The ICF Activities and Participation related to speech-language pathology

ROBYN O’HALLORAN1 & BRIGETTE LARKINS1,2

1The University of Queensland, Australia, and 2Older Persons Health Service, Canterbury District Health Board, New Zealand

Abstract
Increasingly speech-language pathologists are considering the effects of a client’s communication and/or swallowing disability on the client’s day to day life. The activities and life situations that make up a person’s everyday life are described in the Activities and Participation component of the World Health Organization’s International Classification of Functioning, Disability and Health (ICF). This paper describes the Activities and Participation component of the ICF and how communication is currently represented in this component. This paper then explores the current debate between the concepts of activities and participation and how this can continue to inform and develop our understanding of communication activity and communication participation into the future.

Keywords: ICF, World Health Organization, speech-language pathology, Activities and Participation.

Introduction
Many influences may direct a speech-language pathologist to consider the effects of a client’s communication and/or swallowing disorder on his/her everyday life. Three key influences are the clients themselves, payers, and the clinician him/herself. Clients with communication and/or swallowing disorders have a reasonable expectation that speech pathology assessment and intervention will have a positive effect on their everyday lives. In fact some individuals, particularly those whose disorders are associated with cognitive deficits, often refuse to cooperate, or may make little effort, unless they perceive that the clinician’s requests or therapy goals have significance to the goals of their lives (Ylvisaker, Jacobs, & Feeney, 2003). In addition, many individuals with communication disorders may fail to spontaneously integrate therapeutic tasks at the level of impairment into complex real life activities (Ylvisaker, Szekeres, & Feeney, 2001). This further underscores the need to address communication as it occurs in everyday life. Payers too want evidence that speech pathology interventions make a difference to people’s everyday lives (Frattali, 2000). The advances in medical technology added to the ageing population have resulted in increased demand and costs for the healthcare sector. In response, third party payers have required health professionals to extend their accountability beyond diagnosis to precisely describing the meaningful outcomes of rehabilitation (Tarvydas, Peterson, & Michaelson, 2005). Finally, speech-language pathologists’ own values and the values of the organization within which they work may also orient clinicians towards a better understanding of how their assessment and intervention influences their clients’ everyday lives. Clinicians, and/or organizations, who promote values such as respecting the individuality of the client, shared decision making, open communication and mutual respect are more able to consider the impact of a communication disorder on the client’s life (Byng, Cairns, & Duchan, 2002; Worrall, 2000).

From a theoretical viewpoint, a person’s ability to carry out activities and be involved in life situations may be represented by the Activities and Participation component of the World Health Organization’s International Classification of Functioning, Disability and Health (ICF) (WHO, 2001). This paper describes the Activities and Participation component of the ICF and how it currently defines and measures the full range of a person’s everyday activities and life situations. It then discusses some of the problems with the Activities and Participation component of
the ICF, in particular the alternative ways in which activities and participation have been proposed to relate to each other. The final section of this paper draws on the discussion of the relationship between activities and participation to further clarify the concepts of communication activity and communication participation as they relate to the assessment and management of adults with acquired communication disabilities.

The Activities and Participation component of the ICF

The Activities and Participation component of the ICF describes the complete range of human functioning from both an individual and a societal perspective (WHO, 2001). The individual perspective is expressed through the concept of activity which is defined as “the execution of a task or action by an individual” (p. 10, WHO, 2001). The societal perspective is expressed through the concept of participation and is defined as “involvement in a life situation” (p. 10, WHO, 2001). These two perspectives of functioning and disability make up the ICF Activities and Participation component.

There are three qualifiers; “performance” and “capacity” and a fourth qualifier representing participation. The ICF Activities and Participation component consists of a single list of nine chapters or domains. These are “Learning and applying knowledge” (d1); “General tasks and demands” (d2); “Communication” (d3); “Mobility” (d4); “Self-care” (d5); “Domestic life” (d6); “Interpersonal interactions and relationships” (d7); “Major life areas” (d8); and “Community, social and civic life” (d9). As with the organizational structure of other parts of the ICF, each domain in the Activities and Participation component is described in further detail by first, second, and sometimes third and fourth level items.

For example, the domain “Learning and applying knowledge” (d1) consists of 21 first level items, such as “Learning to calculate” (d150) and “Acquiring skills” (d155). Some of these first level items are described in further detail by second level items. For example, “Acquiring skills” (d155) consists of the second level items “Acquiring basic skills” (d1550) and “Acquiring complex skills” (d1551). Finally, a person’s level of functioning in each of the items within these domains is made meaningful by two qualifiers; “performance” and “capacity”. The performance qualifier describes what an individual does in his or her current environment at a given time, whereas the capacity qualifier describes an individual’s highest probable level of functioning, in a standardized or uniform environment at a given time (WHO, 2001). The ICF describes an additional third qualifier representing capacity with assistance and a fourth qualifier representing performance without assistance.

Of particular interest to speech-language pathologists is how the Activities and Participation component describes communication disability. The ways in which the ICF currently conceptualize communication activities and participation is described in the following section.

Communication in the Activities and Participation component

Chapter 3 of the Activities and Participation component is “Communication” and is one of the nine chapters in this component. It describes communication activities and participation at the broad three digit level in terms of “Communicating – receiving” (d310–d329); “Communicating – producing” (d330–d349); and “Conversation and use of communication devices and techniques” (d350–d369). “Communication – receiving” and “Communication – producing” are described in further details in terms of the type of message the person is receiving or producing, that is, whether it is non-verbal or verbal and in terms of the modality the person uses to communicate such as through body gestures and drawings. “Conversation and use of communication devices and techniques” is described in further detail by differentiating conversations from discussions and in terms of the number of people involved.

However, communication activity and participation is also part of many other activities and participation domains. For example, within the “Learning and applying knowledge” (d1) domain are the items: “Reading” (d166), “Writing” (d170) and “Solving problems” (d175) which includes resolving a dispute between two people. Similarly, the “Domestic life” (d6) domain includes items such as the “Acquisition of goods and services” (d620) and “Assisting others” (d660) and not surprisingly the “Interpersonal interactions and relationships” (d7) domain is replete with communication activities such as showing “Respect and warmth in relationships” (d7100), understanding “Social cues in relationships” (d7104) and maintaining “Informal relationships with friends” (d7500).

Therefore the Activities and Participation component of the ICF describes communication activities and participation in two different ways. Chapter 3 on “Communication” describes communication in terms of the component parts of communication, that is, the type of communication that is occurring (e.g., receiving messages, producing messages, or both, as in conversation), the communication modality employed (e.g., verbal or non-verbal) and the number of people engaged in the communication. These communication activities and participation are not described in relation to the context of the communication activity such as the place or purpose of the communication. In contrast, communication related activities included in other chapters of the Activities and Participation component do describe communication activities in relation to the context of the communication. For example, the purpose of the communication is explicit in the communication...
related activities “Resolving a dispute” (d175) and “Shopping” (d6200).

How best to describe communication activities and participation is a difficult issue to resolve. Given that communication is such an essential part of everyday life it is not surprising that communication activities are embedded within so many different domains across the Activities and Participation component. One solution may be to simply subsume communication activities into the other domains. However, this could result in communication being buried within other activities and participation domains and not getting the recognition it requires as an essential aspect of human functioning. The challenge will be to find ways to describe communication activities and participation in ways that make it clear how essential they are across most aspects of human functioning and interaction. For example, for the codes dealing with intimate relationships, which includes creating and maintaining “Romantic relationships” (d7700) and “Spousal relationships” (d7701), speech-language pathologists could work with other professionals and researchers to better understand how people who have communication disabilities create and maintain different types of intimate relationships. In this way, communication activities and participation would not be separate from other activities and participation but recognized as integral to them. The relationships among all the domains should be studied to come to a better understanding of the complexity of human interactions. Our ability to meet this challenge will be greatly influenced by how the Activities and Participation component itself is understood. Therefore the following section examines the concepts underpinning activities and participation.

Activities and Participation concepts

As described above, the Activities and Participation component consists of a single list of domains but actually represents both the individual (Activities) and societal (Participation) perspectives of functioning and disability. The reason the ICF does not have separate Activity and Participation components is because field trials of the beta-2 version of it found no agreement among the active participants in the development of the ICF as to which domains reflected activities and which domains reflected participation. As a result, WHO presents four different possible interpretations of the Activities and Participation component:

1. That the sets of codes are mutually exclusive. That is, some sets of codes represent activities and some represent participation.
2. That some of the sets of codes represent activities, some represent participation, but other domains represent both activities and participation.
3. That all the specific and more detailed items in the codes reflect activities and the general overall headings represent participation. For example, “Moving around” (d455) could be participation but its more detailed subcategory “Crawling” (d4550) could be listed as an activity.
4. That all codes can be considered as activities and as participation (WHO, 2001). An option within this approach would be to consider the capacity qualifiers as activity and the performance qualifiers as participation.

Concerning this variety of options, the ICF states:

It is expected that with the continued use of the ICF and the generation of empirical data, evidence will become available as to which of the above options are preferred by different users of the classification. Empirical research will also lead to a clearer operationalization of the notions of activities and participation. Data on how these notions are used in different settings, in different countries and for different purposes can be generated and will then inform further revisions to the scheme. (WHO, 2001, p. 237).

There is consensus that the Activities and Participation component consists of two different perspectives. One debate is around whether or not these two perspectives represent two separate underlying constructs or reflect different ends of the same continuum. The first WHO framework of disability, the International Classification of Impairment, Disability, and Handicap (ICIDH) (WHO, 1980), conceptualized the individual and societal perspectives of functioning and disability as two separate constructs. The perspective of the individual was referred to as the “disability” and the perspective of society was referred to as the “handicap”. As described above, the revised ICF is less clear about the relationship between these perspectives.

Since the publication of the ICF the relationship between Activities and Participation has been conceptualized in a number of different ways. These perspectives are presented below. The first point of view from speech-language pathology is that activities and participation are not distinctly different but exist at different points along a continuum. The continuum is the influence of contextual factors, that is, environmental and personal factors (Davidson & Worrall, 2000). This model conceptualizes “Activities” as a person’s functioning across simple and complex tasks and actions in a more restricting, limiting context at one end of the continuum, for example, reading a menu, whereas “Participation” represents a person’s functioning in unrestricted contexts at the other end, for example, dining out when a tourist in a foreign country (Davidson & Worrall, 2000). In this view, the concepts of “Activity” and “Participation” are integrally related.
Another framework that views activities and participation as a continuum is the Living with Aphasia: Framework for Outcome Measurement (A-FROM; Kagan et al., 2007) The A-FROM identifies four interrelated factors that have been proposed to influence the overall experience of living with aphasia. These factors are “the severity of the aphasia”, “participation in life situations”, “communication and language environment” and “personal identity, attitudes and feelings”. These factors are similar to the ICF components Body Functions and Structures, Activity and Participation, Environmental Factors and Personal Factors respectively. Of particular interest is that the “Participation in life situations” factor consists of “communication activities”, “communication and conversation”, “roles and responsibilities and relationships”. That is, this model also suggests that communication activities are an integral part of participation in life situations (Kagan et al., 2007). Both these models suggest that activity is part of participation, therefore these models imply that a person’s level of communication activity is related to his/her level of communication participation.

The Australian Institute of Health and Welfare (AIHW) has also considered the relationship between the ICF concepts of activities and participation, by reflecting on the factors that differentiate activities and participation. In contrast to the perspective above, in a 2003 publication, the AIHW suggested that activities and participation were different on six criteria.

These were:

1. “Activities focus on the person’s individual functioning, while Participation emphasises the person’s involvement in society.
2. Activity is completely externally observable. Participation refers to the ‘lived experience of the person’.
3. Activity can relate to a ‘test’ environment (although it can also relate to a real environment), with or without equipment. Participation is essentially ‘confounded’ with the environment, i.e., the concept has little meaning without consideration of the physical and social environment, and it cannot be ‘assessed’ in a ‘test’ environment.
4. ‘Involvement in society’ relates in particular to social roles. This highlights the confounding of Participation with that part of the environment that shapes expected roles and societal norms.
5. Activity is fine grained, whereas Participation is broad brushed.
6. Activity is about action or process, Participation relates to the overall goal of actions or sets of actions” (AIHW, 2003, pp. 35 – 36).

Recently the AIHW has differentiated the concepts of activities and participation further, by proposing that activities and participation are different in relation to their norms, qualifiers and how activities are chosen and participation is determined as described in Table I. Whiteneck (2006) has also considered the differences between the ICF view of activities and participation and has also proposed that they are different. He proposed 11 differentiating criteria which are listed in Table II.

It is of note that some of the criteria used by the AIHW (AIHW, 2003, 2007) and Whiteneck (2006) accommodate the perspective of the first view presented in this section, in that some of their criteria also conceptualize activities and participation as being at different ends of the same continuum. They state variously that activities are simple whereas participation is complex; activities are less dependent on environment whereas participation is more dependent on environment (Whiteneck, 2006); activities are fine grained whereas participation is broad brushed (AIHW, 2003).

Other criteria suggest however that activities and participation are qualitatively different and perhaps represent two distinctly different constructs, for example, the AIHW propose that activity describes activities whereas participation involves choice and judgements (AIHW, 2007). Similarly, activity is

<table>
<thead>
<tr>
<th>Activity</th>
<th>Participation</th>
</tr>
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<tbody>
<tr>
<td>Individual level</td>
<td>Societal level</td>
</tr>
<tr>
<td>Performed alone</td>
<td>Performed with others</td>
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<tr>
<td>Simple</td>
<td>Complex</td>
</tr>
<tr>
<td>Related to impairment</td>
<td>Related to quality of life</td>
</tr>
<tr>
<td>Less environment dependent</td>
<td>More environment dependent</td>
</tr>
<tr>
<td>Medical model of disability</td>
<td>Social model of disability</td>
</tr>
<tr>
<td>Focus of rehabilitation</td>
<td>Focus of consumers</td>
</tr>
<tr>
<td>Assessed in hospital</td>
<td>Assessed in community</td>
</tr>
<tr>
<td>Clinician assessment</td>
<td>Self or proxy report</td>
</tr>
<tr>
<td>Not always possible</td>
<td>Always theoretically possible</td>
</tr>
<tr>
<td>Task</td>
<td>Social role</td>
</tr>
</tbody>
</table>

Table I. The differences between activities and participation in the context of a health condition (AIHW, 2007).

Table II. The ICF concepts of Activity and Participation differentiated by Whiteneck (2006).
assessed by a clinician, whereas participation is assessed by self or proxy report (Whiteneck, 2006). If activity and participation are indeed separate constructs then theoretically they are independent of each other. Therefore, a person’s ability to perform everyday tasks and actions (even with assistance) at the level of “Activity” could be independent of his/her level of “Participation” in everyday life situations.

A third, alternative view has been expressed in the clinical manual being developed by the American Psychological Association (APA) in collaboration with the WHO, to assist healthcare professionals to implement the ICF as a clinical tool. Currently in development, the Procedural Manual and Guide to the Standardized Application of the ICF: A Manual for Health Professionals (American Psychological Association, World Health Organization, in press), described in detail by Threats (2008), has chosen the fourth option offered by the ICF and treats all sets of categories as activities and participation. In the prototype of the manual developed in 2003, they argue that what is most critical for the clinical application of the ICF is not whether an item within a domain is identified as an activity or as participation but that the underlying constructs are fully expressed through the descriptions of the domains and the qualifiers (APA, 2003).

That is, instead of discussing the differences and similarities between activities and participation and then categorizing some domains as activities and/or as participation, the core group developing the Procedural Manual (APA, in press) has focused on ways to describe the differences between what the client does in the clinic room versus what the client does in his/her own life (Reed et al., 2005). This difference is expressed through the qualifiers, where the two capacity qualifiers “capacity without assistance” and “capacity with assistance” are considered measures of the person’s ability within the clinic setting and the performance qualifiers are measures of the person’s real life experiences. For example, the prototype guidelines in the Procedural Manual (APA, in press) for rating the performance qualifier for the code d330 “Speaking” states “when determining this qualifier, consider how the environment facilitates or impedes an individual’s ability to speak, taking into account unique demands encountered by that individual, levels and types of support, socio-cultural factors and laws, as well as the individual’s capacity to speak as determined through assessments that target this area” (p. II. 3–21). Therefore the Procedural Manual (APA, in press) seeks to make a clear distinction between just being able to speak (capacity) and the “lived experience” in the act of speaking.

This distinction is similar to how the AIHW (2003) differentiates activities and participation where activities are described as externally observable and assessable in a test environment versus participation which is described as the lived experience of the person and not assessable in a test environment. It is also similar to Whiteneck’s (2006) position where activities are measured by the clinician whereas participation is measured by self-report or proxy.

Describing the differences between a person’s ability in the clinic room compared with his/her lived experience is one of the most important aspects of the Activities and Participation component of the ICF and this distinction has been effectively captured in the development of the Procedural Manual (APA, in press). However grouping activities and participation together is not unproblematic. Some codes in some chapters, such as “Family relationships” (d760) and “Community life” (d910) are overtly participation in orientation and can not be measured in the clinic setting. The Procedural Manual (APA, in press) handles this situation by simply stating that certain codes will not have possible or feasible capacity codes and thus should be either left blank or coded as “not applicable”, thereby acknowledging that certain codes are participation in nature. Secondly, the capacity qualifier has also been developed to “identify the highest probable level of functioning that a person may reach in a given domain at a given moment” (WHO, 2001, p. 123). By aligning capacity with a person’s ability in the clinic room there is the risk that clinicians may either assume that a person’s highest probable level of functioning can always be revealed in the clinic setting or alternatively, that this aspect of capacity may be overlooked or lost.

Whether or not the Activities and Participation component of the ICF is believed to represent one underlying construct or two will have implications for future developments of the ICF. If it is agreed that the Activities and Participation component represents two different constructs then future versions of the ICF will separate Activities and Participation components and each component will have a separate set of domains, items and qualifiers. If it is decided that the Activities and Participation component represents the one construct, then future versions of the ICF may still choose to represent the individual and societal perspectives of functioning and disability by separate domains, items and qualifiers or may continue with the single list. However, if the Activities and Participation component continues to be represented by a single list of domains, items and qualifiers, there is the risk that this component will begin to be conceptualized and clinically interpreted to mean one perspective. The qualitatively different perspectives of functioning and disability at the level of the individual and at the level of society may become blurred and the potential avenues for assessment and intervention may become more limited as a result. The challenge for speech-language pathologists is to debate what these different perspectives mean for our clients, so that we...
can continue to develop our understanding of communication functioning and disability from both activities and participation perspectives. The discussion of activities and participation in general, provides a platform upon which to specifically explore the separate qualities of communication activities and communication participation, and these are described below.

Communication Activities

A review of functional communication assessments and the Activities and Participation component of the International Classification of Impairment, Disability and Handicap (ICIDH-2), the preliminary version to the ICF, was recently conducted by Worrall and colleagues (Worrall, McCooey, Davidson, Larkins, & Hickson, 2002). This article reviewed the ICIDH-2, described three participant observation studies of everyday communication and summarized currently available measures of functional communication. Whilst the observation studies have been reported in more detail elsewhere (Davidson, Worrall, & Hickson, 2003; Larkins, Worrall, & Hickson, 1999; O’Halloran, Worrall, & Hickson, 2007) they are discussed here in relation to what they can tell us about the nature of communication activities. The three participant observation studies described the everyday communication activities that occur in the lives of people with and without aphasia, people with and without traumatic brain injury (TBI) and people with and without communication disabilities who are patients in hospital.

These observation studies suggested that communication activities have some but not all of the characteristics identified in the discussions about activities described above. Some of the characteristics of communication activities that are consistent with general descriptions of activities are that the communication activities were carried out by an individual, they were externally observable by a clinician and could be described in terms of actions. In addition, it is possible that a person’s capacity to carry out most, if not all of these communication activities, such as, explaining a problem, introducing and giving instructions, could be assessed in a standardized, uniform clinical environment.

However, these studies also indicated that communication activities differ from an evolving understanding of the ICF definition of activities in some important ways. Firstly, the communication activities that were observed ranged from very simple such as greeting, gaining his/her attention to very complex such as explaining a problem, and selling. Secondly, and not surprisingly these studies also found that whilst some communication activities can be performed alone such as watching television, doing crosswords and studying, most communication activities, by their very nature, involve others such as asking for assistance, answering phone calls and telling personal details. Finally, given that many communication activities were carried out with others, the ability of a person to carry out a communication activity is very dependent on the communicative environment, such as the communication partner, rather than less so.

The ICF states that a person’s ability to undertake activities can be described in terms of his/her performance and capacity. As described above, the performance qualifier describes what an individual does in his or her current environment (WHO, 2001). Therefore, a person’s communication activity performance describes a person’s ability to carry out communication activities in his/her current environment. Communication measures such as the American Speech-Language-Hearing Association Functional Assessment of Communication Skills for Adults (ASHA-FACS; Frattali, Thompson, Holland, Wohl, & Ferketic, 1995) and the Communicative Effectiveness Index (CETI; Lomas et al., 1989) measure how well the person actually communicates in everyday life and therefore most closely approximate communication performance.

The capacity qualifier describes an individual’s ability to execute a task or action. The ICF states that a person’s optimal ability is determined in a standardized or uniform environment (WHO, 2001). This suggests that a person’s communication capacity, that is his/her optimal ability to carry out communication activities is revealed in a standardized or uniform environment. However this presents a problem. Given that a person’s ability to carry out communication activities is to a large extent dependent on his/her communicative environment, then a person’s optimal ability to carry out communication activities is unlikely to be revealed in a standardized or uniform environment, rather it is more likely to be revealed in a facilitative communicative environment (Kagan, 1995). Thus, the ICF definition of capacity is more complex for speech-language pathologists. A clinician seeking to understand a person’s communication activity capacity in a standardized, uniform environment may administer a measure such as the Communication Activities of Daily Living (CADL-2; Holland, Frattali, & Fromm, 1998) in the clinic room. The person’s communication activity limitation would be described in terms of the second qualifier “capacity without assistance”. In contrast, a clinician seeking to understand a person’s communicative capacity in terms of his/her optimal communication ability would need to observe the person communicating within an optimally facilitative communicative environment. The person’s communication activity limitation capacity would be described in terms of the third qualifier “capacity with assistance”. In some cases, the support needed by the person to communicate optimally may not be available in the clinic and the clinician would need to observe the person communicating in this facilitative communicative environment.
The ICF concept of participation is perhaps best embodied in aphasia by the social approach. The social approach encourages clinicians to emphasize the perspective of the person with aphasia, to consider the social and personal consequences of aphasia and to explore ways in which the person’s social and physical environment can be modified so that he/she is more likely to experience successful communicative interactions (Simmons-Mackie, 2000, 2001). Similarly, the Life Participation Approach to Aphasia describes ways to develop speech pathology services that support individuals with aphasia and others affected by aphasia in achieving their immediate and longer term life goals (Chapey et al., 2001). The needs and aspirations of the individual with aphasia is central to the social approach and the life participation approach and this quality is also embedded within a revised definition of functional communication as “being able to communicate competently, through your own communication skills and those of others, and feeling comfortable that you are representing who you are” (Byng, Pound, & Parr, 2000, p. 53).

Participation has also been defined in the research literature in various ways. For example, healthcare participation has been defined as how involved people (with communication disabilities) are in decisions about their healthcare. The barriers and facilitators that people with different kinds of communication disabilities and health and social care staff experienced in health care decision making were described through qualitative interviews (Byng, Farrelly, Fitzgerald, Parr & Ross, 2005). Resident participation in aged care facilities has also been investigated. Resident participation was defined as being involved in and consulted about matters that range from day to day care to broad policy (Hickson, Worrall, Wilson, Tilse, & Settlerland, 2005). A range of measures was used to describe residents’ activities and participation, including clinician rated measures, surveys, and questionnaires. The authors found that the surveys and questionnaires that directly investigated the residents’ opinions and experiences provided the most useful insights into resident participation (Hickson et al., 2005). Social participation has also been measured by the extent of people’s social networks and the range and frequency of their social activities (Cruice, Worrall, & Hickson, 2005) and the change in a person’s conversation styles and opportunities as measured on the Conversational Analysis Profile for People with Aphasia (CAPPA; Whitworth, Perkins, & Lesser, 1997) has also been considered evidence of a person’s life participation (Ross, Winslow, Marchant, & Brumfitt, 2006).

Finally, a recent review of communication participation measures also provides insights into the concept of communication participation. In that review, only measures that specifically targeted communication functioning, described communication exchanges involving more than one person and
were rated by the person with the communication disability were included (Eadie et al., 2006). Six measures underwent full review. These included four measures of voice as well as the ASHA Quality of Communicative Life scale (Paul et al., 2004) and the Burden of Stroke Scale (Doyle, McNeil, & Hula, 2003). The authors concluded that no existing instrument adequately measured communicative participation in its entirety.

The concept of communication activities shares some characteristics of the ICF concept of activities, in that they can be simple, observable and assessed in a clinic situation and some characteristics of the ICF concept of participation, in that they can also be complex, dependent on the environment and are usually performed with others. However the concept of communication participation sits well within the ICF concept of participation. This leads to the question: Are the concepts of communication activity and communication participation actually distinct in any way? One way in which they appear to be distinct is in how they are measured. Communication activities can be counted. Furthermore a person’s ability to undertake communication activities can be observed and described by a third person. However communication participation seems ultimately to be a subjective experience. Only people themselves can say if they feel they can express who they truly are in social interactions, how much they enjoy and feel included in a social situation, how much they feel listened to and involved in their own healthcare or how much they are accepted and valued where they live. Measures that identify how meaningful and relevant the life situations are for the person with a communication disability and measures that describe the person’s subjective experience communicating in these life situations seem key to understanding communication participation.

**Summary**

This paper has explored the ICF concepts of Activities and Participation with a particular emphasis on how these two concepts relate to each other and how they have been operationalized in research with adults with acquired communication disability. Although the ICF presents Activities and Participation as a single component with a single list of domains, the ICF states that the Activities and Participation component represents two different perspectives on functioning and disability. The qualitative differences between Activities and Participation are becoming clearer. The challenge for speech-language pathologists is to engage in this exploration. Not only will this assist the developers of future versions of the ICF to more accurately represent communication, but it will inform our clinical efforts as we continue to support our clients in having a say in their lives.

**References**


