology, Ethics and Dementia. A guidebook on how to apply technology in dementia care*. The Norwegian Centre for Dementia Research.
- Blair, S. E. E. (2003). Role. I: Jones, D. *Sociology and Occupational Therapy*. Kap. 5. Edinburgh: Churchill Livingstone.
- Blair, S. E. E., & Robertson, L. J. (2005). Hard Complexities – Soft Complexities: an Exploration of Philosophical Positions related to Evidence in Occupational Therapy. *British Journal of Occupational Therapy*, 68(6).
- Blank, A. (2004). Clients' experience of Partnership with occupational Therapists in Community Mental Health. *British Journal of Occupational Therapy*, March 2004, 67, 3.

- Blennberger, E. m.fl. (1999). *Diakoni - Ideologi, praksis, tro och tanke*. Vol. 2. (Hansson, M. J. Diakonien teologi - et forsök att ställa de grundläggande frågorna.).
- Bojsen-Møller, F. (1996). *Bevægeapparatets anatomi*. Kap.29, s.323-330, 350-356.
- Bondevik M., & Nygaard H. A. (2006). *Tverrfaglig geriatri*. s.179-197. Bergen. Fagbokforlaget.
- Bondevik, M. & Nygård, H. A. (2006). *Tverrfaglig geriatri. En innføring*. Kap. 1,2,15. Bergen: fagbokforlaget.
- Bondevik, M., & Nygård, H. A. (2006). *Tverrfaglig geriatri. En innføring*. (2 utg.). Bergen: fagbokforlaget.
- Borg, A. (2003). *Resiliens risiko og sunn utvikling*. Kap. 1-3. Gyldendal norsk forlag.
- Borg, M. (2004). Endringsagenter og barrierebrytere. *Ergoterapeuten*, nr. 6, s. 30-38.
- Borg, M. & Davidson, L. (2007). The nature of recovery as lived in everyday experience. *Journal of mental health*, 2007; 1-12.
- Borg, M., & Kristiansen, K. (2004). Recovery-oriented professionals: Helping relationships in mental health services. *Journal of Mental Health*, October 2004; 135: 493-505.
- Borg, M., & Topor, A. (2007). *Virksomme relasjoner: om bedringsprosesser ved alvorlige psykiske lidelse*. Oslo: Kommunefolaget.
- Borg, M., Kristensen, K. (2004). Recovery-oriented professionals. Helping relations in mental health services. *Journal of Mental Health*, 13(2004)., no. 5, 493-505.
- Borg, T. et al. (2003). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. Kap. 4. København: Munksgaard.
- Borg, T. et al. (2003). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. s. 92,112-122. Munksgaard.
- Borg, T. et al. (2003). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. s. 54-55. Munksgaard.
- Borg, T. et al. (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. Kap. 12, 13.
- Borg, T. et al. (2007). *Basisbog i ergoterapi – aktivitet og deltagelse i hverdagslivet*. (2. udg.). Kap. 12. København: Munksgaard.
- Borg, T. et al. (2007). *Basisbog i ergoterapi – aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap.11, 13, 18, 19, 22. København: Munksgaard.
- Borg, T. et al. (2007). *Basisbog i ergoterapi – aktivitet og deltagelse i hverdagslivet*. Kap. 17. København: Munksgaard.
- Borg, T. et al. (2007). *Basisbog i ergoterapi – aktivitet og deltagelse i hverdagslivet*. S. 478-511. København: Munksgaard.
- Borg, T. et al. (2007). *Basisbog i ergoterapi – aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap. 15. København: Munksgaard.

- Borg, T. et al. (2007). *Basisbog i ergoterapi aktivitet og deltagelse i hverdagslivet* (2. utg.). København: Munksgaard.
- Borg, T. et al. (2007). *Basisbog i ergoterapi: aktivitet og deltagelse i hverdagslivet*. København: Munksgaard. Kap 1, 3, 5-10.
- Borg, T. et al. (2007). *Basisbog i ergoterapi*. Kap. 3-5, 17-19.
- Borg, T. et al. (2007). *Basisbog i ergoterapi*. Kap. 5 (139-150)., 19.
- Borg, T. et al. (2008). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. s. 547-575.
- Borg, T. et al. (2008). *Basisbog i ergoterapi*. Kap. 7, 16.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap. 1,3-4, 6-7, 9-10. København: Munksgaard.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). s. 547-575. Danmark, Munksgaard.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap 10, s 293-297, 302-313.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap 14. København: Munksgaard.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). (Hare, H., Hjortbak, E. B. & Jacobsen, A. At muliggøre aktivitet og deltagelse i forbindelse med arbejdsfapholdelse, erhvervsrettet rehabilitering og revalidering). København: Munksgaard.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi - aktivitet og deltagelse i hverdagslivet*. Kap. 17, 23. København: FADL's forlag.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi - aktivitet og deltagelse i hverdagslivet*. Kap. 19. København: FADL's forlag.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi: aktivitet og deltagelse i hverdagslivet*. Kap. 4 (92-122), 6 (161-189). København: Munksgaard.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi*.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap 7, s 190-200, 205-216, 223-228.
- Borg, T. et al. (Red.). (2007). *Basisbog i ergoterapi. Aktivitet og deltagelse i hverdagslivet*. (2. utg.). Kap. 16, s. 478-403. København: Munksgaard.
- Bosåen, J. (2000). Affolter-konseptet i praksis med slagrammede. *Ergoterapeuten nr 3, s. 16-21*.
- Bothen-Eide, S., & Skorstad, B. (2008). Menneskesyn og sosialt arbeid. I *Etikk, utfordring til ettertanke i sosial arbeid*. s. 135-156. Oslo: Gyldendal Akademisk.

- Brandt, Å. (2005). *Outcomes of Rollator and Powered Wheelchair Interventions User Satisfaction*. Faculty of Medicine, Division of Occupational Therapy, Lund University.
- Brataas & Steen-Olsen. (2003). *Kvalitet i samspill. Innføring i kommunikasjon og kulturell forståelse for helsepersonell*. Kristiansand: Høyskoleforlaget.
- Brataas, H.V., & Steen-Olsen, T. (2003). *Kvalitet i samspill Innføring i kommunikasjon og kulturell forståelse for helsepersonell*. Høyskoleforlaget AS.
- Bredland E. L. m.fl. (2002). *Det handler om verdighet*. Kap. 1 (22-47), 3 (89-106). Oslo: Gyldendal.
- Bredland, E. (2004). *Når mennesker møtes*. Del II (2. oppl.). s. 61-105, 137-143. Oslo: Kommuneforlaget.
- Bredland, E. L. (2004). *Når mennesker møtes*. s. 9-57. Kommuneforlaget.
- Bredland, E. L. et al. (2006). *Det handler om verdighet - Ideologi og praksis i rehabiliteringsarbeid*. Kap. 17, s. 156-187. Oslo: Gyldendal akademisk.
- Bredland, E. L., Linge, O. A., & Vik, K. (2002). *Det handler om verdighet: ideologi og praksis i rehabiliteringsarbeid*. Kap 8, 9. Oslo: Gyldendal akademisk.
- Bredland, E. L., Linge, O. A., & Vik, K. (2008). *Det handler om verdighet: Ideologi og praksis i rehabiliteringsarbeid*. Kap. 1-4. Oslo: Gyldendal akademisk.
- Bredland, E.L, Linge, O.A., & Vik, K. (2002). *Det handler om verdighet. Ideologi og praksis i rehabiliteringsarbeid*. Gyldendal akademisk.
- Briner, W. et. al. (2006). *Prosjektledelse*. Gyldendal.
- Bringa, O. (2006). *Universell utforming i kommunenes arealplanlegging*. Ergoterapeuten (49). nr 11.
- Brock-Haukedal, W. (2010). *Arbeids- og lederpsykologi*. (8 utg.). Kap. 13. Oslo: Cappelen Dam.
- Brodal, P (2007). *Sentralnervesystemet*. Universitetsforlaget.
- Brodtkorb, E. & Rugkåsa, M. (2007). *Under tak- mellom vegger. Perspektiver på boligens betydning i velferdsstaten*. Gyldendal akademisk.
- Brodtkorb, E. & Rugkåsa, M. (Red.). (2009). *Mellom mennesker og samfunn - sosiologi og sosialantropologi for helse- og sosialprofesjonene*. Kap. 9. Gyldendal Akademisk.
- Brodtkorb, E. & Rugås, M. (Red.). (2007). *Under tak- mellom vegger. Perspektiv på boligens betydning i velferdsstaten*. Oslo: Gyldendal.
- Brodtkorb, E. m.fl. (2003). *Sociologi og sosialantropologi*. Kap. 7 (205-236). København Munksgård.
- Brudal, L.F. (2006). *Positiv psykologi. Empati, flyt, kvinne og mann, humor*. Kap. 1, 2, 4. Bergen: Fagbokforlaget Vigmostad & Bjørke AS.
- Bugge, K. E., Eriksen, H., & Sandvik, O. (Red.). (2003). *Sorg*. Bergen: Fagbokforlaget.
- Bundy, A. C. et al. (2002). *Sensory Integration – Theory and Practice*. p. 3-29, 71-95, 101-120. Philadelphia: F. A. Davis Company.

- Bundy, A. C. Lane, S. J. & Murray, E. A. (Red.). (2002). *Sensory Integration, Theory and Practice*. Kap. 4 s. 101-119. Philadelphia, F. A. Davis.
- Bundy, A., Murray, E. & Lane, S. (2002). *Sensory integration - theory and practice*. (2 utg.). Philadelphia: F. A. Davis.
- Bundy, Lane & Murray. (2002). *Sensory Integration, Theory and Practice*. Kap 1, s. 3-1, 24-29. Philadelphia, F. A. Davis.
- Bunkholdt, V. (2000). *Utviklingspsykologi*. (2 utg.). Kap. 8, 12-13. Oslo: Universitetsforlaget.
- Bø, I. (2000). *Barnet og de andre*. (3 utg.). Oslo: Universitetsforlaget.
- Bø, I., & Schiefloe, P. M. (2007). *Sosiale landskap og sosial kapital. Innføring i nettverkstenkning*. Kap. 3, 8.
- Bø, I., & Schiefloe, P.M. (2007). *Sosiale landskap og sosial kapital. Innføring i nettverkstenkning*. Oslo: Univeristetsforlaget.
- Bøe, T. D. & Thomassen, A. (2007). *Fra psykiatri til psykisk helsearbeid*. Kap. 9. Universitetsforlaget.
- Canadian Association of Occupational Therapists (1999). *Joint Position Statement on Evidence-based Occupational therapy*.
- Carlsson, G. (2002). *Catching the Bus in Old Age*. s. 1-23. (Travelling by urban public transportation).
- Carlsson, I., Rosèn, B. & Cederlund, R. (1993). *Ortoser för händer*. s.1-18. Göteborg: Handgruppen.
- Case-Smith, J. (2005). *Occupational Therapy for Children*. Kap. 6 (160-215), 21 (771-793). Elsevier Mosby.
- Case-Smith, J. (2005). *Occupational Therapy with Children*. Kap. 6, s. 160-165, 167-175, 181-189. Louis: Elsevier Mosby.
- Case-Smith, J. (2010). *Occupational Therapy for Children*. Kap. 4, s. 88-115. St. Louis: Elsevier Mosby.
- Case-Smith, J. (Red.). (2005). *Occupational Therapy for Children*. Kap. 16, s. 571-583. Mosby.
- Case-Smith, J. (Red.). (2005). *Occupational Therapy for Children*. Kap. 6, s. 175-181, 188-203. Mosby.
- Case-Smith, J. (Red.). (2005). *Occupational Therapy for Children*. Kap. 6, s. 160-211. Mosby.
- Case-Smith, J. (Red.). (2005). *Occupational Therapy for Children*. Kap 1, s. 2-26. Mosby.
- Case-Smith, J. (Red.). (2005). *Occupational Therapy for Children*. Kap. 17, s. 587-605. Mosby.
- Case-Smith, J., & O'Brien, J. (2010). *Occupational therapy for children*. (6. utg.). Kap. 1, 3-5, 8, 10. Elevsier Mosby.
- Chapparo, C. & Ranka, J. (1998). En australsk modell for aktivitetsutførelse. *Ergoterapeuten 13*, s. 26-31.

- Christiansen, C & Townsend, E. (2004). *Introduction to occupation. The art and science of living*. s. 248-262. New Jersey: Prentice Hall.
- Christiansen, C. H. (1999). The 1999 Eleanor Clarke Slagle Lecture. Defining Lives: Occupation as Identity: An Essay on Competence, Coherence, and the Creation of Meaning. *The American Journal of Occupational Therapy* 53(6), 547-558.
- Christiansen, C. H., & Matuska, K. M. (2006). Lifestyle balance: A review of concepts and research. *Journal of Occupational Science*, 13(1), 49-61.
- Christiansen, C. H., & Townsend, E. A. (2010). *Introduction to occupation. The art and science of living*. (2nd ed.). Kap 1, s. 1-34. New Jersey: Pearson Education.
- Christiansen, C. H., & Townsend, E. A. (2010). *Introduction to occupation. The art and science of living*. (2nd ed.). s. 101-133. New Jersey Pearson Education.
- Christoffersen, S. A. (2005). *Handling person og samfunn. Innføring i etikk for helse- og sosialfagene*. Kap 1. Oslo: Universitetsfagene.
- Clark, F. et al. (1997). Occupational therapy for independent-living older adults. A randomized controlled trial. *Journal of the american medical association*, 278, 16, p. 1321-6.
- Clark, F. et al. (2001). Embedding Health-promoting changes into the daily lives of independent-living older adults: Long-term follow-up of occupational therapy intervention. *Journal of Gerontology; Psychological sciences*. Vol 56B, nr. 1, s. 60-63.
- Clark, F. et al. (1997). Occupational therapy for independent-living older adults. A randomized controlled trial. *Journal of the american medical association*, vol. 278, nr. 16, 1321-1326.
- Claussen, B. (2008). *Sosiale uliheter i helse*. UNIPUB.
- Cole, M. (2005). *Group Dynamics in Occupational Therapy*. Kap. 2-3. Thorofare Slack. Alternative: Creek, J. (2008). *Occupational Therapy and Mental Health*. Kap. 17, p. 315-329.
- Cole, M. B. (2005). *Group Dynamics in Occupational Therapy* (3. utg.). s. 3-22, 289-314. Thorofare: SLACK.
- Cole, M. B. (2005). *Group dynamics in occupational therapy*. Kap. 5-10. Thorofare, NJ: Slack.
- Cole, M.B. (2005). *Group dynamics in occupational therapy*. Kap. 1, 2, 3, deler av 5-10. Thorofare, NJ: Slack.
- Connon, B. S., Lohman, L. M. & Padilla, L. R. (Red.). (2004). *Occupational therapy with elders*. Kap. 20, s. 254-267. St. Louis, Elsevier Mosby.
- Connon, Lohman & Padilla (Red.). (2004). *Occupational therapy with elders*. Kap. 15, s. 201-211. St. Louis: Elsevier Mosby.
- Convention on the Rights of Persons with Disabilities.
<http://www.un.org/disabilities/default.asp?id=259>
- Craig, C. & Mountain, G. (2007). *Lifestyle matters. An occupational approach to healthy ageing*. UK: Speechmark publishing Ltd.

- Cranenburgh, B. van (2004). Neglekt hos apopleksipasienter – et forsømt problem. *Ergoterapeuten* nr. 1/04/47 s. 20-31.
- Creek, J. (2005). *Psykiatrisk ergoterapi*. Kap. 1,2. FADL's folag Danmark.
- Creek, J. (2005). *Psykiatrisk ergoterapi*. Kap. 18. FADL's folag Danmark.
- Creek, J. (2005). *Psykiatrisk ergoterapi*. Kap. 3. FADL's folag Danmark.
- Creek, J. (2005). *Psykiatrisk ergoterapi*. Kap. 4, deler av 6-11. FADL's folag Danmark.
- Creek, J. (2005). *Psykiatrisk ergoterapi*. Kap. 9. FADL's folag Danmark.
- Creek, J. (2007). Engaging the reluctant client. I J. Creek & A. Lawson-Porte (Red.). *Contemporary Issues in Occupational Therapy: reasoning and reflection*. Wiley.
- Creek, J. (2007). The thinking therapist. I J. Creek & A. Lawson-Porte (Red.). *Contemporary Issues in Occupational Therapy: reasoning and reflection*. Wiley.
- Creek, J. (2008). *Occupational Therapy and Mental Health*. (3rd ed.). Kap. 2, 4-6, 12, 14-18, 20-23, 27-30. Churchill Livingstone, Harcourt Publishers.
- Creek, J. (2008). *Occupational Therapy and Mental Health*. (4th ed.). Kap. 24, s. 425-47.
- Creek, J. (2008). *Occupational Therapy and Mental Health*. (4th ed.). Kap. 2 (17-28), 3 (31-52), 4 (60-77), 5 (81-105), 6 (109-130), 20 (359-377), 28 (514-532), 29 (536-553). Churchill Livingstone.
- Creek, J. (Red.). (2002). *Occupational Therapy and Mental Health*. s. 245-264. Churchill Livingstone Elsevier Science.
- Creek, J. (Red.). (2005). *Psykiatrisk ergoterapi. Teori og metode i praksis*. s. 173-192. FDL's Forlag.
- Creek, J. & Lougher, L. (Red.). (2008). *Occupational Therapy and Mental Health*. Edinburgh. s. 82-105, 109-130, 277-298, 303-308, 333-343, 359-377. Churchill Livingstone.
- Creek, J. & Lougher, L. (Red.). (2008). *Occupational therapy and mental health*. Kap. 17. Edinburgh: Churchill Livingstone.
- Creek, J. & Lougher, L. (Red.). (2008). *Occupational therapy and mental health*. Kap. 2, 3, 4. Edinburgh: Churchill Livingstone.
- Creek, J. & Lougher, L. (Red.). (2008). *Occupational therapy and mental health*. Kap. 29. Edinburgh: Churchill Livingstone.
- Creek, J. & Lougher, L. (Red.). (2008). *Occupational therapy and mental health*. Kap. 5. Edinburgh: Churchill Livingstone.
- Creek, J. & Lougher, L. (Red.). (2008). *Occupational therapy and mental health*. Kap. 6, s. 15-20. Edinburgh: Churchill Livingstone.
- Crepeau et al. (Red.). (2009). *Willard & Spackman's occupational therapy*, (11th ed.). Philadelphia, Lippincott, Williams & Wilkins.

- Crepeau, E. B., Cohn, E., & Schell, B. A. (2009). *Willard & Spackman occupational therapy*, (11th ed.). Kap. 24. Pennsylvania: Lippincott Williams and Wilkins.
- Crepeau, E. et al (2009). *Willard & Spackman's Occupational Therapy*, (11th ed.). Kap 35. Lippincott Williams & Wilkins.
- Crepeau, E. et al. (2009). *Willard & Spackmans Occupational Therapy*. Kap. 35 (359-374). Philadelphia: Lippincott Williams & Wilkins
- Crepeu, et al. (2003). *Willard & Spackman's occupational therapy*. Kap. 1. Philadelphia: Lippincott Williams & Wilkins.
- Cullberg, J. (2003). *Dynamisk Psykiatri*. (5 utg.). Oslo: Tano Ascheoug.
- Curtin, M., Molineux, M. & Supyk-Mellson, J. (Red.). (2010). *Occupational Therapy and Physical Dysfunction. Enabling Occupation* (6th ed.). Kap. 33. Edinburgh: Churchill Livingstone.
- Daatland, S. O. (2008). *Aldring som provokasjon. Tekster om aldring og samfunn*. Kap. 2, 3. Bergen: fagbokforlaget.
- Daatland, S. O. & Solem, P. E. (2000). *Aldring og samfunn. En innføring i sosialgerontologi*. Kap. 6, 7, 9, 10. Bergen: fagbokforlaget.
- Dahl, A. & Rinvik, E. (2010). *Menneskets funksjonelle anatomi- med hovedvekt på bevegelsesapparatets*. (3. utg.). Kap. 1, 2, 3 (88-96), 6, 8, 9, 11, 12, 17, 18, 20, 21, 25. Oslo: Cappelen Akademisk.
- Dahl, H. A. & Rinvik, E. (2002). *Menneskets funksjonelle anatomi*. Kap. 11-12, s. 297-348. Cappelen Akademisk.
- Dahl, H. A. & Rinvik, E. (2007). *Menneskets funksjonelle anatomi*. (2. utg.). Kap. 1 (23-34), 8-9 (227-288), 17-18 (409-480), 20 (499-513). Cappelen Akademisk.
- Dahle, R. & Thorsen, K. (Red.). (2004). *Velferdstjenester i endring*. (Andreassen, T. A. Brukermedvirkning i praksis – Faglig fortolkning av politiske mål). Bergen: Fagbokforlaget.
- Dale, S. (2003). Universell utforming- et bidrag i folkhelsearbeidet. *Ergoterapeuten nr 5*, s. 22-27.
- Dale, S. (2010). Implementering av universell utforming i en kommune. *Ergoterapeuten*, 3, s. 38-44.
- Dalland, O. (1999). *Pedagogiske utfordringer for helse og sosialarbeidere*. Kap. 7. Oslo: Gyldendal.
- Dalland, O. (2007). *Metode for oppgaveskriving*. (4. utg.). Kap. 1-6 (15-127). Oslo: Gyldendal Akademisk.
- Dalland, O. (2007). *Metode for oppgaveskriving*. (4. utg.). Kap. 9. Oslo: Gyldendal Akademisk.
- Dalland, O. (2007). *Metode for oppgaveskriving*. (4. utg.). Oslo: Gyldendal Akademisk.
- Dalland, O. (2007). *Metode og oppgaveskriving for studenter* (4. utg.). Oslo: Gyldendal akademisk.
- Damasio, A. R. (2001). *Descartes' feiltagelse. Fornuft, følelser og menneskehjernen*. Oslo: Pax.
- Dammelftoft, B. C. (2008). *Skjulte handicaps hos personer ramt af hjerneskade. En sansemæssig-kropslig tilgang*. (2 utg.). Kap. 1-9. Haslev: Gammeltoft forlag.

- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 21 (303-310). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 9 (125-136). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 27 (361-68). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 28 (369-76). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 29 (377-81). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 26 (355-359). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 32 (407-17). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 46. København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 50 (769-73). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 6 (77-86). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 4 (47-64). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 48 (727-54). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 51 (775-80). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 5 (65-75). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 25 (349-353). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 18 (273-282). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 7 (87-95). København: Munksgaard.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 11 (147-165). København: Munksgaard.

- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 45-46. København: Munksgaard Danmark.
- Danneskiold-Samsøe, B., Lund, H. & Avlund, K. (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 6, 8, 9, 21, 26-29, 39, 40, 43, 44, 47. København: Munksgaard Danmark.
- Danneskiold-Samsøe, Lund & Avlund (Red.). (2002). *Klinisk reumatologi for ergoterapeuter og fysioterapeuter*. Kap. 1-2 (19-37), 13-14 (177-231), 36 (457-470), 38-40 (477-596), 45 (657-669). København: Munksgaard DK.
- Davies, P. (2001). *Skridt for skridt. Den omfattende behandling af patienter med en hemiplegi*. (2. utg.). København: FADL's folag.
- Davies, P. M. (2001). *Skridt for Skridt*. Kap. 2, 5-8, s. 34-56, 99-234. FADL.
- de Jong, Z., Munneke, M., Zwinderman, A. H., et al. (2004). Long term high intensity exercise and damage of small joints in rheumatoid arthritis. *Ann Rheum Dis. Vol 63*, pp 1399-1405.
- Dekkers, M. (2001). *Ergoterapeutisk undersøkelse*. s. 58-67. FADL.
- Dekkers, M. (2008). *Ergoterapeutisk undersøkelse*. (2. utg.). s. 9-82. Munksgaard DK.
- Dekkers, M. (2008). *Ergoterapeutiske undersøkelse. Undersøkelse av somatiske pasienter*. (2. utg.). s. 24-57, 74-108. København: FADL.
- Dekkers, M. (2008). *Ergoterapeutiske undersøkelser av somatiske pasienter*. (2. utg.). s. 58-74. København: Munksgaard Danmark.
- Dellhag, B. & Bjelle, A. (1995). Grip Ability Test for Use in Rheumatology Practice. *The Journal of Rheumatology*. Vol 22:8;1559-1565.
- Dellhag, B. & Bjelle, A. (1999). A Five-Year Follow-up of Hand Function and Activities of Daily Living in Rheumatoid Arthritis. *Arthritis Care and Research Vol. 12*, No 1, s. 33-41.
- Desrosiers, J. (2005). Participation and occupation. *Canadian Journal of Occupational Therapy*, 2005 October.
- Dietrichs, E. & Gjerstad, L. (2007). *Vår fantastiske hjerne*. Universitetsforlaget.
- Dixon, L., Duncan, D. C., Johnson, P., Kirkby, L., O'Connell, H., Taylor, HJ. & Deane, K. (2007). *Occupational therapy for patients with parkinson's disease*. The Cochrane Library, 2009, 4.
- Dolva, A. S. (2008). Functional performance in children with Down Syndrome. *The American Journal of Occupational Therapy*. s. 621- 629.
- Dolva, A. S. & Aalandslid, M. (2006). *Skolestart med muligheter. Om overgangen fra Barnehage til skole for barn med Down syndrom*. Kap. 6 (93 -105).
- Dolva, A. S., Coster, W. & Lilja, M. (2004). Functional Performance in Children With Down Syndrome. *American Journal of Occupational Therapy*. Vol. 58 (621- 628).
- Douglas, A., Liu, L., Warren, S. & Hopper, T. (2007). Cognitive assessments for older adults: Which ones are used by canadian therapists and why. *CJOT*. Early electronic edition.

- Drageland, Å. & Tønseth, S. (2008). Nøkkelen til arbeidslivet? *Gemini*, september nr. 3, s. 31-37.
- Dunbar, S. B. (2007). *Occupational therapy models for intervention with children and family*. Kap. 4. Thorofare: Slack.
- Dunbar, S. B. (2007). *Occupational therapy models for intervention with children and families*. Thorofare: Slack incorporated.
- Duncan, E. (Ed.). (2006). *Foundations for Practice in Occupational Therapy*. s. 161-187, 217-231, 233-251. Edinburgh: Elsevier.
- Duncan, E. (Ed.). (2006). *Foundations for Practice in Occupational Therapy*. (4th ed.). Kap. 5, 11, 14, 15. Edinburgh: Churchill Livingstone.
- Dunn, W. (2009). *Living sensationally. Understanding your senses*.
- Dunstan, D. A. & Covic, T. (2006). Compensable work disability management: A literature review of biopsychosocial perspectives. *Australian Occupational Therapy Journal*. Volume 5 (67-77).
- Dwyer, G., Baur, L., Higgs, J. & Hardy, L. (2009). Promoting children's health and well-being: broadening the therapy perspective. *Physical occupational therapy pediatric*, 29(1), 27-43.
- Edwards, S. J, Buckland, D. J. & McCoy-Powlen, J. D. (2002). *Developmental & functional hand grasps*. Thorofare: Slack incorporated.
- Edwards, S., McCoy-Powlen, J., Buckland, D. (2002). *Developmental & Functional Hand grasps*. Kap. 3-5 (31-78). Thorofare, NJ: Slack.
- Eide, H. & Eide, T. (2004). *Kommunikasjon i praksis. Relasjon, samspill og etikk i sosialfaglig arbeid*. Kap 1-3,6,7. Oslo: Gyldendal.
- Eide, H. & Eide, T. (2007). *Kommunikasjon i relasjoner. Samhandling, konfliktløsning, etikk*. (2. utg.). Kap. 3, 4, 10, 16. Oslo: Gyldendal Akademisk.
- Eide, T. & Aadland, E. (2008). *Etikkhåndboka for kommunenes helse- og omsorgstjenester*. Oslo: Kommunerolaget AS.
- Eidem Krüger, R. M et al. (Red.). (2008). *Det går an! Muligheter i miljøterapi*. s. 262-270. Tønsberg: forlaget aldring og helse.
- Eidem, Krüger, R. M. et al. (Red.). (2008). *Det går an! Muligheter i miljøterapi*. (Holthe, T. Det går an! Tilrettelegging av fysisk miljø på institusjon, dagsenter og hjemme). Tønsberg: Aldring og helse forlaget.
- Einarsen, S. & Skogstad, A. (Red.). (2000). *Det gode arbeidsmiljø - krav og utfordringer*. Del 2, 4. Bergen: Fagbokforlaget.
- Ekeland, T. J. & Heggen, K. (2007). *Meistring og myndiggjøring – reform eller retorikk?* Kap. 1. Oslo: Gyldendal Akademisk.
- Eklund, K., Sjöstrand, J. & Dahlin-Ivanof, S. (2008). A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. *Scandinavian Journal of occupational Therapy*, 15, nr 2.

- Eklund, K., Sjöstrand, J. & Dahlin-Ivanoff, S. (2008). A randomized controlled trial of a health-promotion programme and its effect on ADL dependence and self-reported health problems for the elderly visually impaired. *Scandinavian Journal of Occupational Therapy*, 15: 68-74.
- Elkjær, S., Klevberg G. L. & Grønner, E. L. (2008). En barnevennlig modell av Constraint-induced movement therapy. *Ergoterapeuten nr 10*, s 23-33.
- Ellingham, B. & Jakobsen, K. (2003). *Worker environment impact scare. Brukermanual*. Norsk version. Høgskolen i Oslo: HiO-rapport 2003 nr 38.
- Ellingham, B. & Jakobsen, K. (2003). *Worker role interview: brukermanual*. Norsk version. Høgskolen i Oslo: HiO-rapport 2003 nr 37.
- Elvbakken, K. T. & Stenvoll, D. (Red.). (2008). Reisen til helseland. Propaganda i folhelsens tjeneste. Bergen: Fagbokforlaget Vigmostad & Bjørke AS.
- Elvrum, A-K. G. (Red.). (2006). *Måltrettet trening basert på motorisk læring - en metodisk framgangsmåte basert på goat attainment scaling*. Oslo: Norsk ergoterapeutforbund.
- Elvrum, A. K. G. (2005). Måltrettet trening basert på motorisk læring. *Ergoterapeuten nr 9*, s 38-44.
- Elvrum, A. K. G. (Red.). (2006). *Måltrettet trening basert på motorisk læring – en metodisk framgangsmåte basert på Goal Attainment Scaling*. Norsk Ergoterapeutforbund (NETF).
- Engedal, K. (2008). *Lærebok i alderspsykiatri i praktisk*. Kap. 3,4,6. Sem: Nasjonalt kompetansesenter for aldersdemens.
- Engedal, K. & Haugen, P. K. (Red.). (2009). Organisering av demensutredningen. I: *Lærebok i demens – fakta og utfordringer*. Kap.12 (235-274). Sem. Nasjonalt kompetansesenter for aldersdemens.
- Engedal, K. & Haugen, P. K. (Red.). (2009). Symptomer ved demens. I: *Lærebok i demens – fakta og utfordringer*. Kap. 2 (33-50). Sem. Nasjonalt kompetansesenter for aldersdemens.
- Engedal, K. & Haugen, P. K. (2006). *Demens. Fakta og utfordringer. En lærebok*. Kap. 1-5
- Engedal, K. & Haugen, P. K. (Red.). (2009). *Lærebok i demens – fakta og utfordringer*. Kap. 17, (343-360). Sem. Nasjonalt kompetansesenter for aldersdemens.
- Engelsrud, G. & Heggen K. (Red.). (2007). *Humanistisk sykdomslære. Tanker om helse og velvære, sykdom og diagnose*. (Heggen, K. Når sosiale relasjoner endrer status.). Universitetsforlaget.
- Engström, B. (2002). *Ergonomi: sitande och rullestolar*. Hässelby: Posturalis books.
- Ergoterapeuten nr 7 (2009). *Temanummer kommunehelsetjenesten*. Norsk ergoterapeutforbund, Oslo:.
- Ergoterapeuten. (2005). *Temahefter om barns helse*. Nr. 9 årg. 48. NETF.
- Eriksen, T. H. & Sørheim, T. A. (2003). *Kulturforskjeller i praksis. Perspektiver på det flerkulturelle Norge*. Oslo: Gyldendal akademiske
- Eriksen, W. & Brage, S. (Red.). (2000). *Korsryggsmarter. En samfunnsmedisinsk og almennt medisinsk utfordring*. s. 43-51. (Indahl, Aa. Smerter ved sykdommer vi ikke riktig forstår - eller forstår riktig.).

- Esnault, M. (2005). *Prosjektoppstart. Du har ikke tid til å ha det travelt*. s. 13-124. Oslo: Gyldendal akademisk.
- Espelund, I. (2007). Hindrer friluftsliv aktivitetsdeprivasjon? *Ergoterapeuten*, 2007/50 nr 6.
- Espnes, G. A. & SmEdslund, G. (2009). *Helsepsykologi*. Kap. 6,9,12. Oslo: Gyldendal akademisk.
- Evjen, R. et al. (2007). *Dobbelt OPP*. s. 29-34, 68-102, 129-179, 185, 223. Oslo: Universitetsforlaget.
- Exner, C. (2005). Development of Hand Skills, Kap. 10. In J. Case-Smith (Ed.). *Occupational Therapy for Children*, s. 304-350. Mosby.
- Festervoll, Å. V. (2001). *Kultur og helse*. Kap. 1, 3. Oslo: Kommuneforlaget AS.
- Finlay, L. (2001). *Groupwork in Occupational therapy*. Kap. 2-7. UK: Nelson Thornes Ltd.
- Finlay, L. (2004). From "Gibbering Idiot" to "Iceman", Kenny's Story: A Critical Analysis of an Occupational Narrative. *British Journal of Occupational Therapy*, 67(11), 474-480.
- Finlay, L. (2004). *The practice of Psychosocial Occupational Therapy*. Kap. 3, s. 40-69. Nelson Thornes.
- Finset, A. & Krogstad, J. (2002). *Hodeskade*. Oslo: Cappelen Akademisk.
- Finset, A. & Krogstad, J. M. (2002). *Hodeskade. Virkninger og behandling av ulike typer hodeskade*. Oslo: Cappelen Akademisk.
- Fiske, J. (1990). *Introduction to communication studies*. London: Routledge
- FNs konvensjon om barnets rettigheter av 20 november 1989. Innledning, artikkel 12, 23.
http://www.reddbarna.no/default.asp?V_ITEM_ID=21088
- Foley, G., O'Mahony, P. & Hardiman, O. (2007). Perceptions of quality of life in people with ALS: effects of coming and health care. *Amyotroph Lateral Scler*. 2007 Jun; 8(3), 164-169.
- Folio, R. & Fewell, R. (2000). *Peabody Developmental Motor Scales PDMS-2*, PRO-ED Austin, Texas.
- Forskrift om BHT (2009).
- Forskrift om tekniske krav til byggverk (*Byggteknisk forskrift*). 1.juli 2010. Kap.1 §1.1, Kap. 8, Kap. 12, Kap.13 § 13-1 og §13-10. www.lovdata.no
- Forstyth, K. & Kielhofner, G. (2003). MOHO. I kunnskap om aktivitet. *Ergoterapeuten*, nr. 11, 2003, årg. 46, s 28-33.
- Fortmeier, S. & Thanning, G. (1994). *Set med patientsens øyne*. Kap. 1,3,10,11,13. København, FADL's forlag.
- Fortmeier, S. & Thanning, G. (2003). *Set med patientens øjne: Ergoterapi og rehabilitering som patientens egen virksomhed*. Kap. 2,3 (21-38), 10-13 (153-227). København: FADL.
- Foss, Ø. (2005). *Omsorgsetikk, Søkelys på omsorgens motivasjon*. Kap 1. Gjennomgående. Oslo: Cappelen Akademisk.

- Foss, Ø. (2005). *Omsorgsetikk, søkelys på omsorgens motivasjon*. Oslo: Cappelen Akademisk.
- Fängen, A. & Iwarsson, S. (2007). Challenges in the developments of strategies for housing adaptation evaluations. *Scandinavian Journal of Occupational Therapy* 2007;14, 140-149.
- Gammeltoft, B. C. (2005). *Skjulte Handicaps*. s.12-152, Sct. Eligius.
- Gammeltoft, B. C. (2008). *Skjulte Handicaps hos personer ramt af hjerneskade. En sansemessig – kroppslig tilgang*. Kap. 1-8 (s. 145-152). Høng: Sct. Eligius.
- Gardsjø, O. (2003). Institusjoner og målsetninger. I O. Gardsjø, *Institusjon som hjem og arbeidsplass*. Gyldendal Akademisk.
- Gjerstad, L. og Skjeldal, O. H. (2007). *Nevrologi og nevrokirurgi*. Vett & Viten.
- Gjertsen, H. (2008). "Så man møter veggen mange ganger". *Aldring med funksjonshemming i lokalmiljø*. Tønsberg: Forlaget aldring og helse.
- Gjesing, G. (2006). *Kroppens muligheter og kropumulige unger, i indskoling, fritid og der hjemme*. (2. utg.). Velje: Kroghs Forlag.
- Gjesing, G., Pachai, M. A. & Årnsholt, R. N. (2007). *Den daglige dosen i skolegården - sådan!* Velje: Kroghs Forlag.
- Gjærum, B. & Ellertsen, B. (2002). *Hjerne og adferd*. (2 utg.). Urolig, uoppmerksomme og impulsive barn. Kap. 13.
- Gjærum, B. & Ellertsen, B. (2004). *Hjerne og atferd*. Kap 7: Psykisk utviklingshemming/mental retardasjon. Oslo: Akademisk.
- Gjøvsund, P. & Huseby, R. (2003). *To eller flere... Basiskunnskaper i gruppepsykologi*. Oslo: Damm & Sønn
- Glasby, J., Marin, G., & Regen, E. (2008). Older people and the relationship between hospital services and intermediate care: Results from a national evaluation. *Journal of Interprofessional care*, Dec2008, Vol. 22 Issue 6, pp 639-649.
- Graff, M. J. et al. (2007). Effects of community occupational therapy on quality of life, mood, and health status in dementia patients and their caregivers: a randomized controlled trial. *J Gerontol A Biol Sci Med Sci*. 2007 Sep; 62(9):1002-9.
- Graff, M. J. et al. (2007). Effects of community occupational therapy on quality of life, mood and health status in dementia patients and their care givers: a randomized controlled trial. *J Gerontol A Biol Sci Med Sci*. September; 62(9), 1002-9.
- Gramstad, A. (2010). Heimebesøk? *Ergoterapeuten* (3), 26-33.
- Granbo, R. Helbostad, J. & Vaskinn, A. H. (2007). Sluttrapport "Forebygging av fall hos eldre – fokus på fysisk aktivitet – samarbeidsprosjekt mellom kommune, sykehus, universitet, høyskole og frivillige lag og organisasjoner". Helse og rehabilitering og Norske Kvinners Sanitetsforening.
- Green, D. P. og Roberts, S. L. (2005). *Kinesiology. Movement in the Context of Activity*. Kap. 1-5 (3-70). St. Louis: Elsevier Mosby.

- Gretland, A. (2006). *Den relasjonelle kroppen, fysioterapi i psykisk helsearbeid*. (11-34). Fagbokforlaget.
- Grimen, H. & Terum, L. I. (2009). *Evidensbasert profesjonsutøvelse*. Kap. 2,7,8. Oslo: Særlig.
- Grimen, H. & Terum, L. I. (2009). *Evidensbasert profesjonsutøvelse*. Kap. 1. Oslo.
- Grøholt, B., Sommerschild, H. & Garløv, I. (2008). *Lærebok i barnepsykiatri*. (4. utg.). Kap 6, 7. Oslo: Tano Aschehoug.
- Grøholt, B., Sommerschild, H. & Garløv, I. (2008). *Lærebok i barnepsykiatri*. Oslo: Universitetsforlaget.
- Gulbrandsen, L. M. (Red.). (2006). *Oppvekst og psykologisk utvikling. Innføring i psykologiske perspetiver*. Oslo: Univeristetsforlaget.
- Gullestad, M. (1989). *Kultur og hverdagsliv, På sporet av det moderne Norge*. Oslo: Universitetsforlaget.
- Gullestad, M. (2000). *Kultur og hverdagsliv. På sporet av det moderne Norge*. (5 opplag). s. 49-66, 69-81. Oslo: Universitetsforlaget.
- Gundersen, K. & Moynahan, L. (2006). *Nettverk og sosial kompetanse*. Kap.10-14. Oslo: Gyldendal Norsk Forlag.
- Gundleiv, M., Kroog, A. & Thøger, B. (1999). *Trandex. Manual*. Gentofte kommune: Tranehaven.
- Gundlev, M., Krog, A. A. & Tøger, B. (1999). *Trandex Manual* s. 8-27, s.41-59 Danmark: Tranehaven. Gentoven kommune.
- Gunnestad, T. (2001). *Boliger for alle*. s. 14-68. Kommuneforlaget.
- Gustavsson, A. (Red.). (2004). *Delaktighetens språk*. (Almquist, L., Eriksson, L. & Granlund, M. Delaktighet I skole aktiviteter – Et systemteoretisk perspektiv). Lund: Studentlitteratur.
- Gustavsson, A. (Red.). (2004). *Delaktighetens språk*. Lund: Studentlitteratur. Kap. 4,7.
- Haarr, K. H. & Heggdal, K. (2010). Sykdom i sosial samspill - helse som prosess. Hvordan kan helsepersonell bidra til personens tilfriskning ved ME? *Ergoterapeuter nr 1*, s. 32-39.
- Hagedorn, R. (2000). *Tools for Practice in Occupational Therapy*. Kap 22- 28. London: Churchill Livingstone.
- Hagen, P. I. (2006). Rapport "Å være pårørende til demenssyke i eget hjem". Samarbeidsprosjekt mellom HiST og Nasjonalforeningen for folkehelsen.
<http://www.nasjonalforeningen.no/archive/Internett/Demens/forskning/Hvordan%20v%E5r%20F8rende%20til%demenssyke%20eget%20hjem.pdf>
- Haley, S. M. et al. (1992). *Pediatric Evaluation of Disability Inventory (PEDI)*., PEDI Research Group Centre for Rehabilitation Effectiveness, Boston.
- Halvorsen, K. (2004). *Når det ikke er bruk for deg. – arbeidsløshet og levekår*. (1.utg. 1.oppl.). s. 16-40, 101-121. Oslo: Gyldendal Norsk Forlag AS.

- Hammel, J., Magasi, S., Heinemann, A., Whiteneck, G., Bogner, J., & Rodriguez, E. (2008). What does participation mean? An insider perspective from people with disabilities. *Disability & Rehabilitation*, 30(19), 1445-1460.
- Hammell, K. W., Miller, W. C., Forwell, S. J., Forman, B. E. & Jacobsen, B. A. (2009). Fatigue and spinal cord injury: a qualitative analysis. *Spinal Cord*, 2009 Jan;47(1), 44-49.
- Hammer, T. & Øverby, E. (Red.). (2006). *Inkluderende arbeidsliv? Erfaringer og strategier*. Kap. 1, 5, 10. Oslo: Gyldendal akademiske.
- Hammerlin, Y. & Larsen, E. (1997). *Menneskesyn i teorier om mennesket*. Kap. 4. Oslo: Ad Notam Gyldendal.
- Hansen, L. K. (2002). *Biomekanik for ergo- og fysioterapeuter*. (2. udg.). s. 63-82. Munksgaard.
- Hansen, L. K. (2002). *Biomekanikk for ergo- og fysioterapeuter*. (2. utg.). Munksgaard, Danmark.
- Hanson, A. (2004). *Hälsopromotion i arbetslivet*. Kap. 7, 10. Studentlitteratur.
- Hasselkus, B. R. (2006). The World of Everyday occupation: Real People, Real Lives. *The American Journal of Occupational Therapy* 2006 Volume 6.
- Hasselkus, B.R. (2006). (Eleanor Clarke Slagle lecture). The world of everyday occupation: real people, real lives. *The American Journal of Occupational Therapy*, vol. 60, no. 6.
- Hauge, H. A. & Mittelmark, M. B. (Red.). (2003). *Helsefremmende arbeid i en brythingstid - fra monolog til dialog?* Kap. 1, 4, 6, 7. Bergen: Fagbokforlaget.
- Hauge, S. & Jacobsen, F. F. (Red.). (2008). *Hjem. Eldre og hjemlighet*. (Avlasvåg, H. Å føle seg hjemme- i egen bolig og på sykehjem?).
- Haugen, T. B. (2007). Ergoterapi gir bedre funksjonsnivå ved demens. *Tidsskrift Nor Lægeforen* 2007; 127: 411. http://www.tidsskriftet.no/?seks_id=1487826
- Haugeto, K. Å. (2009). Omsorgspolitik og ny teknologi. *Ergoterapeuten nr.7*, s. 46-49.
- Haugsgjerd, S. et.al. (2009). *Perspektiver på psykiske lidelse- å forstå, beskrive og behandle*. Kap. 3-7, 9, 20. Oslo: Gyldendal Akademisk.
- Heap, K. (2000). *Snakk med meg! Å samtale med eldre*. s. 11-48,53-67. Oslo: Kommuneforlaget AS.
- Hederson, P. (2006). *Hand function in the child* (2 utg.). St. Louis: Moseby.
- Hegdal, K. (2007). *Kroppskunnsaping. Pasienten som ekspert i helsefremmende prosesser*. Oslo: Gyldendal akademisk.
- Heglum, T. & Krokan, A. K. (Red.). (2006). *Med viten og vilje. Om funksjonshemming, diskriminering og krenkelse*. Kap. 1 (24-41), 6 (91-102), 8 (115-127). Oslo: Kommuneforlaget.
- Helgesen, L. A. (2008). Menneskets dimensjoner Lærebok I psykologi. s.176-208, 212-241, kap. 9 s. 271-292. Kristiansand: Høyskoleforlaget.

- Helgesen, L. A. (2008). *Menneskets dimensjoner. Lærebok i psykologi*. Kap 6. Kristiansand: Høgskoleforlaget.
- Helgesen, L. A. (2008). *Menneskets dimensjoner. Lærebok i psykologi*. Kap. 1-9, 11. Kristiansand: Høgskoleforlaget.
- Helgesen, L. A. (2008). *Menneskets dimensjoner. Lærebok i psykologi*. Kap. 1-5. Kristiansand: Høgskoleforlaget.
- Helse og omsorgsdepartementet. (2007). *Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven)*.
- Helse- og omsorgs-departementet (2001). *Forskrift om habilitering og rehabilitering av 20.07.2001*
- Helse- og omsorgsdepartementet. Nasjonal helseplan 2007-2010. Kap. 2, sammendrag.
- Helse- og omsorgsdepartementet. *St. Meld 20 (2006-2007). Nasjonal strategi for å utjevne helseforskjeller*. Kap 1.6 sammendrag s 8-9.
- Helse- og omsorgsdepartementet. (2001). *Forskrift om habilitering og rehabilitering*.
- Helse- og omsorgsdepartementet. (2003). *Resept for ett sunnere Norge. Folkhelsepolitikken. St.meld. Nr. 16 (2002-2003)*.
- Helse- og omsorgsdepartementet. (2004). *Forskrift om individuell plan*.
- Helse- og omsorgsdepartementet. (2005). *Fra stykkevis til helt. Norges offentlige utredninger no. 13*.
- Helse- og omsorgsdepartementet. (2007). *Nasjonal strategi for å utjevne sosiale helseforskjeller. St. Meld. Nr. 20 (2006-2007)*.
- Helse- og omsorgsdepartementet. (2010). *Forslag til ny folkhelselov. Samhandlingsreformen. Høringsnotat*.
- Helse- og omsorgsdepartementet. *Nasjonal strategiplan for arbeid og psykisk helse 2007-2012, supplement till Stmeld. Nr. 9 (2006-2007). Arbeid, velferd og inkludering*.
- Helse- og omsorgsdepartementet. *St.prp. Nr. 1 (2007-2008)*. Kap. 8 Opptreppingsplan for rusfelet.
- Helse- og omsorgsdepartementet. (2005). *Mestring, muligheter og mening. St.meld. 25, 2005-2006*.
- Helse- og omsorgsdepartementet. (2009). *Samhandlingsreformen. Rett behandling- på rett ste- til rett tid. St.meld. nr. 47 (2008-2009)*.
- Helsebiblioteket. (2009). www.helsebiblioteket.no Startside for ergo- og fysioterapeuter:
<http://www.helsebiblioteket.no/Fysio-+og+ergoterapi>
- Helsedepartementet. (2003). *Resept for et sunnere Norge. Folkhelsepolitikken. St. Meld. Nr. 16 (2002-2003)*.
- Helsedirektoratet. (2008). *Pårørende- en ressurs*.
- Helsedirektoratet. (2008). *Tiltak for økt fysisk aktivitet blant barn og ungdom*.

- Helsedirektoratet. (2009). *Utredningsverktøy til bruk for helse- og omsorgspersonell. Demensutredning i kommunehelsetjenesten.*
- Helsedirektoratet. (2009). *Veileder. Demensutredning i kommunehelsetjenesten.*
- Henriksen, E. (2005). De vokser det av seg, gjør de ikke? En mors erfaringer. *Tidskrift for psykisk helsearbeid*, vol2, nr. 1, s. 64-76.
- Hernes, T., Heum, I. & Haavorsen, P. (Red.). (2010). *Arbeidsinkludering. Om det ny politikk- og praksisfelste i velfers-Norge.* Oslo: Gyldendal akademisk.
- Hjälpmedelinstitutet. (2008). *Resultat och erfarenheter från resursenheterna i Teknik och demensprojektet.* s. 20-28. <http://www.hi.se/shopping/ShowItem.aspx?id=9075>
- Hocking, C. (2006). Having and Using Objects in the Western World. *Ergoterapeuten*, 49. Nr 11.
- Holm, J. (2007). Terapeutrollen: den personlige dimensjon, *Ergoterapeuten nr 1*, s. 4-7.
- Holme, I. M. & Solvang, B.K. (1996). *Metodelvag og metodebruk.* s. 87-182. Oslo: Tano.
- Holthe, T., Thorsen, K. & Josephsson, S. (2007). Occupational Patterns of people with dementia in residential care: An ethnographic study. *Scandinavian Journal of Occupational Therapy*, 14. pp. 97-107.
- Horghagen et al. (2007). *Beste Praksis i ergoterapi.* s. 201-216. Tapir Akademisk.
- Horghagen m.fl. (Red.). (2007). *Beste praksis i ergoterapi.* s.171-183. Trondheim: Tapir Akademisk.
- Horghagen m.fl. (Red.). (2007). *Beste praksis i ergoterapi.* side 59-72. Tapir Akademiske.
- Horghagen m.fl. (Red.). (2007). *Beste praksis i ergoterapi.* side 59-72. Tapir Akademiske.
- Horghagen m.fl. (Red.). (2007). *Beste praksis i ergoterapi.* side 59-72. Tapir Akademiske.
- Horghagen S. (Red.). (2007). *Beste praksis i ergoterapi.* (Lund, A., Svendsen, L. & Lillebø, M. O. Aktiv aldring – rett til aktivitet og deltakelse?). Tapir akademisk.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv.* s. 96-105. Tapir.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv.* s. 116-123. Tapir.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv.* s. 127-132. Tapir.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv.* Kap.15. Trondheim: Tapir Akademisk.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv.* (Eide, A. H. Lokalsamfunnbasert rehabilitering i Norge). Tapir Akademiske.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv.* (Eide, A. H. Lokalsamfunnbasert rehabilitering i Norge). Tapir Akademiske.

- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. (Lohne E. R. Leik i ergoterapi). Tapir forlag.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. s. 87-95. Tapir akademisk.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. s. 87-95. Tapir akademisk.
- Horghagen, Jakobsen & Ness. (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. s. 87-95. Tapir akademisk.
- Horghagen, S. (2003). Historiefortelling som aktivitet. *Ergoterapeuten nr 11*, s 42-47.
- Horghagen, S. (2005). Mellom Elvis og'n Johansen. Hvilke grenser hindrer mennesker fra meningsfull deltagelse? *Ergoterapeuten*, 11.
- Horghagen, S. (2007). *Beste praksis i ergoterapi*. Kap. 6. Trondheim: Tapir.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. (Reichelt, R. Håp, forståelse og egeninnsats – muligheter for en bedre hverdag). Tapir akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. (Tuntland, H. Beste ergoterapi praksis i arbeid med eldre – en kunnskapsoppsummering). Tapir akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. Kap. 1, 7. Trondheim: Tapir akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. Kap. 12,13 (201-230). Trondheim: Tapir akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. Kap. 2 (19-58), 3 (59-72). Trondheim: Tapir akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s. 133-140. Trondheim: Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s. 141-156. Trondheim: Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s. 19-57. Trondheim: Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s. 231-242. Trondheim: Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s. 231-242. Trondheim: Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s. 231-242. Trondheim: Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s.157-170. Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s.157-170. Tapir Akademisk.
- Horghagen, S. (Red.). (2007). *Beste praksis i ergoterapi*. s.157-170. Tapir Akademisk.
- Horghagen, S. et al. (2007). *Beste Praksis i ergoterapi*. s. 243-253. Tapir Akademisk.
- Horghagen, S. et al. (Red.). (2007). *Beste praksis i ergoterapi*. Kap. 3, 13. Trondheim: Tapir akademisk.

- Horghagen, S. m.fl. (Red.). (2005). *Aktivitetsperspektiv på Dugnad*. (Leknes, R. Eldre, tilgjengelighet og aktiviteter utenfor hjemmet). Trondheim: Tapir akademisk.
- Horghagen, S. m.fl. (Red.). (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. Kap. 14, 17. Trondheim: Tapir akademisk.
- Horghagen, S. m.fl. (Red.). (2005). *Aktivitetsperspektiv på Dugnad*. s. 135-62. Trondheim: Tapir Akademisk.
- Horghagen, S. m.fl. (Red.). (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. Kap. 3, 4, 6, 9, 10. Trondheim: Tapir Akademisk.
- Horghagen, S. m.fl. (Red.). (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. Kap. 13 (127- 133), 15 (145-153). Trondheim: Tapir Akademisk.
- Horghagen, S., Jakobsen, K. & Ness, N. E. (Red.). (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. s. 117-123. Trondheim: Tapir Akademisk.
- Horghagen, S., Jakobsen, K. & Ness, N.E. (Red.). (2005). *Aktivitetsperspektiv på dugnad, deltagelse og dagligliv*. Kap. 16, s. 155-162. Trondheim: Tapir Akademiske.
- Horghagen, S., Josephsson, S. & Alsaker, S. (2006). The use of craft activities as treatment during the period of 1952-1960. *Occupational Therapy International*, 14 (1), 42-56 (2007).
- <http://www.shdir.no> (*Individuell plan som pdf-fil*).
- Husbanken (2009). *Rom for trygghet og omsorg. Veileder for utforming av omsorgsboliger og sykehjem*.
- Hyldstrup, L. (1997). *Benskjørhet. Årsaker, forebygging og behandling*. Schibsted.
- Hæstad, H., Normann, B., Gjelsvik, B. & Gjelsvik, O. (2006). Bobathkonseptets utvikling, teoretiske grunnlag og kliniske praksis. *Fysioterapeuten* 03.03.06, s. 16-20.
- Högberg, B. (2004). ICF et verktyg för hälsa och delaktighet? I Gustavsson, A. (Red.). *Delaktighetens språk*. Lund: Studentlitteratur.
- Högberg, B. (2004). ICF- et verktyg for hälsa och delaktighet? I: Gustavsson, A. (Red.). *Delaktighetens stjärk*, s. 83-110. Lund: studentlitteratur.
- Ikiugu, M. N. (2007). *Psychosocial conceptual practice model in Occupational Therapy, building adaptive capability*. Kap.3 (41-71)., 10 (180-195). 13 (237-256)., 17(307-314). Mosby Elsevier USA.
- Ingeberg, M. H., Tallaksen, D. W. & Eide, B. (2006). *Mentale knagger. En innføring i psykisk helsearbeid*. Kap. 2. S. 25-47. Oslo: Akribe.
- Itzkovich, M., Elazar, B. & Averbuch, S. (2000). *LOTCA Lowenstein Occupational Therapy Cognitive Assessment*, Second Edition. s. 7-28. Maddak Inc.
- Iwama, M. (2005). Kawa-modellen. Elvemodellen – som metafor for livsløpet. *Ergoterapeuten* Nr.1, s. 24-35.

- Iwama, M. K. (2005). Kawamodellen. Elvmodellen – som metafor for livsløpet. *Ergoterapeuten*. Nr. 1, s. 24-35.
- Iwama, M. K. (2005). Kawamodellen. Elvmodellen – som metafor for livsløpet. *Ergoterapeuten*. Nr. 1, s.24-35.
- Jackson, J. (1996). Living a Meaningful Existence in Old Age. In: Zemke, R. & Clark, F. *Occupational Science. The evolving discipline*. Ch. 32 pp. 339-61, 374-8.
- Jackson, J. et al. (1998). Occupation in Lifestyle Redesign: The Well Elderly Study Occupational Therapy Program. *The American Journal of occupational Therapy*, s.326-335.
- Jackson, J. et al. (2004). Promoting Quality of Life in Elders. *Ergoterapeuten* nr. 1, s. 14-19.
- Jackson, J. et al. (2004). Promoting quality of life in elders. *Ergoterapeuten* nr. 1, s. 14-19.
- Jacobsen D. I. (2003). *Forståelse, beskrivelse og forklaring. Innføring i samfunnsvitenskapelig metode for helse- og sosialfagene*. Kap. 1-2. Høgskoleforlaget.
- Jacobsen, D. et al. (2009). *Sykdomslære - indremedisin, kirurgi og anestesi*. s. 46-52, 60-77, 93-105, 109-120, 226, 227, 229-231, 236- 238, 239-240, 263-272, 274-277, 291-298, 298-301, 307-309, 344-346, 350-353, 385-391, 392-439, 448- 458, 465-519. Oslo: Gyldendal Akademisk.
- Jacobsen, D. I. (2003). *Forståelse, beskrivelse og forklaring. Innføring i samfunnsvitenskapelig metode for helse- og sosialfagene*. Kap. 1-2. Høgskoleforlaget.
- Jacobsen, D. I. (2003). *Forståelse, beskrivelse og forklaring. Innføring i samfunnsvitenskapelig metode for helse og sosialfagene*. Kristiansand: Høgskoleforlaget. Kap. 8-12.
- Jakobsen, K. (2001). Employment and the reconstruction of self. A model of space for maintenance of identity by occupation. *Scandinavian Journal of Occupational Therapy*, Vol. 8: 40-48.
- Jakobsen, K. (2004). If Work Doesn't Work: How Enable Occupational Justice. *Journal of Occupational Science*, Vol. 11, 3: 125-134.
- Jakobsen, K. (2009). The right to work: Experiences of employees with rheumatism. *Journal of Occupational Science*. 16(2), 120-127.
- Jakobsen, K. (2010). Rett behandling – på rett sted – til rett tid. *Ergoterapeuten* nr. 3, s. 18-22.
- Jakobsen, R. (2007). *Ikke alle vil spille bingo. Om teori og praksis i demensomsorgen på sykehjem*. Bergen: Fagbokforlaget.
- Jamtvedt, G. & Nordtvedt, M. W. (2008). Kunnskapsbasert ergoterapi - et bidrag til bedre praksis! *Ergoterapeuten nr 1*, 2008/51 (10-18).
- Jamtvedt, G. & Nortvedt, M. W. (2008). Kunnskapsbasert ergoterapi - et bidrag til bedre praksis! *Ergoterapeuten nr 1*, 2008/51 (10-18).
- Jamtvedt, G. & Nortvedt, M. W. (2008). Kunnskapsbasert ergoterapi – et bidrag til bedre praksis! *Ergoterapeuten nr 1*, 2008/51 (10-18).
- Jensen, A. et al. (2009). *Planlægning i teori og praksis- et tværfagligt perspektiv*. Roskilde universitetsforlag.

- Jensen, L., Petersen, L. & Stokholm, G. (2007). *Rehabilitering. Teori og praksis*. København: FADL's forlag.
- Jensen, L., Petersen, L. & Stokholm, G. (Red.). (2007). *Rehabilitering- teori og praksis. Samfundsmæssige rammer og barriere for en helheds- og brukerorientert rehabiliteringsindsats*. København: FADL's forlag.
- Jentoft R., Ranka J. & Chapparo C. (2006). PRPP- en ergoterapeutisk kartleggingsmetode basert på observasjon, *Ergoterapeuten nr. 6*, (28-35).
- Jerlang, E. (Red.). (2008). *Udviklingspsykologiske teorier* (4 utg.). Kap. 3, 9, 10. København: Hans Reitzels forlag.
- Johannessen, A., Tufte, P. A. & Kristoffersen, L. (2006). *Introduksjon til samfunnsvitenskapelig metode*. (3. utg.). Kap. 1-3, 19. Oslo: Abstract forlag.
- Johnsen, Å., Sletnes, I. & Vabo, S. I. (Red.). (2004). *Konkurransetsetting i kommunene*. (Bogen, H. Konkurransetsetting av pleie – omsorgstjenester: bruker i spillet mellom bestiller og leverandør). Oslo: Abstrakt.
- Jones, D. (2003). *Sociology and Occupational Therapy*. Kap. 8. Edinburgh: Churchill Livingstone.
- Jones, D., Blair, S., Hartery, T. & Jones R. K. (1998). *Sociology & occupational therapy*. Kap. 11, 13. Edinburgh: Churchill Livingstone.
- Joss, M. (2007). The importance of job analysis in occupational therapy. *British Journal of Occupational Therapy*, vol 70(7). p. 301-303.
- Juhler, M. & Vorstrup, S. (2004). *Neurologi og neurokirurgi*. s. 32-50, 53-89, 150-158. Munksgaard.
- Kamper-Jørgensen, F. Almind, G. & Jensen, B. B. (2009). *Forebyggende sundhedsarbejde*. (5 utg.). Kap. 1, 2, 8, 9, 14, 15, 17, 27, 28. Munksagaard Danmark.
- Kelloway, E. K. & Day, A. A. (2005). Building Healthy Workplaces; what we know so far. *Canadian Journal of Behavioural Science* 2005; 37:4, 223-235.
- Kielhofner, G. (1995). *A Model of Human Occupation*. Kap.8 (ferdighetsverb oversatt til norsk). Lippincott Williams & Wilkins.
- Kielhofner, G. (2001). *Ergoterapi - det begrepsmæssige grundlag*. København: FADL's forlag.
- Kielhofner, G. (2001). *Ergoterapi-det begrepsmæssige grundlag*. Kap. 6. FADL's Forlag.
- Kielhofner, G. (2002). *A Model of Human Occupation. Theory and Application*. s 1-170, 217-223, 311- 336. Lippincott Williams & Wilkins.
- Kielhofner, G. (2004). *Conceptual Foundations of Occupational Therapy*. (3rd ed.). Kap.11. Philadelphia, F. A. Davis.
- Kielhofner, G. (2004). *Conceptual foundations of occupational therapy*. (3 utg.). Kap. 6, 9, 11. Philadelphia: F.A. Davis Company.
- Kielhofner, G. (2004). *Conceptual Foundations of occupational Therapy*. Kap. 5, 6. Philadelphia: F. A. Davis Company.

- Kielhofner, G. (2007). A perspicitve on the history, current status and future of occupational therapy. *Ergoterapeuten* 02.07. Årg. 50 s. 12-19.
- Kielhofner, G. (2008). *A Model of Human Occupation. Theory and Application*. (4th ed.). Kap. 16, s. 223-236. Lippincott Williams & Wilkins.
- Kielhofner, G. (2008). *A Model of Human Occupation. Theory and Application*. (4th ed.). s. 1-154. Lippincott Williams & Wilkins.
- Kielhofner, G. (2008). *A model of human occupation. Theory and application* (3 utg). Kap. 11-27.
- Kielhofner, G. (2008). *A model of human occupation. Theory and application*. Kap. 12-20.
- Kielhofner, G. (2008). *Model of human occupation: theory and application*. Kap. 1-9, 11, 12. Philadelphia: Wolters Kluwer/ Lippincott Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. (4th ed.). Kap. 17, s. 278-287. Baltimore: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. (4th ed.). pp. 136-138, 204-213, 258-261, 337-340, 360-365. Baltimore: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. Kap 15. Lippincott, Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. Kap 23. Lippincott, Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. Kap 9. Lippincott, Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. s. 143-203. Baltimore: Lippincott, Wiliams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. s. 143-203. Baltimore: Lippincott, Wiliams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation*. s. 32-51, 51-68, 68-84, 85-101, 313-326, 379-404. Baltimore: Lippincott, Wiliams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation. Theory and Application*. s.85-100. Baltimore: Lippincott Williams & Wilkins.
- Kielhofner, G. (2008). *Model of Human Occupation. Theory and Application*. Kap. 13, 14. Baltimore: Lippincott, Williams & Wilkins.
- Kielhofner, G. (2009). *Conceptual foundations of occupational therapy*.
- Kielhofner, G. (2009). *Conceptual foundations of occupational therapy practice*. (4 ed). Kap 1-5. Philadelphia: F.A. Davis Company.
- Kielhofner, G. (Red.). (2008). *Model of human occupation. Theory and application*. (4th ed.). Kap. 1-10. Philadelphia: Lippincott Williams & Wilkins.
- Kielhofner, G. (Red.). (2008). *Modell of human occupation. Theory and application*. (4 utg.). Kap. 11. Philadelphia: Lippincott Williams & Wilkins.

- Kielhofner, G. et al. (2002). *A Model of Human Occupation Theory and application*. (3rd ed.). Kap. 7, 9, 15. Baltimore: Lippincott Williams & Wilkins.
- Kielhofner, G. et al. (2008). *A Model of Human Occupation Theory and application*. (4th ed.). Kap. 7, 17. Baltimore: Lippincott Williams & Wilkins.
- Kielhofner, G., Braveman, B., Baron, K., Fisher, G., Hammel, J. & Littleton, M. (1998). The model of human occupation: understanding the worker who is injured or disabled. *Work* 12:37-45.
- Kilvik, A. & Lamøy, L. I. (2007). *Litteratursøking i medisin og helsefag*. Tapir Akademisk.
- Kirkevold, M., Brodtkorb, K. & Ranhoff, A. H. (Red.). (2008). *Geriatrisk sykepleie. God omsorg til den gamle pasienten*. Kap. 1-5, 7, 19, 23, 26. Oslo: Gyldendal norsk forlag.
- KITH. (2004). *Internasjonal klassifisering av funksjon, funksjonshemming og helse*. s 1-27. Oversettelse av World Health Organisation WHO (2001). International Classification of Functioning, Disability and Health Besøksdato: 2008-06-25. <http://www.kith.no/upload/1855/NorskBrukerveiledning-v1.pdf>
- Kjeken, I. (2003). ICF- et rammeverk i rehabilitering. *Ergoterapeuten nr. 2*, s. 16-23.
- Kjeken, I. (2006). Ergoterapi for personer med artrose - hva slags kunnskap baseres praksis på? *Ergoterapeuten*, 8, 49, s. 16-21.
- Kjeken, I. (2006). Ergoterapi for personer med artrose- hva slags kunnskap baseres praksis på? *Ergoterapeuten*, 8/06, s.16-21.
- Kjeken, I. & Lillemo, S. (2004). Har leddvern gått ut på dato? *Ergoterapeuten* 9,47, s. 22-27.
- Kjeken, I. & Lillemo, S. (2004). Har leddvern gått ut på dato? *Ergoterapeuten nr. 9*, s. 22-27.
- Kjeken, I. & Rønningen, A. (2008). Effect of an intensive hand exercise programme in patients with rheumatoid arthritis. *Scandinavian journal of occupational therapy*, 15, p. 173-183.
- Kjeken, K. (2003). "Den kanadiske ergoterapimodellen. Teori, forskning og praksis". *Ergoterapeuten* nr. 11, s. 18-23.
- Kjærsgaard, A. (2005). *Ansigt, mund og svælg: undersøgelse og behandling etter Coombes konseptet*. FADL.
- Klausen, A. M. (1992). *Kultur – mønster og dialog*. Kap 2. Oslo: Ad Notam Gyldendal A/S.
- Kleveberg, G. L & Elkjær, S. (2008). Behandlingsmodeller for å bedre håndfunksjon hos barn med neurologisk sykdom eller skade. *Ergoterapeuten nr 10*, s. 14-22.
- Kloep, M. & Hendry, L. B. (2003). *Utviklingspsykologi i praksis*. Kap. 2 (27-56), 4-5 (86-144). Oslo: Abstrakt forlag.
- Knutagård, H. (2003). *Introduksjon til verksamhetsteori*. Kap. 12. Lund: Studentlitteratur.
- Kragbæk, S. (2008). *Fornyelse av livsstil. Lifestyle redesign® programme i et dansk erspektiv. En aktivitetsvidenskabelig tilgang til vellykket aldring*.

- Kramer, P., Hinojosa, J. & Royeen, C.B. (Red.). (2003). *Perspectives in Human Occupation*. Kap. 10, s. 278-295. Lippincott, Williams and Wilkins.
- Kranowitz, C. S. MA. (1998). *The out-of-sync child Recognizing and coping with Sensory Processing disorder*.
- Kristensen, H. & Nielsen, G. (2006). *Ergoterapi og hjerneskade. Aktiveter i kognitiv rehabilitering*. København: FADL's forlag.
- Kristensen, H. K. & Nielsen, G. E. (2006). *Ergoterapi & hjerneskade – aktiviteter i kognitiv rehabilitering*. Kap. 1, 2. København: FADL's Forlag.
- Kristensen, H. K. & Nielsen, G. E. (2006). *Ergoterapi & hjerneskade – aktiviteter i kognitiv rehabilitering*. s. 69-109, 117-143, 158-289. København: FADL's Forlag.
- Kristensen, H. K. & Nielsen, G. E. (2006). *Ergoterapi & hjerneskade*. FADL's Forlag.
- Kristensen, H. K. & Nielsen, G. E. (2006). *Ergoterapi og hjerneskade: aktiviteter i kognitiv rehabilitering*. (3 utg.). København: FADL's forlag.
- Krogsgaard, M. R., Rheinländer, P. & Larsen, A. E. (2009). *Ortopædkirurgi for ergoterapeuter og fysioterapeuter*. Kap. 15, 17, 19, 21, 22, 24. København: Munksgaard.
- Kronenberg F., Algado S. S. & Pollard N. (Eds.). (2005). *Occupational Therapy without borders*. Kap. 8, 13. New York: Churchill Livingstone.
- Kronenberg, F. (2005). *Occupational therapy without borders*. (Algado, S. S. & Burgman, I. Occupational therapy intervention with children survivors of war). Edinburgh: Elsevier.
- Kronenberg, Frank (2005). *Occupational Therapy without borders*. Kap.1, 6, 8, 10, 14. Elsevier. Churchill Livingstone.
- Kvale, S. & Brinkmann, S. (2008). *Interviews – An introduction to Qualitative Research Interviewing*. (2nd ed.). Ch. 1, 6, 7. London: Sage.
- Kversøy. (2005). *Etikk - en praktisk vinkling, ulike perspektiver på det etiske landskapet*. Bergen: Fagbokforlaget.
- Laberg, T. (2009). Norsk Ergoterapeutforbund har valgt begrepet kunnskapsbasert ergoterapi. *Ergoterapeuten nr 1*, s. 16-17.
- Laberg, T. (2009). Norsk ergoterapeutforbund har valgt begrepet kunnskapsbasert ergoterapi. *Ergoterapeuten. Nr 01-09*, s 1-2.
- Langslet, G. J. (1999 och senare opplag). *LØFT; løsningsfokusert tilnærming til organisasjonsutvikling, ledelseutvikling og konfliktløsning*. Oslo: Ad Notam Gyldendal.
- Langørgen, E. & Stock, R. (2007). Trening av slagrammede med begrenset bruk av frisk side. *Ergoterapeuten nr 9/07/50*, s. 22-27.
- Larsen, Ø. et al. (2008). *Samfunnsmedisin*. Oslo: Gyldensal norsk forlag.

- Larson, E. (2009). Psychological Well-being and Meaning-Making when caregiving for children with disabilities : Growth through difficulties or sinking Inward. *Occupational, participation and health*. Vol 30, No 2;2010.
- Larun, L. (2008). Kritisk vurdering - hvorfor og hvordan?. *Ergoterapeuten, Nr 1* (46-50).
- Larun, L. (2008). Kritisk vurdering –hvorfor og hvordan?. *Ergoterapeuten, nr 1*.
- Lauveng, A. (2005). *I morgen var jeg alltid en løve*. (s. 17-71). Cappelen.
- Lauveng, A. (2005). *I morgen var jeg alltid en løve*. Oslo: Cappelen.
- Lauvås, K. & Lauvås, P. (2004). Tverrfaglig samarbeid- perspektiv og strategi. (2 utg.). s. 65-108. Oslo: Universitetsforlaget.
- Law, M. (2002). Participation in Occupations of Everyday Life. *AJOT*, vol 56, nr 6: p. 640-649.
- Law, M. (2002). Participation in the occupations of everyday life. *AJOT*, 56(6), 640-9.
- Law, M. et al. (2008). *Canadian occupational performance measure*. Norsk Utgave. s. 15-27. Oslo: NRRK.
- Law, M., Baptiste, S., Carswell, A., McColl, M. A., Polatajko, H. & Pollock, N. (2008). *Canadian Occupational Performance Measure*. Manual, norsk versjon. NRRK. Side 15-27, 35-40.
- Lazarus, R. S. (2006). *Strss og følelser - en ny syntese*. Kap. 3-6. København: Akademisk forlag.
- Leclair, L. L. (2010). Re-examining concepts of occupation-based models: Occupational therapy and community development. *Canadian Journal of Occupational Therapy*, 77(1), 15-21.
- Leenderts, T. A. (1997). *Person og profesjon. Om menneskesyn og livsverdier i offentlig omsorg*. Kap. 8-9. Oslo: Gyldendal Akademisk.
- Legg, L. et. al. (2007). Occupational therapy for patient s with problems in personal activiteis of daily living after stoke: systematic reciew of randomized trials. *BMJ*, 3;335(7626),922.
- Lekeplassen for alle - Om hvordan tilrettelegge barnehagens uteområde også for barn med funksjonshemming.*
http://www.helsedirektoratet.no/vp/multimedia/archive/00003/Lekeplassen_for_alle__381
- Leknes, R. (2006). Sammenhenger mellom fysiske omgivelser, universell utforming og menneskelig aktivitet. *Ergoterapeuten nr 11*.
- Leknes, R. (2006). Sammenhenger mellom fysiske omgiverlser, universell utforming og menneskelig aktivitet. *Ergoterapeuten nr 11*, 40-45.
- Lemoire, L. P. S. (2001). Professional Expertise of Community-Based Occupational Therapists. *Occupational Therapy in Health Care Vol. 13*, Issue 3/4.
- Lemvik, B. (2006). *Å skape gode livsvikår*. Oslo: Kommuneforlaget.
- Lemvik, B. (2006). *Å skape gode livsvilkår – psykisk helsearbeid i kommunen*. Oslo: Kommuneforlaget.
- Lerdal, B. (2009). *Handlingsplan for habilitering av barn og unge*. Oslo: Helsedirektoratet.

- Letts, L., Rigby, P. & Stewert, D. (2003). *Using environment to enable occupational performance*. (Ringaert, L. Universal Design of the Built Environment to enable occupational performance). USA: SLACK.
- Lexell, E. M., Iwarsson, D. & Lexell, J. (2006). The complexity of daily occupations in multiple sclerosis. *Scandinavian Journal of Occupational Therapy*, 13:241-248.
- Lid, I. M. (2009). *Hva kan man oppnå gjennom universell utforming? En undersøkelse av ulike sider av begrepet*.
- Lie, A. (2007). Journalføring og journalhåndtering i bedriftshelsetjenesten. *Ergoterapeuten nr. 1*, s. 32-35.
- Lillefjell, M. & Jakobsen, K. (2007). Sense of Coherence as a Predictor of Work Re-Entry Following Multidisciplinary Rehabilitation for Individuals with Chronic Pain. *Journal of Occupational Health Psychology*, 12, 222-231.
- Lindbæk, B. (2001). Utvikling av kommunikasjonsferdigheter. *Embla 7* (20-26).
- Lindland, T., Øvstedal, L. & Lid, I. M. (2005). Ledelinjer i gategrunn. Veileder. s. 6-13. Sosial- og helsedirektoratet/Deltasenteret.
- Lindøe, P., Bakke, Å. & Aas, R. W. (2006). Avtalen for et inkluderende arbeidsliv. *Tidsskrift for Arbejdsliv nr2*.
- Lingås, G. (2005). *Ansvar for likeverd. Etikk i tverrfaglig arbeid med habilitering og rehabilitering*. Oslo: Gyldendal akademisk.
- Lingås, G. (2005). *Over andres dørstokk- yrkesetikk i arbeid hjemme hos klienter og pasienter*. (3. utg). Oslo: Gyldendal akademisk.
- Lloyd, C. & Waghorn, G. (2007). The importance of Vocation in Recovery for Young People with Psychiatric Disabilities. *British Journal of Occupational Therapy*, febr 2007; 70.
- Lohne, E. R. (1999). Leiken- virkelighet og mysterium. *Ergoterapeuten nr. 3*, s. 16-21.
- Lohne, E. R. (2003). Observasjon ved bruk av leiketøy. *Ergoterapeuten nr. 6*, s. 12-17.
- Lohne, E. R. (2005). Kognitiv tilnærming i ergoterapi med barn. *Ergoterapeuten nr. 9*, s. 28-33.
- Lov av 2 juli 1999 nr 63. Om pasientrettigheter.
- Lov av 2 juli 1999. Om helsepersonell.
- Lov av 20 juni 2008. Om forbud mot diskriminering på grunn av nEdsatt funksjonsevne (diskriminerings- og tilgjengelighetsloven).
- Lov av 20 juni 2008. Lov om forbud mot diskriminering på grunn av nEdsatt funksjonsevne (diskriminerings- og tilgjengelighetsloven).
- Lov om arbeidsmiljø, arbeidstid og stillingsvern mv. (arbeidsmiljøloven). (2005). Kap. 1-4, 6, 7.
- Lov om planlegging og byggesaksbehandling (plan- og bygningsloven). Lov av 27 juni 2008. § 1.1.

- Lund, A. & Engelsrud, G. (2008). I am not that old: inter-personal relations at a senior centre. *Ageing & Society*, 28, pp. 675–692.
- Lund, A. & Englesrud, G. (2008). I am not that old: inter-personal relations at a senior centre. *Ageing & Society*, 28, s. 675-692.
- Lund, B. & Rognes, G. (2006). *Å kjenne tyngden av egen verdi*. Oppgave ved videreutdanning i psykisk helsearbeid. PVES, HiST.
- Lunde, P. H. (2011). *Forflytningskunnskap: aktivisering, hjelp og trening ved forflytning* (5. utg). Oslo: Gyldendal akademiske.
- Lunde, P. H. (2003). *Forflytningskunnskap. Aktivisering, hjelp og trening ved forflytning*. Kap 2, 5, 8. Oslo: Gyldendal Akademiske Forlag.
- Luxembourg Declaration. http://www.enwhp.org/fileadmin/rs-dokumente/dateien/Luxembourg_Declaration.pdf
- Lystad, A. (1999). Håndhygiene. Et beskjedent tiltak med god smitteforebyggende effekt. *Tidsskrift Norsk Legeforening*, nr. 17, s. 119.
- Løkken, L. & Overgaard, K. (2009). *Lifestyle redesign® i Aalborg kommune. Et ergoterapeutisk sundhedsfremmeprojekt 2007-2009*.
- Løvgren, M. (2009). *Unge funksjonshemmede, Selvbilde, Sosial tilhørighet og deltakelse i fritidsaktiviteter*. NOVA – Norsk institutt for forskning om oppvekst, velferd og aldring. Rapport nr 9/09.
- Mac Donald, R. (1998). What is Cultural Competency. *The British Journal of Occupational Therapy*, 61 (5).
- Magelsen, R. (2002). *Kultursensiviteten. Om å finne likhetene i forskjellene*. Oslo: Akkribe.
- Magelssen, R. (2008). *Kultursensiviteten. Om å finne likhetene i forskjellene*. Kap. 1. Oslo: Akkribe.
- Mailloux, Z. & Burke, J. P. (2008). Play and the Sensory Integrative Approach. I: Parham, L.D. & Fazio, L.S. *Play in occupational Therapy for children*. Kap. 9. St. Louis: Mosby Elsevier.
- Malia, K. B. et al. (2002-2003). Brainwave (Attention, Cognitive Strategies and Techniques for Brain Injury Rehabilitation, Executive Functions, Information Processing, Memory, Visual Processing). pro-ed Texas.
- Mandel, D. R. et al. (1999). *Lifestyle redesign. Implementing the well elderly program*. USA: The American Occupational Therapy Association, Inc.
- Markowitz, M. (2006). Occupational therapy intervention in low vision rehabilitation. *Can J Ophthalmol*; 41, s. 340-347.
- Martinsen, E. W. (2004). *Kropp og sinn. Fysisk aktivitet og psykisk helse*. Fagbokforlaget Bergen.
- Martinsen, E. W. (2005). *Kropp og sinn, fysisk aktivitet og psykisk helse*. Kap 1, 17. Fagbokforlaget.
- Mathisen, V. (2008). *Barn og ungdom i krise – hvordan bli en god hjelper?* s. 33-87. Eureka Læremiddelserie nr. 1-2008, Tromsø: Eureka Forlag.

- Mattingly, C., & Fleming, M. H. (1994). *Clinical Reasoning. Forms of inquiry in a therapeutic practice*. Kap.10, 11 (239-291). Philadelphia: F A Davis Company.
- McIntyre, A. & Atwal, A. (2005). *Occupational Therapy and Older People*. Kap. 1, 5. Oxford: Blackwell.
- McIntyre, A. & Atwal, A. (2005). *Occupational therapy and older people*. Kap. 1. Oxford: Blackwell.
- McIntyre, A. & Atwal, A. (2005). *Occupational Therapy and Older People*. Kap. 1-3, 6-7. Oxford: Blackwell Publishing.
- Meriano, C., & Latella, D. (Eds.). (2008). *Occupational Therapy Interventions. Function and Occupations*. (1st ed.). Kap. 6b, 7, 8, 9 (363-488). Thorofare, NJ: Slack Incorporated.
- Meriano, C., & Latella, D. (Eds.). (2008). *Occupational Therapy Interventions. Function and Occupations*. (1st ed.). Kap. 1. Thorofare, NJ: Slack Incorporated.
- Mesteig, M. (2006). Eldre og aktivitet. *Ergoterapeuten* nr. 6, s. 22-26.
- Meyer, A. (1922). The Philosophy of Occupational Therapy. *The American Journal of Occupational Therapy*, vol. 31, No. 10, 1977.
- Midtsundstad, A. (2006). *Fritidsorganisasjoner vil og de kan*. Paper til NFF2. Nasjonale forskningskonferanse. Trondheim 30- 31. Okt 2006.
- Mikkelsen, A. (2002). Tiltak mot sykefravær. Kap, 1, 3, 6. Oslo: Cappelen Akademiske.
- Miljøverndepartementet. (2009). Lov om planlegging og byggesaksbehandling.
- Miljøverndepartementet. (2009). *Universell utforming og planlegging etter Plan- og bygningsloven*. Veileder. T-5/99, T-1468, T-1472.
- Miller-Kuhaneck, H. (2004). *Autism. A comprehensive occupational approach*. (2 utg.). AOTA press.
- Miller, L. J. Dr. (2006). *Sensational Kids hope and help for children with Sensory Processing disorder*.
- Miller, L. J., Coll, J. R. & Schoen, S. A. (2007). A randomized controlled pilot study of the effectiveness of occupation therapy for children with sensory modulation disorder. *AJOT* 61(2), 228-238.
- Missiuna C et al. (2004). *The Perceived Efficacy and Goal Setting System (PEGS)*. PsykhCorp.
- Missiuna C. & Pollock N. (2000). Perceived efficacy and goal setting in young children. *Canadian Journal of Occupational Therapy*, 67(2), s.101-9.
- Moen, B. (2003). *Håndbok for BHT*. Bind 1: Fysiske og biologiske arbeidsmiljøfaktorer, samt arbeidsulykker. Kap. 2, 3, 5. Bind 3: Arbeidsmiljøfaktorer som påvirker hele mennesket. Kap. 2, 3, 6, kap. 7.2, 7.6, 7.7, kap. 11.2, 11.3, 11.4, kap. 19, kap. 20.3, 20.4, kap. 21, kap. 24.1, 24.2, 24.3, 24.4. Oslo: Arbeidsmiljøforlaget.
- Moen, B. (Red.). (2003). *Arbeidsmiljøfaktorer som påvirker hele mennesket*. Del 3. Kap. 1-3, 5-9, 12-17, 19. Oslo: Arbeidsmiljøforlaget.

- Moen, B. E. (Red.). (2003). *Arbeidsmiljøfaktorer som påvirker hele mennesket. Håndbok for bedriftshelsetjenesten*. Del. 3. Kap. 2 & 3 (s. 23-47). Kap 6 (s. 73-96). Kap 9 (123-142). Oslo: Arbeidsmiljøforlaget.
- Moen, E. & Jacobsen, K. B. (2007). *Skritt for skritt: fysisk fostring/kroppsovin i barnehage og grunnskole*. (5 utg.). Nesbu: Vett og viten.
- Mountain, G. (2004). *Occupational therapy with older people*. London, Philadelphia: WHURR Publishers.
- Mæland, J. G. (2005). *Forebyggende helsearbeid – i teori og praksis*. Kap. 1-2, 4-5, 16. Tano Aschehoug.
- Mæland, J. G. (2005). *Forebyggende helsearbeid i praksis*. (2 utg. 3 oppl.). s.13-24 og s 65-75. Universitetsforlaget.
- Mæland, J. G. (2005). *Forebyggende helsearbeid i teori og praksis*. (2. utg.). Kap. 16; s 208-212. Oslo: Universitetsforlaget.
- Mæland, J. G. (2005). *Forebyggende helsearbeid- i teori og praksis*. Oslo: Universitetsforlaget.
- Mæland, J. G. (2009). *Sosial epidemiologi: sosiale årsaker til sykdom og helsesvikt*. Kap. 4, 6, 11, 15, 17. Oslo: Gyldendal akademisk.
- Mæland, J. G. (2010). *Forebyggende helsearbeid i teori og praksis*. (3 utg.). Oslo: Universitetsforlaget.
- Mørk, G. et al. (2010). *IA-forankring i ledelsen*. IRIS-rapport 2009/157/Idebanken/NAV
- Nasjonalt kunnskapssenter for helsetjenesten og Høgkolen i Bergen (2008). *Felles hjemmesider med opplæring i Kunnskapsbasert praksis (Trinn 1-6)*.
<http://kunnskapsbasertpraksis.no/index.php?action=static&id=156>
- Nelson, D. (1988). Occupation: Form and Performance. *The American Journal of Occupational Therapy* vol.42 nr.10, s.633-641. (eller Nelson, D. (1995). Aktivitet: Form og utførelse. I: *Ergoterapeuten* nr. 9, s. 14-29).
- Ness, N. E. (1994 rev 2008). Klinisk resonnering *NETF's hjemmesider*
http://kunnskapsbasertpraksis.no/ep_tmp/files/863148a573189bcb3.pdf
- Ness, N. E. (1999). *Helse gjennom aktivitet*. I: Norsk Ergoterapeutforbund (deler også på www.netf.no). s. 8-47.
- Ness, N. E. (2002). Ergoterapifagets aktivitetsperspektiv – et historisk blick på ideer som påvirker faget. *Ergoterapeuten nr 10*. 2002/45 bilag. Norsk Ergoterapeutforbund.
- Ness, N. E. (2002). Ergoterapifagets aktivitetsperspektiv. Bildag til *Ergoterapeuten, nr. 10*, 2002, årg. 45, s. 1-24.
- Ness, N. E. (2002). Ergoterapifagets aktivitetsperspektiv. Et historisk blick på ideer som påvirker faget. *Ergoterapeuten nr 10* bilag (2-20).
- Ness, N. E. (2002). Ergoterapifagets aktivitetsperspektiv. I: Bilag til *Ergoterapeuten nr 10/2002*.
<http://www.netf.no/artikler/historikk.htm>

- Nicholls, L. (2007). A psychoanalytic discourse in occupational therapy. In Creek, J & Lawson-Porte A (Red.). *Contemporary Issues in Occupational Therapy: reasoning and reflection*. p. 55-82. Wiley
- Nordenskiöld, U. (1993). Grip force in Patients with Rheumatoid Arthritis and Fibromyalgia and in Healthy Subjects. A Study with the Grippit Instrument. *Scand. Journal of Rheumatology*, 22;14-19.
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: Kilder og søkestrategier. *Ergoterapeuten, Nr 1*, s. 39-46.
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: en oversikt. *Ergoterapeuten*, 01, s. 34-38.
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: En oversikt, *Ergoterapeuten, nr 1*, s. 34-38. <http://www.netf.no/Netf/Fag-og-yrkesutoevelse/Kunnskapsporten/Litteratur>
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: En oversikt". *Ergoterapeuten, Nr 1*, s. 34-39.
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: En oversikt. *Ergoteraputen. Nr. 01*, s. 34-38.
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: Kilder og søkestrategier. *Ergoterapeuten* 01, s. 39-45.
- Nordheim, L. (2008). Hvordan finne forskningsbasert kunnskap: Kilder og søkestrategier, *Ergoterapeuten, nr 1*, s. 39-45. <http://www.netf.no/Netf/Fag-og-yrkesutoevelse/Kunnskapsporten/Litteratur>
- Nordrik, B. (2010). Psykososial arbeidsmiljøkartlegging- en trojansk hels? Gyldendal akademisk.
- Norges Blindforbund. (2004). *Et inkluderende samfunn. Håndbok om synshemmedes krav til tilgjengelighet*. s. 38-93. www.blindforbundet.no
- Norges Handikapforbund. (1997). *Veien mot ny bolig - en veileder for brukere og fagfolk*. Norges Handikapforbund. www.nhf.no
- Norling Schmidt, R., Villadsen, A. (2003). Børn med cerebral parese. Kap. 6. I M. M. Andersen, I. Hass, G. Quist Lauritzen & R. Norling Schmidt, (Red.). *Ergoterapi og børn*, s. 220-257. FADL.
- Norsk elektronisk legehåndbok. (2008). <http://www.legehandboka.no/>
- Norsk Ergoterapeutforbund. (2001). *Rapportering og journalføring av ergoterapi*. I: NETF's veileder 2001:1. Kan bestilles: netf@netf.no. Nettsider: www.netf.no
- Norsk Ergoterapeutforbund. (2001). *Rapportering og journalføring av ergoterapi*. NETF's veileder 2001:1.
- Norsk Ergoterapeutforbund. (2002). *Søk etter kunnskap i praksis*. <http://www.netf.no/ergoterapi/ebp.htm>

- Norsk Ergoterapeutforbund. (2008). *Hjemmesidene med Kunnskapsporten*, Trinn 1- 5.
<http://www.netf.no/Netf/Fag-og-yrkesutoevelse/Kunnskapsporten>
- Norsk Ergoterapeutforbund. *Litteratur - Kunnskapsbasert praksis*. <http://www.netf.no/Netf/Fag-og-yrkesutoevelse/Kunnskapsporten/Litteratur>
- Nortvedt, P. & Grimen, H. (2004). *Sensibilitet og refleksjon. Filosofi og vitenssteori for helsefag*. Kap. 2-5.
- Norvoll, R. (Red.). (2002). Samfunn og psykiske lidelser. s. 19-28, 33-60, 61-76, 79-96, 98-120, 121-144, 145-159, 255-262. Oslo: Gyldendal.
- NOU 2000:27 *Sykefravær og uførepensjonering. Et inkluderende arbeidsliv*, Sosial og helsedepartementet. s.141-169.
- NOU 2001:22 *Fra bruker til borger. En strategi for nedbygging av funksjonshemmende barrierer*. s. 13-26 Kap. 1. Oslo: Sosial- og helsedepartementet.
- NOU 2005:8 *Likeverd og tilgjengelighet. Rettslig vern mot diskriminering på grunnlag av nedsatt funksjonsevne. Bedret tilgjengelighet for alle*. s. 35-42. Kap. 3. Oslo: Justis- og politidepartementet.
- Nyboe, L. & Hvalsøe, B. (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (2009). *Lærebok i psykiatri*. Kap 14, 24. København: Munksgaard.
- Nyboe, L. & Hvalsøe, B. (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. s. 17-126, 139-153, 187-198, 207-225, 275-288, 295-307, 329-438, 489-498, 523-526. Danmark: Munksgaard.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 10, 11. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 13, 16.1-22.1. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 16.1. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 17.1. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 19.1, 22.1. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 21.1. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 6, 7. København: Munksgaard Danmark.
- Nyboe, L. & Hvalsøe, B. (Red.). (2009). *Lærebok i psykiatri for ergoterapeuter og fysioterapeuter*. Kap. 5, 13, 17.1. Munksgard Danmark.

- Nygård, B. (2004). *Et inkluderende Samfunn. Håndbok om synshemmedes krav til tilgjengelighet*. (1. utg.).
- Nylenna, M. (Red.). (1999). *Store medisinske leksikon* (om skulderanatomi, om håndanatomi, lumbago, diskusprolaps). Oslo: Kunnskapsforlaget.
- Okada S. M. (2004). Fall Prevention I: B. S. Connon, L. M. Lohman & L. R. Padilla (Eds.). *Occupational therapy with elders*. Kap.13 part 3, s.186-190. St. Louis, Elsevier Mosby.
- Olsen, B. m.fl. (2002). *Undersøgelser af patienter med apopleksi- et grundlag for ergoterapeutisk arbejde*. (2. utg.). s. 3-33.
- Olsen, B., Dahl, T., Andersen, M., Gammeltoft, B. & Hansen, C.S. (2008). *Apopleksiundersøgelse. AOUS. Et grundlag for ergoterapeutisk arbejde*. (6 utg.). Haslev: Gammeltoft.
- Olsen, B., Dahl, T., Andresen, M., Gammeltoft, B. & Hansen, C. S. (2008). *Apopleksiundersøgelse APU SIDER. Et grundlag for ergoterapeutisk arbeid*. (6 udg.).
- Opsahl, K. & Ravn, G. (2003). Virksomhetsteorien - den kulturhistoriske skole. I Kunnskap om aktivitet. *Ergoterapeuten*, nr. 11, 2003, årg. 46.
- Opsahl, K. & Ravn, G. (2003). Virksomhetsteorien – den kulturhistoriske skole. *Ergoterapeuten*, 11: 54-61.
- Opsahl, K. & Ravn, G. (2003). Virksomhetsterorien - den kulturhistoriske skole. I Kunnskap om aktivitet. *Ergoteraputen*, nr. 11, 2003, årg. 46.
- Oussoren-Voors, R. (1995). *Skrivedans 1: Hvordan frie bevegelser blir til konkrete linier*. København: Klitrose.
- Oussoren-Voors, R. (1995). *Skrivedans 2: Sammanhengende skrift*. København: Klitrose.
- Parham & Fazio (Red.). (1996). *Play in Occupational Therapy for Children*. Kap. 4, s. 52-65. St. Louis, Elsevier Mosby.
- Parham & Fazio (Red.). (1996). *Play in Occupational Therapy for Children*. Kap. 16. St. Louis, Elsevier Mosby.
- Parham, D. & Fazio, L. (2007). *Play in occupational therapy for children*. (2 utg.). Kap. 4, 5, 17. St. Louis: Mosby Elsevier.
- Parham, L. D. & Fazio, L. S. (2008). *Play in occupational Therapy for children*. (2 ed.) Kap. 4. St. Louis: Mosby Elsevier.
- Parham, L. D. & Fazio, L. S. (2008). *Play in occupational Therapy for children* Kap. 1. St. Louis: Mosby Elsevier.
- Parhan, L. D. & Fazio, L. S. (2008). *Play in Occupational Therapy for Children* (2 utg.). (Skard, G & Bundy, A Test of playfulness). Mosby Elsevier
- Passer, M. W. & Smith, R. E. (2008). *Psychology: The science of mind and behavior*. (4 utg.). New York: McGraw Hill

- Paterson, K. & Hughes, B. (1999). Disability studies and phenomenology: the carnal politics of everyday life. *Disability and Society*, vol 14, 5, s. 597-610.
- Pedersen, A. (2002). Barn med dårlig motorikk-klossete barn: kan vi hjelpe dem? *Fysioterapeuten nr. 9*, s. 10-14.
- Pedersen, A. V. (2004). Motorisk kontroll. I H. Sigmundsson & M. Haga (Red.). *Motorikk og samfunn*. Kap. 3, s. 41-64. Sebu.
- Pedretti, L. & Early, M. (Red.). (2001). *Occupational therapy. Practice Skills for Physical Dysfunction*. (Keenan, D. D. & Morris, P. A. General Considerations of Upper and Lower Extremity Amputations). p. 924-929, 955-965.
- Persson, D. m.fl. (2001). "Value Dimensions, Meaning, and complexity in Human Occupation – A Tentative Structure for Analysis". *Scandinavian Journal of Occupational Therapy*, 8: 7-18.
- Pettersen R. (2002). Falltendens hos gamle. *Tidsskrift Nor Lægeforen nr. 6*; 631-4.
- Pettersen, R. C. (2005). *PBL for studenten: en introduksjon til PBL for studenter og lærere* (2. utg.). Oslo: Universitetsforl.
- Pettersen, R.C. (2005). *PBL: en introduksjon til PBL for studenter og lærere*. Kap. 1-4 (10-130), 7 (148-166). Oslo: Universitetsforlaget.
- Pienecker, L. & Jørgensen, P.S. (2006). *Den gode oppgaven. Håndbok i oppgaveskrivning på univervitet og høyskole*. Kap. 1-3, 7, 8, 10. Bergen: Fagbokforlaget.
- Pierce, D. (2001). "Untangling Occupation and Activity". *American Journal of Occupational Therapy*; 55 (2): 132-146.
- Pierce, D. E. (2003). *Occupation by Design. Building Therapeutic Power*. Philadelphia: F. A. Davis.
- Polatajko, H. & Mandich, A. (2004). *Enabling Occupation in Children: The cognitive orientation to daily Occupational Performance (CO-OP) Approach*. CAOT Publications ACE, Ottawa, Canada.
- Polatajko, H. et al. (2001). Cognitive Orientation to Daily Occupational Performance (CO-OP), Part III. s. 107-120. *Physical and Occupational Therapy in Pediatrics 2/3*.
- Polatajko, H. J. & Mandich, A. (2004). *Enabling occupation in children: the cognitive orientation to daily occupational performance (CO-OP) Approach*. Ottawa: CAOT publications ACE.
- Powell, T. & Malia, K (2003). *The Brain Injury Workbook*. Speechmark.
- Raaheim, A. (2002). *Sosialpsykologi*. Oslo: Fagbokfolaget.
- Radomski, M. & Latham, C. (2008). *Occupational Therapy for Physical Dysfunction*. (6th ed.). s. 173-176. Lippincott Williams & Wilkins, USA
- Radomski, M. V. & Latham, C. A. T. (Eds.). (2008). *Occupational Therapy for Physical Dysfunction* (6th ed.). Kap. 22, 23, 24. Baltimore: Lippincott Williams and Wilkins.
- Radomski, M. V. & Trombly Latham, C. A. (2008). *Occupational Therapy for Physical Dysfunction*. Kap. 24, s. 642-666. Wolters Kluwer/ Lippincott Williams & Wilkins.

- Radomski, M. V. & Trombly Latham, C. A. (2008). *Occupational Therapy for Physical Dysfunction*. Kap. 6, s. 186-211. Wolters Kluwer/ Lippincott Williams & Wilkins.
- Radomski, M. V. & Latham, C.A.T. (Red.). (2008). *Occupational therapy for physical dysfunction* (6 utg.). Kap. 17, 18, 41-43, 46. Baltimore: Lippincott William and Wilkins.
- Redzovic, S., Werge-Olsen, I. B. & Horghagen, S. (2004). Aktivitetsperspektivet i modul om psykisk helse. *Ergoterapeuten*, nr. 6, s. 64-67.
- Reed, K. L. (2001). *Quick Reference to Occupational Therapy*. (2nd Ed.). Seksjon XI. Gaithersburg, Maryland, Aspen Publishers, Inc.
- Reeves, G. D., Cermak, S. A. (2002). Disorders of Praxis. I: A. C. Bundy, S. J. Lane & E. A. Murray, (Red.). *Sensory Integration, Theory and Practice*. Kap. 3, s. 71-95. Philadelphia, F. A. Davis.
- Reinseth, L. (1996). AMPS brukt for pasienter med Revmatoid Artritt. *Ergoterapeuten* nr. 11;30-33.
- Reinseth, L. (2000). *The influence of hand function on daily activities in patients with rheumatic disease*. Congrès Européen D'Ergotherapie. Communications Thematiques.
- Reinseth, L. (2006/2007). Women with Rheumatoid Arthritis; Non-vocational activities and quality of life. *Scandinavian Journal of Occupational Therapy*, Online Preview article 1-8. Volume 14, Issue 2, pp 108 – 115.
- Reinseth, T. (2005). Funksjonsvurdering – nye forventninger til dialog på arbeidsplassen. *Ergoterapeuten* nr. 8, s. 10-17.
- Repstad, P. (2004). *Sosiologiske perspektiver for helse- og sosialarbeidere*. Kap. 7. Otta: Tano Aschehoug.
- Repstad, P. (2004). *Sosiologiske perspektiver for helse- og sosialarbeidere*. (2 utg.). Kap. 4. Oslo: Universitetsforlaget.
- Richardson, A. (2006). Individual support for a person with motor neurone disease. I: Addy, L. M. (Ed.). *Occupational Therapy Evidence in Practice for Physical Rehabilitation*. s. 128-148. Oxford: Blackwell.
- Rico, E. (2004). Ergoterapeutisk tilnærming til synet etter hjerneslag. *Ergoterapeuten* nr. 9/04/47 s. 28-31.
- Riksrevisjonen. *Rapport: adgang til samfunnslivet for personer med funksjonsnedsettelse*. Dokument 3:10(2008-2009).
- Rikstrygdeverket. (1999). *Elektriske rullestoler i trafikken*. www.nav.no/Helsetjenester/Hjelpemidler/Temahefter og nasjonale standarder
- Rikstrygdeverket. (2000). *Elektriske rullestoler*. www.nav.no/Helsetjenester/Hjelpemidler/Temahefter og nasjonale standarder
- Rodger, S. & Ziviani, J. (2006). *Occupational therapy with children. Understanding children's occupations and enabling participation*. Oxford: Blackwell publishing Ltd.

- Rodger, S. & Ziviani, J. (2006). *Occupational Therapy with Children. Understanding Children's Occupations and Enabling Participation*. Kap 1 (3-22), 6 (115-136), 9-10 (177-222). Oxford: Blackwell.
- Rokstad, A. M. & Spedbye, K. L. (Red.). (2008). *Personer med demens. Møte og samhandling*. Kap. 12. Oslo: Akribe AS.
- Runnquist, K. m.fl. (1992). *Handens rehabilitering. Skador. Sjukdomar*. s. 53-70. Stockholm: Studentlitteratur.
- Runnquist, K. m.fl. (1992). *Handens rehabilitering. Undersökning. Behandling*. Stockholm: Studentlitteratur.
- Ruyter, K. W., Solbakk, J. H. & Førde, R. (2007). *Medisinsk og helsefaglig etikk*. Kap 1. Oslo: Gyldendal Akademisk.
- Ryhl, C. (2003). *Sansernes bolig*. København: Kunstakademiets Arkitektskole.
- Røed Andersen & Bergh. (2003). *Universell utforming over alt!* (Andersen, R. R. Universell utforming – utopi eller realitet?). s. 11-25. www.shdir.no
- Røed Andersen & Bergh. (2003). *Universell utforming over alt!* (Aslaksen, F. Samfunnsplanlegging. Hensyn til ulike behov krever økt planleggerkompetanse.). s. 27-41. Sosial- og helsedirektoratet. www.shdir.no
- Røer, A. (2006). *Spiseforstyrrelser. Symptomforståelse og behandlingsstrategier*. s. 21-32. Gyldendal Akademisk.
- Røkenes, O. H. & Hansen, P. H. (2006). *Bære eller breste. Kommunikasjon og relasjon i arbeid med mennesker*. Kap. 7 (191-216).
- Røkenes, O. H. & Hanssen, P-H. (2006). *Bære eller breste. Kommunikasjon og relasjon i arbeid med mennesker*. Kap 1, 2. Fagbokforlaget.
- Røkenes, O. H. & Hanssen, P-H. (2006). *Bære eller breste. Kommunikasjon og relasjon i arbeid med mennesker*. Bergen: Fagbokforlaget.
- Rønningen, A. & Kjekken, I. (2008). Effect of an intensive hand exercise programme in patients with rheumatoid arthritis. *Scandinavian Journal of Occupational Therapy*, Vol. 15, 3, pp. 173-183.
- Sakiyama, M., Josephsson, S., & Asaba, E. (2010). What is participation? A story of mental illness, metaphor, & everyday occupation. *Journal of Occupational Science*, 17(4), (in press).
- Saksvik, P. Ø. & Nytrø, K. (Red.). (2006). *Ny personalpsykologi for et arbeidsliv i endringer. Nye perspektiver på samspillet organisasjon og menneske* (2 utg). Kap. 6, 11, 12. Oslo: Cappelen akademisk forlag.
- Salter, M. (2000). *Hand therapy: principles and practice*. Oxford: Butterworth, Heinemann.
- Sand, O. m.fl. (2006). *Menneskekroppen. Fysiologi og anatomi*. Kap. 4-9 (41-312), 12-15 (356-449). Oslo: Universitetsforlaget.
- Sand, O., Sjaastad, Ø. & Haug, E. (2001). *Menneskets fysiologi*. Kap. 3-4 s. 104-197. Gyldendal.

- Sandvin J. (Red.). (2008). *Arbeid, sykdom og moral*. s. 19-123. Bergen: Fagbokforlaget.
- Scaffa, M. (2001). *Occupational Therapy in Community-Based Practice Settings*. Kap.15, 16. Philadelphia, F. A. Davis Company.
- Scaffa, M. E., Van Slyke, N. & Brownson, C. A. (2008). Occupational therapy services in the promotion of health and the prevention of disease and disability. *AJOT*; 62, 6, 694-703.
- Schafft, A. (2009). *Å få seg en jobb*. Oslo: Kommuneforlaget.
- Schell, J. & Schell, B. A. (2008). *Clinical and professional reasoning in occupational therapy*. Kap. 1-2. Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.
- Schmid, T. (2004). Meanings of creativity within occupational therapy practice. *Australian Occupational Therapy Journal*, vol 51, s. 80-88.
- Schmidt, R. A. & Wrisberg, C. A. (2008). *Motor Learning and Performance*. Human Kinetics.
- Schulze, S. & Schroeder, T. V. (2010). Basisbog i sygdomslære. (2 utg.). s. 135-138, kap 6, s. 331-357, 376-380, 384-386, 390-391. København, Mungsgaard Danmark.
- Selboe, A., Bollingmo, L., Ellingsen, K. E. (Red.). (2005). *Selvbestemmelse for tjenestenytere*. Kap 2, s. 38-69. Oslo: Gyldendal Norsk Forlag AS.
- Shepherd, J. (2005). Activities of Daily Living and Adaptations for Independent Living. I: J. Case-Smith, (Red.). *Occupational Therapy for Children*. Kap.15, s. 521-583. Mosby.
- Shumway-Cook, A. & Wollacott, M. H. (2007). *Motor Control, Theory and Practical Applications*. (2. utg.). Baltimore. Lippincott, Williams & Wilkins.
- Shumway-Cook, A. & Wollacott, M. H. (2007). *Motor Control. Theory and Practical Applications*. (3rd ed.). Kap 1, 2. Baltimore: Lippincott Williams & Wilkins.
- Shumway-Cook, A. & Wollacott, M. H. (2007). *Motor Control. Translating Research into Practice*. (3rd ed.). Ch 9, pp 212-232 and Ch 13 pp 345-358. Lippincott Williams & Wilkins.
- Sigmundsson, H. & Haga, M. (2005). *Ferdighetsutvikling: grunnbok i utvikling av barns ferdigheter*. Oslo: Universitetsforlaget
- Sigmundsson, H. & Haga, M. (Red.). (2005). *Ferdighetsutvikling. (Ferdighetsutvikling – fra teori til praksis)*. s. 13-27. Universitetsforlaget.
- Simonsen, E. B. & Hansen, L. Kern (2007). *Lærebog i biomekanikk*. Kap. 6, s.66-73. Munksgaard, Danmark.
- Sjaastad, Ø.V. et al. (2006). *Arbeidsbok til menneskekroppen: fysiologi og anatomi*. Oslo: Gyldendal akademiske.
- Sjøvold, E. (2006). *Teamet. Utvikling, effektivitet og endringer i grupper*. Kap 2-4,7-9,14-17. Oslo: Universitetsforlaget.
- Skar, R. (2010). Hobbyaktiviteter - bare for moro skyld? Om menns erfaringer med engasjement i hobbyer. *Ergoterapeuten* (3), 56-61.

- Skar, R. (2010). Hobbyaktiviteter – bare for moro skyld? Om menns erfaringer med engasjement i hobbyer. *Ergoterapeuten*, nr. 3, s. 56-61.
- Skau G. M. (2005). *Gode fagfolk vokser... Personlig kompetanse som utfordring*. Kap. 4. Oslo: Cappelen Akademiske Forlag.
- Skau, G. M. (2005). *Gode fagfolk vokser – personlig kompetanse i arbeid med mennesker*. Kap. 2, s. 31-49. Oslo: Cappelen.
- Skau, G. M. (2005). Personlig kompetanse i arbeid med mennesker. Kap. 6 (126-136). I: *Gode fagfolk vokser*. Oslo: Cappelen Akademisk.
- Smith, L. (1996). *Småbarnsalderens nevropsykologi*. Kap. 3, 6, 7. Oslo: Universitetsforlaget.
- Smith, S. & Roberts, P. (2005). An investigation of occupational therapy and physiotherapy roles in a community setting. *International Journal of Therapy and Rehabilitation*, Vol 12(1) pp. 21-29.
- Sneppen, O., Bünger, C. & Hvid, I. (2006). *Ortopædisk Kirurgi*. (6. utg.). s. 81-97, 180-195, 450-456, 537-540. København: FADL's Forlag.
- Snoek, K. E & Engedal, K. (2008). *Psykiatrici: kunnskap, forståelse, utfordringer*. Kap. 1, 2. Oslo: Akribe.
- Sosial og helsedirektoratet. (2003). *Universell utforming over alt! Planlegging og utforming av uteområder, bygninger, transport og produkter for alle*. Artikkelsamling. Kap 1 og 2 (28 sider). http://www.helsedirektoratet.no/vp/multimedia/archive/00001/IS-1141_1657a.pdf
- Sosial- og helsedepartementet. (1998). *Det er bruk for alle. Styrkning av folkelsearbeidet i Norge. NOU 1998:18*.
- Sosial- og helsedirektoratet. (2001 och senare). *Internasjonal klassifikasjon av funksjon, funksjonshemming og helse, ICF*. KITH, Sosial- og helsedirektoratet.
- Sosial- og helsedirektoratet. (2002). *Veileder for individuell plan 2001*. s. 1-44. ISBN 82-8081-006-4.
- Sosial- og helsedirektoratet. (2003). *Internasjonal klassifikasjon av funksjon, funksjonshemming og helse, ICF*. Innledning.
- Sosial- og helsedirektoratet. (2005). *Barn og unge med nEdsatt funksjonsevne - hvilke rettigheter har familien?* Oslo: Sosial- og helsedirektoratet.
- Sosial- og helsedirektoratet. (2007). *Korsryggsmerter- med og uten nerverotaffeksjon* (kortversjon).
- Sosial- og helsedirektoratet. (2007). *Korsryggsmerter- med og uten nerverotaffeksjon*. Nasjonale kliniske retningslinjer (www.formi.no).
- Sosialdepartementet. (2003). *Nedbygging av funksjonshemmende barrierer. Strategier, mål og tiltak i politikken for personer med nEdsatt funksjonsevne*. St. Meld. Nr. 40 (2002-2003).
- St. meld. Nr. 21 (1998-1999). *Ansvar og meistring. Mot ein heilskapleg rehabiliteringspolitikk*. Kap. 3. Sosial- og helsedepartement.
- St.meld. Nr. 16 (2002-2003). *Resept for et sunnere Norge. Folkehelsepolitikken*. Kap. 1, s. 5-9. Oslo: Helsedepartementet.

- St.meld. Nr. 20 (2006-2007). *Nasjonal strategi for å utjevne sosiale helseforskjeller*. s. 11-28, 42-47. Det kongelige helse og omsorgsdepartement.
- St.meld. Nr. 21 (1998-1999). *Ansvar og meistring. Mot ein heilskapleg rehabiliteringspolitikk*. Sosial- og helsedepartementet.
- St.meld. Nr. 25 (2005-2006). *Mestring, muligheter og mening*. Kapittel 1, 2, 3.
- St.meld. Nr. 29 (2002- 2003). *Om familien – forpliktende samliv og foreldreskap*. Kap. 2, s. 9 -14. Oslo: Barne- og familiedepartementet.
- St.meld. Nr. 39 (2001-2002). *Oppvekst og levekår for barn og ungdom i Norge*. Oslo: Barne- og familiedepartementet, Akademia AS.
- St.meld. Nr. 40 (2002 – 2003). *Nedbygging av funksjonshemmende barrierer. Strategier, mål og tiltak i politikken for personer med nEdsatt funksjonsevne*. Kap. 1,2, s. 5-25. Oslo: Sosialdepartementet.
- St.meld. Nr. 47 (2008–2009). *Samhandlingsreformen. Rett behandling – på rett sted – til rett tid*. Kap.1, s.13-16. Det kongelige helse og omsorgsdepartement.
- St.meld. Nr. 47 (2008–2009). *Samhandlingsreformen. Rett behandling – på rett sted – til rett tid*. Kap.1, s.13-16. Det kongelige helse og omsorgsdepartement.
- St.meld. Nr. 9 (2006–2007). *Arbeid velferd og inkludering*. s. 11–76. Det kongelige helse og omsorgsdepartement.
- St.meld. Nr.21 (1998-99). *Ansvar og meistring. Mot en heilskapeleg rehabiliteringspolitikk*. Kap.1, 2. Sosial- og helsedepartementet.
- Statens helsetilsyn. (2000). *Veileder i habilitering og rehabilitering ved synstap og hørselstap*, nr.3, s. 17-28. www.shdir.no/vp/multimedia/archive/00000/IS-2715_927a.pdf
- Stein F. & Cutler S. K. (2002). *Psychosocial Occupational Therapy. A Holistic Approach*. (2nd ed.). Kap. 1, 5, 6, 9, 10, 11. Canada, Delmar division of Thomson Learning.
- Stultjens, E. M. J., Dekker, J., Bouter, L. M. m.fl. (2002). Occupational Therapy for Rheumatoid Arthritis; A Systematic Review. *Arthritis & Rheumatism (Arthritis Care & Research)*, Vol. 47, No 6, Dec 15; 672-85.
- Stoffel, S. (2004). Working with elders who have hearing impairments. I B. S. Connon, L. M. Lohman & L. R. Padilla (Red.). *Occupational therapy with elders*, kap. 16, s. 213-222. St. Louis, Elsevier Mosby.
- Stone, R. J. & Stone, J. A. (2003). *Atlas of Skeletal Muscles*. Kap. 5. New York: McGraw-Hill.
- Stone, R. J. & Stone, J. A. (2003). *Atlas of Skeletal Muscles*. Kap. 6. Mc Graw Hill.
- Strand, G. (Red.). (2004). *Om AD/HD, Tourettes syndrome og narkolepsi- en grunnbok*. Bergen: Fagbokforlaget.
- Strandquist K, Liukko, A. & Tham, K. (2003). “The Meaning of the Working Cooperative for Persons With Long-Term Mental Illness: A Phenomenological Study”. *The American Journal Occupational Therapy*; 57(3), 262-271.

- Størksen m.fl. (Red.). (2006). *Bevegelse - fysisk aktivitet - helse*. (Østerås, Berit Skei Behandling av skuldersmerter i nytt lys). s. 169-172.
- Svartdal, F. (2009). *Psykologiens forskningmetoder - en introduksjon*. (3 utg). s. 136-160.
- Svedberg, L. (2002). *Gruppesykologi. Om grupper, organisasjoner og ledelse*. Oslo: Abstrakt Forlag
- SvEdsen, L. K. & Lillebø, M. O. (Red.). (2007). *Aktivitet og livsstil. Livsstilprogram - en helsefremmende og forebyggende metode*. Del 1, 2. Oslo: Stiftelsen kirkens bymisjon.
- Sveen, U. (2004). Ergoterapi i rehabilitering etter hjerneslag - fokus på aktivitet og deltakelse. *Ergoterapeuten norsk*, 8/47, s.12-19.
- Sveen, U. (2004). Ergoterapi i rehabilitering etter hjerneslag. *Ergoterapeuten nr.8 04/47* s. 12-19.
- Sveen, U., Melhus, M. & Kjekken, I. (2008). *Ergoterapi: Undersøkelse og behandling av personer med revmatoid artritt*. DVD 1 og 2. Undervisningsmateriale for ergoterapistudenter.
- Sveen, U., Melhus, M. & Kjekken, I. (2008). *Ergoterapi: Undersøkelse og behandling av personer med hjerneslag. Undervisningsmateriale for ergoterapistudenter*. Ullevål Universitetssykehus, Høgskolen i Oslo: og Diakonhjemmet sykehus.
- Svendsen, L. & Clemenson, L. (2003). Lifestyle Redesign – også for norske eldre? *Ergoterapeuten* 46 nr. 5, s. 28-33.
- Svendsen, L. & Otterholdt, M. (2006). *Eldre gjenskaper livsstil*. Oslo: Kirkens bymisjon
- Svendsen, L. & Otterholt, M. (2006). "Eldre gjenskaper livsstil". Prosjektet bygger på programmet Lifestyle Redesign. Samarbeidsprosjekt mellom Ammerudhjemmet Bo- og kultursenter i Oslo: og Stiftelsen Kirkens Bymisjon.
- Svendsen, L. K. & Lillebø, M. O. (Red.). (2007). *Aktivitet og livsstil – livsstilsprogram – en helsefremmende og forebyggende metode*. Stiftelsen Kirkens Bymisjon www.bymisjon.no
- Svendsen, T., Sæther, R., & Trælnes, K. (2008). Fokus på vanene – rehabilitering. *Ergoterapeuten* 5, s. 20-25.
- Svisdahl, M. (2008). *Veien ut av psykisk lidelse. Erfaringer, medborgerskap og bedringsprosesser*. Oslo: Cappelen Akademisk.
- Swain, J., French, S., Barnes, C. & Thomas, C. (Red.). (2007). *Funksjonshemmende barrierer – funksjonsfremmende samfunn*. Kap. 36 (292-299), 38 (306-315). Oslo: Kommuneforlaget.
- Swain, J., French, S., Barnes, C. og Thomas, C. (Red.). (2007). *Funksjonshemmende barrierer – funksjonsfremmende samfunn*. Kap 5-6 (51-66), 41-45 (330-365). Oslo: Kommuneforlaget.
- Sylvestersen, J. (2007). Arbejdets betydning. I: Jensen, L., Ptersen, L. & Stockholm, G. (Red.). *Rehabilitering. Teori og praksis*. s. 279-296. København: FADL's forlag.
- Søndergaard, M. (2004). *Demens og aktiviteter i et livshistorisk perspektiv*. System Academic.
- Taylor, M. C. (2007). *Evidence-based Practice for Occupational Therapists*. Kap. 1,2 (evt kap. 3 og utover). Blackwell Publishing, UK.

- Taylor, M. C. (2007). *Evidence-based practice for occupational therapists*. Kap. 1-3, 6.
- Taylor, R. R. (2004). Quality of life and symptom severity for individuals with chronic fatigue syndrome: findings from a randomized clinical trial. *American journal of occupational therapy*; 58(1):35-43.
- Temannummer om Kunnskapsbasert ergoterapi, nummer 1 2008/ 51 (Ergoterapeuten).
- Tetzchner, S., Hesselberg, F. & Schiørbeck, H. (2008). *Habilitering: tverrfaglig arbeid for mennesker med utviklingsmessige funksjonshemminger* (2 utg.). Oslo: Gyldendal Akademiske.
- Thagaard, T. (2002). *Systematikk og innlevelse. En innføring i kvalitativ metode*. Bergen: Fagbokforlaget. Vigmostad & Bjørke AS.
- Theorell, T. (Red.). (2003). *Psycosocial miljø och stress*. Kap. 1, 5. Lund: Studentlitteratur.
- Thomassen. (2006). *Vitenskap, kunnskap og praksis*. Kap. 1, 2, 5, 6. Oslo: Gyldendal.
- Thommesen, H. (2010). *Rehabilitering som politikk virksomhet og studiefelt*. Kap. 4, 6. Gyldendal Akademisk.
- Thommesen, H. (Red.). (2010). *Rehabilitering - som politikk, virksomhet og studiefelt*. Kap. 1, 2, 4, 5. Oslo: Gyldendal akademisk.
- Thorbjørnsrud, B. (2009). Kap 8: Kultur, helse og sykdom. I Brodtkorp, E. & Rugkåsa, M. (2009). *Mellom mennesker og samfunn. Sosiologi og sosialantropologi for helse- og sosialprofesjonene*. Oslo: Gyldendal akademisk.
- Thorsen, K. (Red.). (2003). Å falle mellom to stoler? Om aldring blant funksjonshemmede mennesker. *Nordisk sosialt arbeid, nr. 1*, s. 46-54.
- Thorsen, K. & Myrvang, V. H. (2008). *Livsløp og hverdagsliv med utviklingshemming. Livsberetninger itl personer med utviklingshemming*. Tønsberg: Forlaget aldring og helse.
- Thyberg, I., Hass, U., Nordenskiöld, U., Gerdle, B., Skogh, B. (2005). Activity limitation in rheumatoid arthritis correlates with reduced grip force regardless of sex. *Arthritis & Rheumatism*, 53(6), 888-96.
- Thyberg, I., Hass, U., Nordenskiöld, U. & Skogh, T. (2004). Survey of the Use and Effect of Assistive Devices in Patients with Early Rheumatoid Arthritis: A Two-Year Follow-up of Women and Men. *Arthritis & Rheumatism (Arthritis Care & Research)*. 51(3) pp. 413-21.
- Thygesen, H. (2008). *Technology and good dementia care: A study of technology and ethics in everyday care practice*. Ch 6-7, pp 131-177. Ph. D. thesis Centre for Technology, Innovation and Culture TIK. University of Oslo.
- Thygesen, H. (2009). *Technology and good dementia care: a study of technology and ethics in everyday care practice*. Kap. 5, 6. Sosialvitenskaplig fakultet, UiO.
- Thygesen, H. (2009). *Technology and good dementia care: a study of technology and ethics in everyday care practice*. Kap. 6, 7. Doktorgradsavhandling, senter for teknologi, innovasjon og kultur (TIK), UiO.

- Thygesen, H. & Moser, I. (2009). Dagsentrenes betydning i demensomsorgen. Om å opprettholde pasientkollektiver. *Omsorg. Nordisk tidsskrift for palliativ medisin*, nr 2/2009, årg 26, s. 47-51.
- Thyness, P. (1999). *Sosialt arbeid, lokal organisering og selvhjelp*. (Thyness, P. Frivillighetssentralene og frivillig innsats). Kap. 4. Tano Aschehoug.
- Tollén, A., Frederikson, C. & Kamwendo, K. (2007). Elderly persons' expectations of day-care rehabilitation. *Scandinavian Journal of Occupational Therapy*, Nr 14, 173-182.
- Toomingas, A., Mathiassen, S. E. & Tornqvist, E. W. (Red.). (2008). *Arbeidslivsfysiologi*. Kap. 4, 5. Lund: Studentlitteratur.
- Topor, A. (2006). *Hva hjelper? Veier til bedring fra alvorlige psykiske problemer*. Oslo: Kommuneforlaget.
- Torp, H. (Red.). (2005). *Nytt arbeidsliv. Medvirkning, inkludering og belønning*. Oslo: Gyldendal akademisk.
- Townsend, E. (1999). "Enabling occupation in the 21st century: Making good intentions a reality". *Australian Occupational Therapy Journal*; 46: (147-159).
- Townsend, E. A. & Polatajko, H. J. (2007). *Enabling Occupation II, Advancing in occupational Therapy, Vision for health, well-being and justice through occupation*. s. 229-272. Ottawa: CAOT Publications.
- Townsend, E. A. & Polatajko, H. J. (2007). *Enabling Occupation II, Advancing in occupational Therapy, Vision for health, well-being and justice through occupation*. s. 229-272. Ottawa: CAOT publications.
- Townsend, E. A. & Polatajko, H. J. (2007). *Enabling Occupation II, Advancing in occupational Therapy, Vision for health, well-being and justice through occupation*. Section II pp 83-171. Ottawa: CAOT publications.
- Townsend, E.A. (Red.). (2002). *Fremme av menneskelig aktivitet - ergoterapi i et canadisk perspektiv*. København: FADL's forlag.
- Townsend, E.A. & Polatajko, H.J. (2008). *Menneskelig aktivitet II: En ergoterapeutisk visjon om sundhed, trivsel og retfærdighed muliggjort gennem betydningsfulde aktiviteter*. Kap, 1, 2, 4, 9, 10. København: Munksgaard forlag.
- Townsend, E.A. & Polatajko, H.J. (Red.). (2008). *Menneskelig aktivitet II. En ergoterapeutisk visjon om sundhed, trivsel og retferdighet muliggjort gjennom betydningsfulde aktiviteter*. København: FADL's forlag.
- Townsend, E.A. & Polatajko, H.J. (Red.). (2008). *Menneskelig aktivitet II. En ergoterapeutisk visjon om sundhed, trivsel, og retferdighet muliggjort gjennom betydningsfulde aktiviteter*. København: Munksgaard Danmark.
- Trombly, C. & Radomski, M. V. 2002 *Occupational Therapy for Physical Dysfunction*. (5th ed.). Kap. 41, 42 s. 909-963, kap. 46 s. 1045-1070. USA: Williams & Wilkins.
- Tuntland, H. (2006). *En innføring i ADL- teori og intervensjon*. Kap. 1, 2, 6, 8. Høyskoleforlaget.

- Tuntland, H. (2006). *En innføring i ADL*. Kap. 1, 4. Kristiansand: Høgskoleforlaget.
- Tuntland, H. (2006). *En innføring i ADL*. Kap. 5. Høgskoleforlaget.
- Tuntland, H. (2006). *En innføring i ADL. Teori og intervensjon*. Kap. 4, s.77-109.
- Tuntland, H. (2006). *En innføring i ADL. Teori og intervensjon*. Kap. 4, 5, 6, 7. Kristiansand: Høgskoleforlaget.
- Tuntland, H. (2006). *En innføring i ADL. Teori og intervensjon*. Kap 1, 2, 3, 4, 6. Kristiansand: Høgskoleforlaget.
- Tuntland, H. (2006). *En innføring i ADL. Teori og intervensjon*. Kap. 1, 2 (17-64), 5 (111-134). Kristiansand: Høgskoleforlaget.
- Tuntland, H. (2006). Faktorer som fremmer læring av ferdigheter. En oppgaveorientert tilnærming – del 2. *Ergoterapeuten nr. 8*, s. 30- 36.
- Tuntland, H. (2006). Læring av ADL-ferdigheter. En oppgaveorientert tilnærming- del 1. *Ergoterapeuten nr. 8*, s. 26- 29.
- Tuntland, H. (2008). Kunnskapsbasert ergoterapi i et internasjonalt perspektiv. *Ergoterapeuten, nr 1*, s. 19-26. <http://www.netf.no/Netf/Fag-og-yrkesutoevelse/Kunnskapsporten/Litteratur>
- Tuntland, H. (Red.). (2005). *Forebygging, rehabilitering og omsorg*. Kap. 11. København: N. W. Damm & Søn AS.
- Tuntland, H. (Red.). (2006). *Sykdomer hos eldre*. Kap. 2. Oslo: N.W. Damm & Søn AS.
- Turner, A. et al. (2002). *Occupational Therapy and Physical Dysfunction*. (5th ed.). Kap. 24, 26. Churchill Livingstone.
- Turner, A. et al. (2002). *Occupational therapy and physical dysfunction*. (5 utg.). Kap. 24, 26. Churchill Livingstone.
- Turner, A. et al. (Eds.). (2002). *Occupational therapy and physical dysfunction: principles, skills, and practice*. (5th ed.). Kap 15-21 (395-522), 23-26 (543-615). Edinburgh: Churchill Livingstone.
- Turner, A., Foster, M. & Johnson, S. E. (2002). *Occupational Theraphy and Physical Dysfunction*. Kap. 21, s. 507-521. Churchill Livingstone.
- Turner, A., Foster, M. & Johnson, S. E. (ed.). (2002). *Occupational Therapy and Physical Dysfunction*. (5th ed.). Kap. 3 s. 69-79, Kap. 16, 17, 21, 22, 23 s. 543-554, 561-563 og 27 s. 617-626. Edinburgh: Churchill Livingstone.
- Tveiten, S (2002). *Veiledning- mer enn ord*. (2. utg.). s. 9-46. Bergen: Fagbokforlaget.
- Tveiten, S. (2002). *Veiledning- mer enn ord*. (2. utg.). Kap. 1. Bergen: Fagbokforlaget Vigmostad & Bjørke AS.
- Tynes, T. et al. (2008). *Arbeidsmiljø og helse- slik norske yrkesaktive opplever det*. STAMI-rapport. Årg. 9, nr. 16.
- Tynes, T. et al. (2008). *Ergonomisk arbeidsmiljø*. STAMI-rapport. Årg. 9, nr. 15.

- Tøssebro, J. (2006). Introduksjon: Å vokse opp med funksjonshemming – i kontekst. I Tøssebro, J. og Ytterhus, B. *Funksjonshemmete barn i skole og familie. Inkludering og hverdagspraksis*. s. 11-38. Oslo: Gyldendal Norsk Forlag.
- Tøssebro, J. (2008). Introduksjon, å vokse opp med funksjonshemming i kontekst. I: Tøssebro, J. & Ytterhus, B. *Funksjonshemmete barn i skole og barnehage*. Kap. 1. Gyldendal Akademisk.
- Tøssebro, J. (2009). Innledning – norsk forskning om funksjonshemming. I Tøssebro, J. (Red.). *Funksjonshemming - politikk, hverdagsliv og arbeidsliv*. s. 11-20. Oslo: Universitetsforlaget.
- Ulstein, I. (2009). Pårørendes situasjon I: K. Engedal & P. K. Haugen, (Red.). *Lærebok i demens – fakta og utfordringer*. Kap. 16 s. 329-342. Sem. Nasjonalt kompetansesenter for aldersdemens.
- Unsworth, C. (2005). Using a Head-Mounted Video Camera To Explore Current Conceptualizations of Clinical Reasoning in Occupational Therapy. *American Journal of Occupational Therapy*. Vol 59 (1). s. 31-40.
- Van Cranenburgh, B. (2004). Neglekt hos apopleksipasienter – et forsømt problem. *Ergoterapeuten norsk*, 1/47, 20-27.
- Vavik, T. (2003). Brukervennlighet i produktdesign I: R. Røed Andersen, & S. Bergh, *Universell utforming over alt!* s. 91-105. Sosial- og helsedirektoratet www.shdir.no
- Vavik, T. (2009). *Inclusive buildings, products & services. Challenges in universal design*. Trondheim: Tapir academic press
- Vavik, T. (2009). *Inclusive buildings, products & services. Challenges in universal design*. (Fuglerud, K. S. Universal design in ICT services). s. 244-267. Trondheim: Tapir Academic Press.
- Vetlesen, A. J. (2007). Livet som avhengig og sårbart. Kap. 5. I: Vetlesen, A. J. & Henriksen, J.-O. *Nærhet og distanse*. Oslo: Gyldendal Akademisk.
- Vifladt, E. & Hopen, L. (2004). *Helsepedagogikk- samhandling om læring og mestring*. Nasjonalt kompetansesenter for læring og mestring ved kronisk sykdom, Oslo.
- Vik, K. (2003). ICF i norsk oversettelse. *Ergoterapeuten nr. 11.03* s. 84-87.
- Vik, K. (2008). Eldre og deltakelse - erfaring fra eldre som har fått eller får kommunale tjenester. *Ergoterapeuten (8)*, 16-23.
- Vik, K. (2008). Eldre og deltakelse - erfaring fra eldre som har fått eller får kommunale rehabiliteringstjenester *Ergoterapeuten nr 08* s. 16-23.
- Vik, K. (2008). Eldre og deltakelse - erfaringer fra eldre som har fått kommunale rehabiliteringstjenester. *Ergoterapeuten nr. 8.08* (s. 16-22).
- Vik, K. (2008). Hvordan erfares deltagelse for personer som mottar kommunale tjenester i hjemmet. *Ergoterapeuten nr. 8* s. 24-30.
- Vik, K. (2008). *Older adults' participation in occupation in the context of home-based rehabilitation*. Karolinska Institutet.

- Vik, K. (2008). *Older adults' participation in occupation in the context of home-based rehabilitation*. Division of occupational therapy, Karolinska Institutet, Huddinge.
- Vik, K. m.fl. (2007). Perceived Environmental Influence on Participation Among Older Adult After Home-Based Rehabilitation. *Physical & Occupational Therapy in Geriatrics* vol. 24 (4).
- Vik, K. m.fl. (2007). The influence of the environment on participation subsequent to rehabilitation as experienced by elderly people in Norway. *Scandinavian Journal of Occupational Therapy*. 2007; 14: 86-95.
- Vik, K., Nygård, L., Borell, L., & Josephsson, S. (2008). Agency and engagement: Older adults' experiences of participation in occupation during home-based rehabilitation. *Canadian Journal of Occupational Therapy*, 75(5), 262-271.
- Vikse, K. O. og Røthing, M. (2005). Konsekvenser av senskader slik personer med ervervet hjerneskade opplever dem. *Ergoterapeuten* nr 5, 05/48. s. 28-33.
- Vikström, S., Borell, L., Stigsdotter-Neely, A., Josephsson, S. (2005). Caregivers' Self-Initiated Support Toward Their Partners With Dementia When Performing an Everyday Occupation Together at home. *OTJR: Occupation, Participation and Health* 25(4), p. 149-59.
- Von Tetzchner, S. (2001). *Utviklingspsykologi. Barne- og ungdomsalderen*. Kap. 8: Utvikling av motorikk og bevegelse. Oslo: Gyldendal akademisk.
- Von Tetzchner, S. (2008). *Habilitering, tverrfaglig arbeid for mennesker med utviklingsmessige forstyrrelser*. Kap.1, 5. Oslo: Gyldendal.
- Walsh, A. L., & Blesedell Crepeau, E. (1998). My Secret Life: The Emergence of One Gay Man's Authentic Identity. *American Journal of Occupational Therapy*, (52)7, (563-569).
- Ween, E. (2004). Bevegelsesapparatet. I L. Wekre & K. Vardeberg, (Red.). *Lærebok i rehabilitering. Når livet blir annerledes*, s. 184-187.
- Wekre L. L. & Vardeberg K. (Red.). (2004). *Lærebok i rehabilitering. Når livet blir annerledes*. (Vik, K. ICF – en felles modell og et felles språk i rehabilitering). s. 57-63. Fagbokforlaget.
- Wekre L. L., Vardeberg K. (Red.). (2004). *Lærebok i rehabilitering – når livet blir annerledes*. Kap. 18, s. 213-224.
- Wekre, L. L. & Vardeberg, K. (2003). *Lærebok i rehabilitering. Når livet blir annerledes*. (Vik, K. ICF - en felles modell og et felles språk i rehabilitering). s. 57-63. Fagbokforlaget.
- Wekre, L. L. & Vardeberg, K. (Red.). (2004). *Lærebok i rehabilitering*. (Hjeltnes, N. Ryggmargsskader). s.149-167. Fagbokforlaget.
- Wekre, L. L. & Vardeberg, K. (Red.). (2004). *Lærebok i rehabilitering*. (Indredavik, B. Hjerneslag). s. 125-148. Fagbokforlaget.
- Wekre, L. L. & Vardeberg, K. (Red.). (2004). *Lærebok i rehabilitering*. (Vik, K. ICF - en felles modell og et felles språk i rehabilitering) Kap. 6.
- Wekre, L. L. Vardeberg K. (Red.). (2004). *Lærebok i rehabilitering*. Kap. 1-2 (s. 15-33), 6 (s. 57-64). Fagbokforlaget Vigmostad & Bjørke AS.

- Werge-Olsen, I. B. (2003). *Hverdagsaktiviteter og kulturelle verdier: brødbaking hver lørdag*. HIST/AHS-notat; 2003 nr 1, Tapir Akademisk Forlag, Trondheim.
- Wessel Johnsen, L. G. (2009). *Risikovurdering*. Kap. 2, s. 105-111. Oslo: Gyldendal arbeidsliv.
- Wessel, J. (2004). The effectiveness of Hand Exercises for Persons with Rheumatoid Arthritis: A systematic review. *Journal of Hand Therapy*, No. 17, pp. 174-180.
- Whiteford, G. (2004). When people cannot Participate: Occupational deprivation. I C. H. Christiansen, & E. Townsend. *Introduction to Occupation - The art and science of living*. Pearson Education, New Jerseyation).
- Whiteford, G. (2010). Occupational Deprivation: Understanding Limited Participation. I C. H. Christiansen, & E. Townsend. *Introduction to Occupation. The Art and Science of Living*. s. 303-328. New Jersey: Pearson.
- WHO. (2007). *International classification of functioning, disability and health: children and youth version: ICF-CY*
- Wiktorin, C. H. (2003). *Exempelsamling i biomekanik*. Kap. 2, s. 22-42. Lund: Studentlitteratur.
- Wiktorin, C. H. (2003). *Exempelsamling i biomekanik*. Kap. 9, s. 122-33. Lund: Studentlitteratur.
- Wilcock, A. A. & Townsend, E. (2009). Occupational Justice. I E. Crepeau, et al. (2009). *Willard & Spackman's Occupational Therapy*, (11th ed.). Kap 20. Lippincott Williams & Wilkins.
- Wilcock A. (1993). A Theory of the human Need for Occupation. *Journal of Occupational Science*, April 1993, Vol 1, No 1, s. 17-24.
- Wilcock A. (1998). Å ta i bruk menneskets evner. *Ergoterapeuten nr 9*.
- Wilcock, A. A. (2005). Older people and Occupational Justice. In: A. McIntyre, & A. Atwal, (Eds.). (2005). *Occupational Therapy and Older People*. Kap. 2. Oxford: Blackwell Oxford.
- Wilcock, A. A. (2006). *An Occupational Perspective of Health*. Kap. 1-2 (14-75). Slack Inc.
- Wilcock, A. A. & Hocking, C. (2004). Occupation, Population Health and Policy Development. In M. Moloneux. *Occupation for occupational therapists*. s. 219-230. Oxford: Blackwell.
- Wilhelmsen, F. K. (2007). Bedre samarbeid, færre fallskader! – Fysioterapeutens og ergoterapeutens samarbeid og resultater. *Ergoterapeuten nr. 8* s. 24-29.
- Wilhelmsen, L. S., & Manger, T. (2005). *Effektiv læring: et hefte ved studiestart for alle nye studenter*. Bergen: Fagbokforlaget.
- Willumsen, E. (2009). Differensiering og integrering – dynamikken i tverrprofesjonelt samarbeid. I: E. Willumsen. *Tverrprofesjonelt samarbeid i praksis og utdanning*. Kap. 3. Oslo: Universitetsforlaget.
- Willumsen, E. (2009). *Tverrprofesjonelt samarbeid i praksis og utdanning*. Oslo: Universitetsforlaget.
- Willumsen, E. (2009). *Tverrprofesjonelt samarbeid i praksis og utdanning*. Kap. 6. Oslo: Universitetsforlaget.

- Wilson, B., Cockburn, J. & Baddeley, A. (1985 1991). *The Rivermead behavioural memory test. Norsk utgave. Håndbok – voksne*. s. 5-21. Pedagogisk psykologisk.
- Wågø, R. (2009). *Rakst tilbake*. Idebanken/NAV
- Wæhrens, E. & Fisher, A.G. (2007). Improving quality of ADL performance after rehabilitation among people with acquired brain injury. *Scandinavian journal of occupational therapy*: 14(4):250-257.
- Wæhrens, E., Winkel, A. & Gyiring, J. (2006). *Neurologi og neurorehabilitering*. Munksgaard.
- Wæhrens, E., Winkel, A. & Gyiring, J. (Red.). (2006). *Neurologi og neurorehabilitering: for ergoterapeuter og fysioterapeuter*. Kap. 1-5, 9-12, 14, 19, 21-24, 26, 32, 34, 36. København: Munksgaard forlag.
- Wæhrens, E., Winkel, A. & Gyiring, J. (Red.). (2006). *Neurologi og neurorehabilitering: for ergoterapeuter og fysioterapeuter*. Kap. 27, 37. København: Munksgaard forlag.
- Yrkesetikk; Samfunnskontrakten: <http://old.netf.no/ergoterapi/samfunnskontrakt.htm>
- Ziviani, J. & Rodger, S. (2006). *Occupational therapy with children: understanding children's occupations and enabling participation*. Kap. 3 (41-66). Oxford: Blackwell.
- Ziviani, J. & Rodger, S. (2006). *Occupational therapy with children: understanding children's occupations and enabling participation*. Kap. 2 (22-40), 8 (158-176), 12 (241-260). Oxford: Blackwell
- Åbyholm, A. S., & Hjortdahl, P. (2000). Kroniske rygg smerter-pasienters opplevelser og møte med helsevesenet. I W. Eriksen & Brage, S. (Red.). *Korsrygg-smerter. En samfunnsmedisinsk og almenmedisinsk utfordring* (s. 103-111).
- Åhlstedt, L. (2006). *Ergoterapi for barn med Cerebral Parese*. Trondheim: Communicatio Forlag AS. Kap 1, 2, 4, 6.
- Åhlstedt, L. (2006). *Ergoterapi for barn med cerebral parese – med fokus på mestring og deltagelse*. Kap. 1,2,6, from 4.2 (96-112)., from 5.2 (130-167).
- Åhlstedt, L. (2006). *Ergoterapi for barn med cerebral parese. Med fokus på mestring og deltagelse*. Trondheim: Communicatio Forlag. Kap. 1-6.
- Åhlstedt, L. (2006). *Ergoterapi for barn med cerebral parese*. Kap. 1, 8. Trondheim: Communicatio.
- Østergaard, H. (2008). *Motorisk usikre børn*. København: Munksgaard Danmark.