UNIT I

Occupation Therapy: Profile of the Profession

Meditation on a Calling

To know what a calling truly is
you must discover its soul.
You must see those it has touched
— meet the people who have looked it in the eyes
and trusted in its possibilities.

To fully know what *this* calling is about
you must feel the deep emptiness of not doing,
of unfilled roles, abandoned goals and lost identities.
You must experience the indignities of pity—
how children stare, keenly aware of difference,
how others, more perfect, are offered work.

To be rightly immersed in this calling
you must learn the hymns of its language.
Let the words become notes that inspire you
to occupy fully the landscape its lyrics describe,
and explore its farthest boundaries with those you serve.

Only then can you begin to comprehend its fullness,
to appreciate why strangers once gathered near waters
to unify their vision in the service of others.
Only then can you grasp why their shared ideas endured
despite wars, rivalries and the seductions of simplicity.

Those with shattered bodies and minds appeared.
They came from great battles and daily calamities.
They sought healers with insights and ways for living
who grasped the truth that meaning arises from doing.

You have fully fathomed the depth of this calling
when your understanding starts with each story;
when participation is perceived as a primal need;
and when you recognize that therapy of value is alchemy
that melds science with imagination to enable hope.

Dedicated to the memory of my friend and colleague Gary Kielhofner (1949-2010).

—Charles Christiansen
March, 2017
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CHAPTER

1

What Is Occupation?

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OUTLINE

"MR. JOURDAIN. You mean to say that when I say, 'Nicole, fetch me my slippers' or 'Give me my nightcap' that's prose?
PHILOSOPHER. Certainly, sir.
MR. JOURDAIN. Well, my goodness! Here I've been talking prose for forty years and never known it. . . . "

—MOLIERE (1670)

LEARNING OBJECTIVES

After reading this chapter, you will be able to:

1. Identify and evaluate ways of knowing occupation.
2. Articulate different ways of defining and classifying occupation.
3. Describe the relationship between occupation and context.

Knowing and Learning about Occupation

In the myriad of activities people do every day, they engage in **occupations** all their lives, perhaps without ever knowing it. Many occupations are ordinary and become part of the **context** of daily living. Such occupations are generally taken for granted, and most often are habitual (Aarts & Dijksterhuis, 2000; Bargh & Chartrand, 1999; Wood, Quinn, & Kashy, 2002). Reading blogs, washing hands, gaming on the Internet, walking through a colorful market in a foreign country, and telling a story (in poetry or prose) are occupations people do without ever thinking about them as being occupations.

Occupations are ordinary, but they can also be special when they represent a new achievement such as driving a car or when they are part of celebrations and rites of passage. Preparing and hosting a holiday dinner for the first time and baking the pies for the annual family holiday for the twentieth time are examples of special occupations. Occupations tend to be special when they happen infrequently and carry symbolic meanings such as representing achievement of adulthood or one's love for family. Occupations are also special when they form part of a treasured routine such as reading a bedtime story to one's child, singing "Twinkle, Twinkle, Little Star," and tucking the covers around the small, sleepy body. But even special occupations, although heavy with tradition, may change over time. Hocking, Wright-St. Clair, and

Bunrayong (2002) illustrated the complexity of traditional occupations in their study of holiday food preparation by older women in Thailand and New Zealand. The study identified many similarities between the groups (such as the activities the authors named "recipe work"), but the Thai women valued maintenance of an invariant tradition in what they prepared and how they did it, whereas the New Zealand women changed the foods they prepared over time and expected such changes to continue. Nevertheless, the doing of food-centered occupations around holidays was a tradition for both groups.

To be human is to be occupational. Occupation is a biological imperative, evident in the evolutionary history of humankind, the current behaviors of our primate relatives, and the survival needs that must be met through doing (Clark, 1997; Krishnagiri, 2000; Wilcock, 2006; Wood, 1998). Fromm (as cited by Reilly, 1962) asserted that people have a "physiologically conditioned need" to work as an act of self-preservation (p. 4). Humans also have occupational needs beyond survival. Addressing one type of occupation, Dissanayake (1992, 1995) argued that making art, or, as she describes it, "making special," is a biological necessity of human existence. According to Molineux (2004), occupational therapists now understand humans, their function, and their therapeutic needs in an occupational manner in which *occupation is life itself* [emphasis added]. Townsend (1997) described occupation as the "active process of living: from the beginning to the end of life, our occupations are all the active processes of looking after ourselves and others, enjoying life, and being socially and economically productive over the lifespan and in various contexts" (p. 19).

The Need to Understand Occupation

Occupational therapy (OT) practitioners need to base their work on a thorough understanding of occupation and its role in health and survival. That is, OT practitioners should understand what people need or are obligated to do in order to survive and achieve health and well-being. Wilcock (2007) affirmed that this level of understanding includes how people feel about occupation, how it affects their development, the societal mechanisms through which that development occurs, and how that process is understood. Achieving that understanding of occupation is more than having an easy definition (which is a daunting challenge in its own right). To know what occupation is, it is necessary to examine what humans do with their time, how such activities are organized, what purposes they serve, and what they mean for individuals and society.

Personal experience of doing occupation, whether consciously attended to or not, provides a fundamental understanding of occupation—what it is, how it happens, what it means, what is good about it, and what is not. This way of knowing is both basic and extraordinarily rich. It is the way we learn to participate in the social worlds we inhabit.

Looking Inward to Know Occupation

To be useful to OT practitioners, knowledge of occupation based on personal experience demands examination and reflection. What do we do, how do we do it, when and where does it take place, and what does it mean? Who else is involved directly and indirectly? What capacities does it require in us? What does it cost? Is it challenging or easy? How has this occupation changed over time? What would it be like if we no longer had this occupation? To illustrate, Khalilah (first author) shares her experiences with cooking as she transitioned from home to college (Case Study 1-1).

Between college and the beginning of Khalilah's postgraduate career, cooking took on a different *form* (the need to prepare meals for herself as an independent adult), *function* (family-style meals were no longer reserved for times with family and friends but became a means to forge relationships with strangers), and *meaning* (a way to bridge and create new cultural experiences with her family and friends). These elements—the form, function, and meaning of occupation—are the basic areas of focus for the science of occupation (Larson, Wood, & Clark, 2003).

Khalilah's cooking and communal mealtime example described in Case Study 1-1 illustrates how occupation is a *transaction* with the *environment* or *context* of other people and cultures, places, and tools. It includes the *temporal* nature of occupation—seasonal travel to particular destinations and the availability of specific ingredients based on the season of travel. That she calls herself a cook exemplifies how occupation has become part of her *identity* and suggests that it might be difficult for her to give up cooking.

Basic as it is, however, understanding derived from personal experience is insufficient as the basis for practice. Reliance solely on this source of knowledge has the risk of expecting everyone to experience occupation in the same manner as the therapist. So, although OT practitioners will profit in being attuned to their own occupations, they must also turn their view to the occupation around them and to understanding occupation through study and research.

Looking Outward to Know Occupation

Observation of the world through an occupational lens is another rich source of **occupational knowledge**.

CASE STUDY 1-1 COOKING "SOUTHERN" AT COLLEGE

My first real attempt at cooking a meal independently was my freshman year of college. My dorm had a full kitchen, and I, like many college students, loathed dining hall dinners. I had grown up in a home where my parents prepared dinner nightly and we ate together as a family. My grandparents cooked dinner for our extended family every Sunday, and as Southern culture would suggest, I learned the proper way to braise vegetables, season and smoke meat and fish, concoct gravies, and bake an array of casseroles prior to graduating high school. Meal preparation and meal execution generally adhere to rules and techniques according to the macro culture, local or home culture of the person(s) performing it. Going to college required that I translate that cultural knowledge and adapt those rules to my new environment, understanding that the same products and tools to which I was accustomed would not be available. To build community, I began to cook traditional Southern meals in several kitchens around campus, taking up new ideas and techniques as I "broke bread" with other students. It was not until I received recognition from my peers that I considered myself a true Southern cook. Since that time, I have taken my love of cooking to international spaces, where I learn to prepare traditional meals of the native culture in a local person's home (Figure 1-1).

FIGURE 1-1 Khalilah (on the right) preparing fish.

Connoisseurs of occupation can train themselves to new ways of seeing a world rich with occupations: the way a restaurant hostess manages a crowd when the wait for seating is long, the economy of movement of a construction worker doing a repetitive task, the activities of musicians in the orchestra pit when they are not playing, the almost aimless tossing of a ball as students take a break from class, texting while engaging in social situations. Furthermore, people like to talk about what they do, and the scholar of occupation can learn a great deal by asking for information about people's work and play. By being observant and asking questions, people increase their repertoire of occupational knowledge far beyond the boundaries of personal interests, practices, and capabilities.

Observation of others' occupations enriches the OT practitioner's knowledge of the range of **occupational possibilities** and of human responses to occupational opportunities. But although this sort of knowledge goes far beyond the limits of personal experience, it is still bounded by the world any one person is able to access, and it lacks the depth of knowledge that is developed through research and scholarship.

Turning to Research and Scholarship to Understand Occupation

Knowledge of occupation that comes from personal experience and observation must be augmented with the understanding of occupation drawn from research in OT and occupational science as well as other disciplines. Hocking (2000) developed a framework of needed knowledge for research in occupation, organized into the categories of the "essential elements of occupation . . . occupational processes . . . [and the] relationship of occupation to other phenomena" (p. 59). This research is being done within OT and occupational science, but

there is also a wealth of information to be found in the work of other disciplines. For example, in anthropology, Orr (1996) studied the work of copy machine repairmen, and Downey (1998) studied computer engineers and what they did. Consumer researchers have studied Christmas shopping (Sherry & McGrath, 1989), motorcycle riding (Schouten & McAlexander, 1995), and many other occupations of consumption. Psychologists have studied habits (Aarts & Dijksterhuis, 2000; Bargh & Chartrand, 1999; Wood et al., 2002) and a wealth of other topics that relate to how people engage in occupation. Understanding of occupation will benefit from more research within OT and occupational science and from accessing relevant works of scholars in other fields. Hocking (2009) has called for more occupational science research focused on occupations themselves rather than people's experiences of occupations.

Defining Occupation

For many years, the word *occupation* was not part of the daily language of occupational therapists, nor was it prominent in the profession's literature (Hinojosa, Kramer, Royeen, & Luebben, 2003). According to Kielhofner and Burke (1977), the founding paradigm of OT was occupation, and the occupational perspective focused on people and their health "in the context of the culture of daily living and its activities" (p. 688). But beginning in the 1930s, OT strove to become more like the medical profession, entering into a paradigm of reductionism that lasted into the 1970s. During that time, occupation, both as a concept and as a means and/or outcome of intervention, was essentially absent from professional discourse. With time, a few professional leaders began to call for OT to return to its roots in occupation (Schwartz, 2003), and since the 1970s, acceptance of occupation as the foundation of OT has grown (Kielhofner, 2009). With that growth, professional debates about the definition and nature of occupation emerged and continue to this day.

Defining occupation in OT is challenging because the word is part of common language with meanings that the profession cannot control. The term *occupation* and related concepts such as *activity*, *task*, *employment*, *doing*, and *work* are used in many ways within OT. It seems quite logical to think of a job, cleaning house, or bike riding as an occupation, but the concept is fuzzier when we think about the smaller components of these larger categories. Is dusting an occupation, or is it part of the occupation of house cleaning? Is riding a bike a skill that is part of some larger occupation such as physical conditioning or getting from home to school, or is it an occupation in its own right? Does this change over time?

The founders of OT used the word *occupation* to describe a way of "properly" using time that included work and work-like activities and recreational activities (Meyer, 1922). Breines (1995) pointed out that the founders chose a term that was both ambiguous and comprehensive to name the profession, a choice, she argued, that was not accidental. The term was open to holistic interpretations that supported the diverse areas of practice of the time, encompassing the elements of occupation defined by Breines (1995) as "mind, body, time, space, and others" (p. 459). The term *occupation* spawned ongoing examination, controversy, and redefinition as the profession has matured.

Nelson (1988, 1997) introduced the terms **occupational form**, "the preexisting structure that elicits, guides, or structures subsequent human performance," and **occupational performance**, "the human actions taken in response to an occupational form" (Nelson, 1988, p. 633). This distinction separates individuals and their actual doing of occupations from the general notion of an occupation and what it requires of anyone who does it.

Yerxa et al. (1989) defined occupation as "specific 'chunks' of activity within the ongoing stream of human behavior which are named in the lexicon of the culture. . . . These daily pursuits are self-initiated, goal-directed (purposeful), and socially sanctioned" (p. 5). Yerxa (1993) further elaborated this definition to incorporate an environmental perspective and a greater breadth of characteristics. She stated,

> Occupations are units of activity which are classified and named by the culture according to the purposes they serve in enabling people to meet environmental challenges successfully. . . . Some essential characteristics of occupation are that it is self-initiated, goal-directed (even if the goal is fun or pleasure), experiential as well as behavioral, socially valued or recognized, constituted of adaptive skills or repertoires, organized, essential to the quality of life experienced, and possesses the capacity to influence health. (Yerxa, 1993, p. 5)

According to the Canadian Association of Occupational Therapists (as cited in Law, Steinwender, & Leclair, 1998), occupation is "groups of activities and tasks of everyday life, named, organized and given value and meaning by individuals and a culture." In a somewhat circular definition, they went on to state "occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity)" (p. 83). More recently, occupational scientists Larson et al. (2003) provided a simple definition of occupation as "the activities that comprise our life experience and

can be named in the culture" (p. 16). Similarly, after referencing a number of different definitions of occupation, the Occupational Therapy Practice Framework concluded with the statement that "the term *occupation*, as it is used in the *Framework*, refers to the daily life activities in which people engage (American Occupational Therapy Association [AOTA], 2014, p. S6). The previous definitions of occupation from OT literature help in explaining why occupation is the profession's focus (particularly in the context of therapy), yet they are open enough to allow continuing research on the nature of occupation. Despite, and perhaps because of, the ubiquity of occupation in human life, there is still much to learn about the nature of occupation through systematic research using an array of methodologies (e.g., Aldrich, Rudman, & Dickie, 2017; Dickie, 2010; Hocking, 2000, 2009; Johnson & Bagatell, 2017; Molke, Laliberte-Rudman, & Polatajko, 2004). Such research should include examination of the premises that are built into the accepted definitions of occupation.

At a more theoretical level, such an examination has begun. Several authors have recently challenged the unexamined assumptions and beliefs about occupation of Western occupational therapists (cf. Hammell, 2009a, 2009b; Iwama, 2006; Kantartzis & Molineux, 2011). These critiques center on the Western cultural bias in the definition and use of occupation and the inadequacy of the conceptualization of occupation as it is used in OT in Western countries to describe the daily activities of most of the world's population. Attention to these arguments will strengthen our knowledge of occupation.

Context and Occupation

The photograph of the two young boys playing in the garden sprinkler evokes a sense of a hot summer day and the experience of icy cold water coming out of the sprinkler, striking, and stinging the boys' faces (Figure 1-2). Playing in the sprinkler has a context with temporal elements (summer, the play of children, and the viewer's memories of doing it in the past), a physical environment (grass, hot weather, hose, sprinkler, cold water), and a social environment (a pair of children and the likelihood of an indulgent parent). Playing in the sprinkler cannot be described or understood—or even happen—without its context. It is difficult to imagine that either boy would enjoy the activity as much doing it alone; the social context is part of the experience. A sprinkler might be set up for play on an asphalt driveway but not in a living room. Parents would

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Occupation: Returning to Our Roots

An enhanced understanding of the contemporary ideas of the profession requires a review of its history. More specifically, this Centennial Notes box aims to review *occupation* as the construct central to our professional identity. Founders of the profession purposefully chose the term *occupation* as it was conceptualized as essential to achieving balance through *doing* or occupying one's time (Dunton, 1917), inherent in human nature, and manifested through in self-care, work, rest, play, and leisure (Meyer, 1922). Adolf Meyer believed engaging in occupations facilitated competence and pleasure in these areas; that is, a blending of work and pleasure—" . . . pleasure in the use and activity of one's hands and muscles . . . " (Meyer, 1922, p. 6). Adopting occupation as the core concept was confirmation and commitment to the profession's original mission and purpose (Evans, 1987). In 1922, Adolf Meyer and Eleanor Clarke Slagle "described a system of 'occupational analysis' as an essential component of the education for occupational therapists" (Bauerschmidt & Nelson, 2011, p. 339). However, the definition and conceptualization of occupation itself over the last 100 years has been influenced by the evolving climate of health care and scientific research. In their review of OT literature from 1922 through 2004, Bauerschmidt and Nelson (2011) noted that *occupation* was used heavily in the 1920s, replaced in whole or part by the word *activity* during the 1940s through 1960s, was not used much at all in the 1970s and 1980s, and resurged in the 2000s. This coincides with paradigm shifts from the crafts and rehabilitation of the 1920s and 1930s to medicalization mid-century and specialization of therapy services during the 1970s and 1980s. The 1990s and 2000s saw a return to occupation-centeredness. Today, occupation is simply defined in the third edition of the AOTA Occupational Therapy Practice Framework (2014) as the daily life activities in which people perform including activities of daily living (ADL), instrumental activities of daily living (IADL), rest, sleep, work, education, play, leisure, and social participation (AOTA, 2014). This shift now reflects the original values and ideas guiding practice and research.

FIGURE 1-2 Children playing in sprinklers.

be unlikely to allow their children to get soaking wet in cold weather. The contexts of the people viewing the picture are important, too; many will relate the picture to their own past experiences, but someone who lives in a place where lawn sprinklers are never used might find the picture meaningless and/or confusing, and a person living where drought is a constant would probably find this image upsetting. In this example, occupation and context are enmeshed with one another.

It is generally accepted that the specific *meaning* of an occupation is fully known only to the individual engaged in the occupation (Larson et al., 2003; Pierce, 2001; Weinblatt, Ziv, & Avrech-Bar, 2000). But it is also well accepted that occupations take place in *context* (sometimes referred to as the environment) (e.g., Baum & Christiansen, 2005; Kielhofner, 2002; Law et al., 1996; Schkade & Schultz, 2003; Yerxa et al., 1989) and thus have dimensions that consider other humans (in both social and cultural ways), temporality, the physical environment, and even virtual environments (AOTA, 2014).

Description of occupation as taking place *in* or *with* the environment or context implies a separation of person and context that is problematic. In reality, person, occupation, and context are inseparable. Context is changeable but always present. Cutchin (2004) offered a critique of OT theories of adaptation-to-environment that separate person from environment and proposed that John Dewey's view of human experience as "always situated and contextualized" (p. 305) was a more useful perspective. According to Cutchin, "situations are always inclusive of us, and us of them" (p. 305). Occupation occurs at the level of the situation and thus is inclusive of the individual and context (Dickie, Cutchin, & Humphry, 2006). Occupational therapy interventions cannot be context-free. Even when an OT practitioner is working with an individual, contextual element of other people, the culture of therapist and client, the physical space, and past experiences are present.

Is Occupation Always Good?

In OT, occupation is associated with health and well-being, both as a means and as an end. But occupation can also be unhealthy, dangerous, maladaptive, or destructive to self or others and can contribute to societal problems and environmental degradation (Blakeney & Marshall, 2009; Hammell, 2009a, 2009b). For example, the seemingly benign act of using a car to get to work, run errands, and pursue other occupations can limit one's physical activity and risk injury to self and others. Furthermore, Americans' reliance on the automobile contributes to urban sprawl, the decline of neighborhoods, air pollution, and overuse of nonrenewable natural resources. Likewise, industry and the work that provides monetary support to individuals and families may cause serious air pollution in expanding economies such as that of China (Facts and Details, 2012).

Personal and societal occupational choices have consequences, good and bad. In coming to understand occupation, we need to acknowledge the breadth of occupational choices and their effects on individuals and the world.

Organizing Occupation

Categorization of occupations (e.g., into areas of activities of daily living [ADL], work, and leisure) is often problematic. Attempts to define work and leisure demonstrate that distinctions between the two are not always clear (Csikszentmihalyi & LeFevre, 1989; Primeau, 1996). Work may be defined as something people *have* to do, an unpleasant necessity of life, but many people enjoy their work and describe it as "fun." Indeed, Hochschild (1997) discovered that employees in the work setting she studied often preferred the homelike qualities of work to being in their actual homes and consequently spent more time at work than was necessary. The concept of leisure is problematic as well. Leisure might involve activities that are experienced as hard work, such as helping a friend to build a deck on a weekend.

Take the two men plating salmon and vegetables (Figures 1-3) for example. Categorizing their activity presents a challenge. They are hovering over a kitchen counter, meticulously placing microgreens on top of the salmon using chef's tweezers. Their activity may be categorized as engaging in work or other productive activity. However, what is not known is whether this is

FIGURE 1-3 Two men plating salmon and vegetables.

paid work, caregiving work (e.g., feeding others in the home), or leisure. Both men are dressed in a chef's coat and an apron and utilizing tools that are not commonly used in home kitchens. This may give the appearance that they are engaging in paid work—chefs preparing a meal for paying patrons. But only the gentleman on the left is a chef, which may lead you to interpret the situation as a leisure activity for the gentleman on the right. Categorizing the totality of this occupational situation is complicated. No simple designation of what is happening in the picture will suffice.

Another problem with categories is that an individual may experience an occupation as something entirely different from what it appears to be to others. Weinblatt and colleagues (2000) described how an elderly woman used the supermarket for purposes quite different from provisioning (that would likely be called an instrumental activities of daily living [IADL]). Instead, this woman used her time in the store as a source of new knowledge and interesting information about modern life. What should we call her occupation in this instance?

The construct of occupation might very well defy efforts to reduce it to a single definition or a set of categories. Many examples of occupations can be found that challenge other theoretical approaches and definitions. Nevertheless, the richness and complexity of occupation will continue to challenge occupational therapists to know and value it through personal experience, observations, and scholarly work. The practice of OT depends on this knowledge.

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The Future of Occupation

The use of occupations to optimize engagement in daily life situates OT practice in a unique place in the health care landscape (Rogers, Bai, Lavin, & Anderson, 2017). Occupational therapy has been demonstrated to improve and maximize functional and social needs of clients through cost-effective occupation-based interventions, and the value of occupation is presumed to establish the profession as a health care leader for years to come (Lamb & Metzler, 2014). Within and beyond the health care arena, the challenge practitioners and researchers face is the evolving nature of occupations. Occupations change over time. Consequently, how individuals engage in them also changes over time. Some occupations come and go (e.g., for many, balancing a personal budget now requires access to online banking) or are entirely new (e.g., Khalilah's example of cooking in a local person's home when traveling abroad), and how occupations, in and of themselves, and occupational participation are conceptualized requires perpetual adaption. For instance, technology is so embedded in how occupations are performed every day that it is considered part of performance skills (AOTA, 2016).

In his 2017 Eleanor Clarke Slagle Lecture, Dr. Roger Smith charged OT practitioners to harness the potential of technology as it is inextricably linked to occupation and practice. Tech-driven occupations have changed our capacities for *doing*. That is, how individuals use their hands or bodies for engaging in occupation is not exclusive to the physical but includes virtual and sensorial experiences. Take self-driving vehicles for example. Autonomous driving systems have the potential to change the roles of occupational therapists as driver rehabilitation specialists by shifting focus from the physical capabilities of the person to the cognitive applications of the vehicle. Occupational therapy practitioners utilize technology to meet the needs of their clients, from using the timer function on an iPhone to pace activity to using an app to facilitate motor learning. Thus, incorporating application software technologies into intervention requires practitioners to be flexible, innovative, and knowledgeable of how tech trends impact occupation.

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CHAPTER 2

A Contextual History of Occupational Therapy

Charles H. Christiansen, Kristine L. Haertl

OUTLINE

LEARNING OBJECTIVES

After reading this chapter, you will be able to:

1. Examine how historical accounts are retrospective attempts to reconstruct and understand the events of the past with the purpose of gaining improved insight into the present.
2. Identify key personalities and events that influenced the founding and development of occupational therapy.
3. Analyze how wars, social movements, and legislation were associated with significant developments in occupational therapy.
4. Evaluate how mind/body dualism and the competition between social and biomedical approaches to health care have been persistent points of tension since occupational therapy's founding.

Introduction

Occupational therapy (OT) has a rich and complex history. It has been influenced, as all professions have, by world events, personalities, and social movements. In this chapter, we identify some of these factors as a way of understanding how OT came into being and evolved as a profession. Industrialization, the civil rights struggles for women and children, world wars, economic shifts, health care legislation, globalization, and the digital age have been major influences on the evolution of the profession. Occupational therapy's history demonstrates Kuhn's contention that science (and science-based professions) do not always progress in logical, uninterrupted, or predictable ways (Kuhn, 1996). Moreover, although OT began in the United States, it is important to remember that many of the factors influencing its development originated in Europe.

What Is a Contextual History?

Historical events happen in larger contexts. History shows that ideas that take hold often benefit from historical timing, the chance good fortune that we sometimes describe as "being in the right place at the right time." Successful ideas also require effective advocates and other conditions (Gladwell, 2002). The conditions that have influenced OT during its history have not always related to health care, yet they shaped attitudes and beliefs

that made people and societies more or less amenable to ideas, innovations, and actions. By providing a description of the contexts for events, historians offer *possible* explanations for why events occurred when and how they did. These explanations are of value if people are to derive lessons from the past. To present histories without contexts and without critical examination is to potentially oversimplify events and to miss opportunities to learn from them (Molke, 2009).

The Periods Covered by This Chapter

The periods identified for this chapter include 1700 to 1899 (a prehistory), 1900 to 1919, 1920 to 1939, 1940 to 1959, 1960 to 1979, 1980 to 1999, and 2000 to present. No two eras can claim equivalent impact on the profession because the people, ideas, contexts, and events influencing OT during each time period varied significantly in their importance.

To begin, we draw from Bing (1981), who identified the Age of Enlightenment as an especially fruitful time in the generation of ideas that influenced OT, a period that is appropriately called a "prehistory."

Occupational Therapy Prehistory: 1700 to 1899

Historical Context

During the first hundred years of this time frame (roughly 1700 to 1799), significant social movements sprang up in Western civilization that challenged authority and conventional thinking. This "age of enlightenment" marked the beginning of logical thinking as a trustworthy way of knowing (Paine, 1794). Great artists, composers, and thinkers in history flourished. The concepts of egalitarianism and idealism emerged, and the corruption, abuses, and intolerance of the church and state were challenged. Ideas broadened through intellectual discourse, conducted through regular social gatherings called salons and in academic societies (Sawhney, 2013). With the beginning of the Industrial Revolution, methods of mass production led to the printing and wide distribution of books, helping to spread ideas broadly (Hackett, 1992).

Industrialization brought new opportunities, yet there is evidence that the resulting human migration overwhelmed social infrastructures and created conflict as workers rebelled against exploitation and poor working conditions. Such migration, particularly in Great Britain and the United States, brought people from rural areas to the cities looking for work, often resulting in overcrowding and unsanitary work environments (Wilcock & Hocking, 2015). Great social change also challenged the ability of people to adapt; many relocated from rural to urban areas, encountered new cultures, and became factory workers.

In the United States, this period also witnessed a collision of moral values and economic traditions that resulted in a great Civil War. Tensions between moral values and economics have recurred at several points in American history, and these tensions are important to OT because the philosophy of the field has such a strong moral core, anchored in concerns for social justice (Bing, 1981).

Nowhere is this moral influence more apparent than in treatment for persons with mental illness. During the late eighteenth century, dramatic changes in how people with mental illness were viewed resulted in more humane treatment, first in Europe and later in the United States (Whiteley, 2004). An emerging belief influencing this change was that the "insane" were people reacting to difficult life situations and therefore must be treated with compassion (Gordon, 2009).

Although often associated with mental illness, **moral treatment** was also applied to physical illness because health and illness had been viewed as related to patient character and spiritual development (Luchins, 2001). This emergence of humanitarian treatment influenced the development of therapeutic communities and the emphasis on engagement of groups in productive activities (Whiteley, 2004).

The ideas of moral treatment also influenced social services, as exemplified by the settlement house movement. The settlement house movement originated in London at Toynbee Hall in 1884, (Harvard University Library, n.d.) a residence where middle class men and women lived collectively with the goal to share knowledge, skills, and resources with the poor and those less educated living nearby (Wade, 2005). It quickly spread to the United States, first at Coit Hall in New York and later at Hull House established in Chicago by Jane Addams and Ellen Gates Starr in 1889 (Harvard University Library, n.d.). Funded through philanthropy, Hull House aimed to create opportunity, participation, and dignity for those served and also became a center for social activism (Carson, 1990). Volunteer workers often lived in the settlement house communities and taught crafts and other practical skills of living. A related and concurrent development, called the arts and crafts movement, also began in Britain and sought to counter the negative consequences of industrialization by encouraging a return to artistic design and the unique and genuine appeal of handmade articles (Levine, 1987). Both the settlement house and arts and crafts movements, originating in Europe, influenced the use of curative occupations in mental illness, and this ultimately led to the birth of OT.

People and Ideas Influencing Occupational Therapy

In his Eleanor Clarke Slagle Lecture, Bing (1981) recounted many of the historical figures and ideas of the eighteenth and nineteenth centuries that he believed influenced the founding of OT. The figures he identified from the eighteenth century were John Locke, Philippe Pinel, and William Tuke. From the nineteenth century, Bing identified Adolf Meyer as a key figure.

John Locke, a physician and philosopher who lived in the late seventeenth century, is credited with advancing many ideas that later influenced the philosophy and practices of OT, including sensory learning and pragmatism (Faiella, 2006).

Philippe Pinel, superintendent of the Bicetre and Salpetriere asylums in Paris, reportedly ordered the removal of chains from some of the inmates held in these places and is widely regarded as a pioneer for more humanitarian treatment. His work emphasized leisure and occupational activities that later formed the foundation for the moral treatment era (St. Catherine University, 2017).

William Tuke, an English philanthropist who founded the York retreat, is credited with being the father of the moral treatment movement. Tuke was appalled by the inhumane conditions he observed in asylums and sought a more compassionate approach to mental health treatment. He eliminated restraints and physical punishment and encouraged conditions where patients could learn self-control and improve self-esteem through participation in leisure and work activities (Digby, 1985; Stanley, 2010).

Adolf Meyer, a Swiss-educated physician who emigrated to the United States in 1892 and became head of an asylum in Kankakee, Illinois, introduced the concept of individualized treatment and began a long career of innovation and leadership in American psychiatry, emphasizing the importance of understanding the key events in the life history of each patient (Figure 2-1) (Christiansen, 2007). While on a trip to the Chicago World's Fair in 1893, Meyer injured his leg and, during a brief convalescence in the city, visited Hull House, and this experience was thought to influence Meyer's thinking about the connections between daily occupations and mental illness. These concepts appeared in an important paper (the philosophy of occupation therapy) he would deliver three decades later at an early meeting of the newly created American Occupational Therapy Association (AOTA) (Lief, 1948; Meyer, 1922).

Influences on the Evolution of Occupational Therapy

During OT's prehistory, the seeds had clearly been planted for the ideas that would lead to the founding of the profession (Box 2-1). However, by 1899, its time had not yet come. In fact, the rise of large public asylums teeming with inmates, the shortage of well-trained physicians, and cost concerns led to a standard of care that fell far short of the individualized treatment and conditions idealized by the moral treatment movement. The ideas that eventually formed the beginning of the Society for the Promotion

FIGURE 2-1 Dr. Adolf Meyer (seated at far left), a Swiss immigrant known as the father of American Psychiatry, is shown with his staff at the Eastern Illinois Asylum at Kankakee, Illinois, around 1895. Dr. Meyer later became the head of psychiatry at Johns Hopkins University and was a strong advocate for OT after its founding. His philosophy paper on OT, delivered at the Fifth Annual Meeting of the AOTA, continues to be widely cited even today. (Photo credit: Meyer Collection, Allen Chesney Memorial Library, Johns Hopkins University. Used with permission.)

BOX 2-1 KEY POINTS: PREHISTORY (1700–1899)

- The Age of Reason emphasized logical ways of knowing, ultimately leading to scientific health care and today's evidence-based practice.
- Early roots of social justice led to moral treatment and more humane care for persons with mental illness, ultimately leading to curative treatment involving work.
- Industrialization and technological advances led to global migration and the settlement house movement, a birthplace of many ideas influencing OT.
- Key persons during this period included John Locke, Philippe Pinel, William Tuke, and Adolf Meyer.

of Occupational Therapy would have to be nurtured and applied by several different people in different settings before the profession of OT would take root in the United States.

1900 to 1919

Historical Context

The first two decades of the twentieth century was a period of bold optimism in the United States, driven by rapid innovation and growing prosperity. The century began with the assassination of President McKinley by an anarchist protesting corruption and social inequities tied to industrialization. McKinley was succeeded by his vice president, Theodore Roosevelt, an intelligent and audacious reformer. Although he was from a privileged background, Roosevelt was a populist who supported worker rights and consumer protection, fought cartels, started the Panama Canal project, created a powerful navy, and established a national park system to preserve federal lands (Brinkley, 2009).

This **progressive era** was rounded out by Presidents William Taft and Woodrow Wilson, each of whom was a highly educated and task-oriented leader. Overall, significant social progress, including reforms in education and mental health, occurred during this period; thanks to the influence of John Dewey (an educator) and William James (a psychologist), both of whom were supporters of pragmatism (Schutz, 2011).

The 19th Amendment of the U.S. Constitution, ratified in 1920, afforded women the right to vote, providing a springboard for the advancement of women throughout the culture, particularly in the workplace (Greenwald, 2005). This was significant for OT because its workforce was overwhelmingly dominated by women.

Three years earlier, in 1917, after a period of neutrality and unsuccessful efforts to broker peace, the United States was drawn into the "The Great War," a pointless and horrendous world conflict that began in 1914 and ended on November 11, 1918. Overall, the war resulted in more than 15 million deaths, with 7 million soldiers sustaining wounds resulting in permanent disability (Votaw, 2005). As American soldiers prepared for battle, the War Department, at the request of General John J. Pershing, mobilized plans for the care of wounded soldiers whose disabilities would require rehabilitation and vocational reeducation (collectively called *reconstruction* at the time) to return them to civilian employment (Andersen & Reed, 2017; Quiroga, 1995). Given the horrors of the war, the idea of sending untested occupational and physical therapists, called **reconstruction aides**, to Europe was novel but incongruous, reflecting the sense of unrestrained optimism permeating American culture. Yet, because the war ended in November 1918, casualties for the American forces were relatively modest in comparison to other countries. Historians generally agree that the timing and fresh troops provided by America's entry, coupled with the attrition of enemy forces, were the primary reasons for the allied victory, not superior training, tactics or bravery per se (Hallas, 2009). Importantly, the reconstruction aide "experiment" was deemed a success, thus assuring that reconstruction aides (and later a field called *rehabilitation*) would have a permanent place within American health care.

People and Ideas Influencing Occupational Therapy (1900 to 1919)

Recall that the assassination of President William McKinley, who died from infection of his bullet wound, began this era. McKinley's preventable death and controversial medical care illustrated the variable quality of American medicine in 1900 (Fisher, 2001). This tragic event was an unfortunate precursor to reform efforts affecting medicine.

Not long thereafter (in 1910), Abraham Flexner completed a report on medical education for the Carnegie Foundation. His critical finding that most medical schools were substandard led to the closing of many "storefront" schools. His report recommended that only medical schools affiliated with large universities be recognized (Beck, 2004). The Flexner report ultimately led to increased emphasis on research and greater public awareness about the connection between science and its application in health care.

These developments set medicine on a firm course that emphasized science to the exclusion of other important factors in health, such as social, psychological, and spiritual influences (Kielhofner & Burke, 1977). It also increased the public standing and political power of organized medicine to an extent insulating it from legitimate criticism (Starr, 1983). Yet, a public that still believed that illness needed to be understood in spiritual and psychological terms did not universally welcome scientific medicine. These sentiments led to social movements that involved patients in the healing process and viewed spiritual and psychological factors as important aspects of healing.

One such movement was *Emmanuelism*, started by an Episcopal minister named Elwood Worcester in Boston (Andersen & Reed, 2017;Quiroga, 1995). The Emmanuel movement was patient-centered, holistic, community-based, and comprehensive, involving social services and lay practitioners. In 1909, public awareness of the movement increased with a series of articles in the widely popular weekly magazine, *Ladies Home Journal*

(Quiroga, 1995). This increased visibility brought criticism from conservative physicians, who questioned its church-based delivery and its use of lay practitioners (Williams, 1909).

During this period, Massachusetts-based physician **Herbert J. Hall** adopted a work-based approach for treating *neurasthenia*, a functional nervous disorder resulting in fatigue and listlessness thought to be caused by the stress of societal change and the new cultural emphasis on productivity and efficiency (Beard, 1880). Hall agreed that the "rest cure" (popular at the time) was the wrong treatment for neurasthenia (Figure 2-2). Instead, Hall's "work cure" at the Marblehead sanatorium in Massachusetts sought to actively engage patients in activities such as weaving, basketry, and pottery, taught by skilled artisans, such as Jessie Luther, who had worked at Hull House in Chicago (S. H. Anthony, 2005). The new "work cure" approach became a suitable response to calls for improved mental health care. The "work cure" was also adopted at the Adams Nervine Asylum in Jamaica Plain, Massachusetts, where nurse **Susan E. Tracy** was hired to train nurses and to develop an active approach for treating patients (Quiroga, 1995).

In 1910, Tracy wrote the first book on therapeutic use of occupations, sometimes referred to as the "work cure approach", called *Studies in Invalid Occupation* (Tracy, 1910). Although primarily a craft book, Tracy's work applied the ideas of William James's pragmatism and led to her involvement in the first course on occupations for patients in a general hospital setting at the Massachusetts General Hospital (Quiroga, 1995).

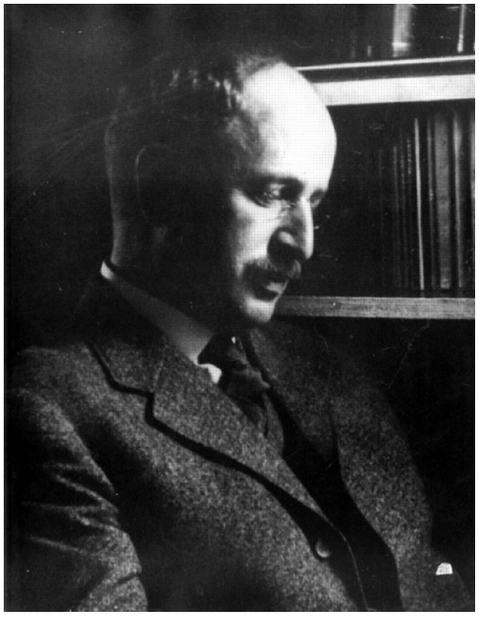


FIGURE 2-2 Dr. Herbert J. Hall, Massachusetts psychiatrist and proponent of curative occupations, played a prominent role in the evolution of OT. (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

Tracy's book influenced **William Rush Dunton**, Jr., a psychiatrist practicing at the Sheppard and Enoch Pratt Asylum in Baltimore, to teach his own course on occupations and recreations for nurses working there. In 1912, Dunton was placed in charge of programs in occupation and later wrote his own book on OT (Andersen & Reed, 2017; Bing, 1961). Dunton's enthusiasm was such that he later became a significant advocate and leader in developing the OT profession.

In 1908, **Clifford Beers**, a Yale-educated businessman, wrote *A Mind That Found Itself*, a critical account of his treatment for mental illness in an asylum and his eventual recovery (Beers, 1908). His book spurred reforms in mental health care that led to the creation of the mental hygiene movement. This movement aimed to improve treatment of mental illness by placing emphasis on prevention efforts and providing care outside asylums (Dain, 1980).

As the first decade of the twentieth century ended, many state mental hospitals were using occupations as a regular part of their treatment. Under the auspices of the Hull House in Chicago and influenced by the mental hygiene movement, coursework in occupations and amusements for attendants at public hospitals and asylums began under the newly formed Chicago School of Civics and Philanthropy (Loomis, 1992; Quiroga, 1995).

One of the social work students at the school in a course called *curative occupations and recreations*, **Eleanor Clarke Slagle**, believed that the principles taught there could be applied usefully to idle patients in the state mental hospital at Kankakee, Illinois (Christiansen, 2007; Quiroga, 1995). Slagle's interest in curative occupations gave her impetus to do more study and later develop the curative occupations therapy program with Adolf Meyer at the prominent Phipps Clinic in Baltimore (associated with Johns Hopkins University), where she collaborated with Dr. William Rush Dunton, Jr., at the nearby Sheppard and Enoch Pratt Asylum (Andersen & Reed, 2017; Bing, 1961).

Meanwhile, in 1912, Elwood Worcester of Boston, one of the founders of the Emmanuelism movement, was invited to the Clifton Springs Sanitarium in upstate New York to teach courses to the patients there. One of the patients was an architect, **George Edward Barton**, who was recovering from tuberculosis and hysterical paralysis resulting from his experiences in the Western United States. Barton was so influenced by his personal benefit from the work cure that he became a zealot for using occupations in the recovery of physical illness. Upon his discharge, from the sanitarium, he studied nursing at the facility's school and opened "Consolation House," a convalescence center through which he hoped to apply the ideas of the emerging curative occupation ("work cure") philosophy (Figure 2-3) (Andersen & Reed, 2017; Quiroga, 1995).

Barton began corresponding with prominent advocates for curative occupations, including Susan Tracy, Susan Cox Johnson, and William Rush Dunton, Jr. From 1914 to 1917, Barton wrote articles and developed plans for establishing a profession of caregivers dedicated to the use of occupations in therapy. Dr. Dunton assisted him, but Barton was initially hesitant to use the physician's help, fearing that his lack of medical credentials might diminish his own role. Finally, in mid-March, 1917, the first organizing meeting of the Society for the Promotion of Occupational Therapy was hosted by George Barton at Consolation House in Clifton Springs, New York (Andersen & Reed, 2017; Bing, 1961).

In attendance at that meeting were Barton, Isabel Newton (his secretary and future wife), William Rush Dunton, Jr., Eleanor Clarke Slagle, Thomas Kidner, and Susan Cox Johnson, who had organized many curative occupation programs in New York City. Susan Tracy of Massachusetts had been invited but was not able to attend (Andersen & Reed, 2017). The meeting at Consolation House drew up a charter of incorporation, drafted a constitution for the new society, named committees, planned for an annual conference, and elected officers, with Barton as the inaugural president and Slagle as the vice-president (Andersen & Reed, 2017; Bing, 1961).

The following month, after the loss of American citizens with the sinking of the ocean liner *Lusitania* by German submarines, the United States entered World War I (WWI). The war had begun in 1914, but public opposition to involvement in the United States had remained strong because the casualties wrought by modern weaponry were enormous and neither the Allies (mainly Russia, France, and Great Britain) nor the Central Powers (Germany, Austria-Hungary, and the Ottoman Empire) were making much progress despite these losses. Once public sentiment changed and war was declared, a massive war mobilization effort was undertaken during the ensuing months. Mindful of the war's huge scale and its immense number of casualties, the War Department undertook careful planning to provide assistance to wounded and disabled soldiers who would return from combat (Andersen & Reed, 2017; Quiroga, 1995).

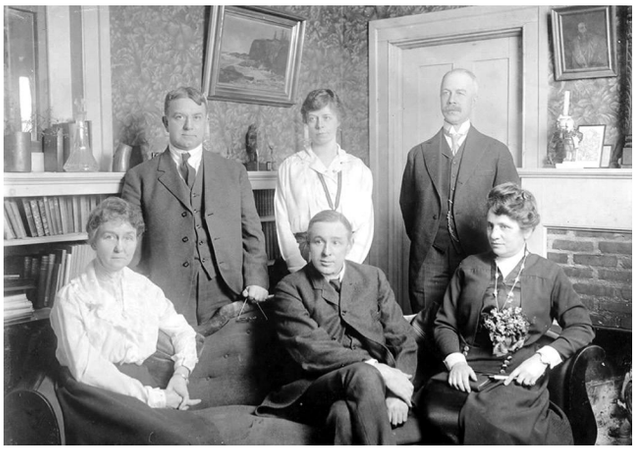


FIGURE 2-3 Society for the Promotion of Occupational Therapy Founders at Consolation House, Clifton Springs, New York, March 1917. Front row (left to right): Susan Cox Johnson, George Edward Barton, and Eleanor Clarke Slagle. Back row (left to right): William Rush Dunton, Jr., Isabel Newton, and Thomas Bessell Kidner. (Photo credit: Archives of AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

These planning efforts were given a head start through work by the Canadians, who, as part of the British Commonwealth, had been involved in the war since its inception. The vocational secretary for the Canadian Military Hospitals Commission, **Thomas B. Kidner**, a noted expert in manual training and technical education who had experience with vocational rehabilitation in England, was loaned to the U.S. government to assist with vocational rehabilitation efforts (Friedland & Davids-Brumer, 2007; Friedland & Silva, 2008). Then, emerging medical specialties, such as orthopedics, also sought to improve their standing during the war, which created some resistance to the inclusion of an untested group of occupation workers in this effort (Quiroga, 1995, p. 152).

Developments in Occupational Therapy (1900 to 1919)

In the period before WWI, several activities pursued independently by different individuals in different locations would come together in March 1917 during the meeting organized by Barton in Clifton Springs. The organizational meeting establishing OT included discussion about training programs and the need for standards (Andersen & Reed, 2017).

At that time, several programs for training occupation workers had been established in the United States, some of which were organized for nurses and others that were freestanding or organized under the auspices of settlement houses. The need for occupation workers in asylums had received significant impetus from the mental hygiene movement, reform efforts in mental health, and for patients recovering from physical injuries and chronic illnesses such as tuberculosis.

During its mobilization planning for WWI, the United States anticipated the need for a significant number of facilities and rehabilitation workers. Although there were efforts to recruit men to these roles, the military soon realized that women could be recruited and be trained to support the effort (Crane, 1927, p. 57). Some existing programs for curative occupations added courses to meet the anticipated standards of the surgeon general, whereas others were established in large East Coast cities explicitly for the war effort (Figure 2-4) (Andersen & Reed, 2017; Quiroga, 1995).

FIGURE 2-4 Reconstruction aides on parade in New York c. 1918. (Photo credit: Image Archive, U.S. Army Medical Department, Office of Medical History.)

Success in quickly establishing these important war training courses for reconstruction aides was made possible through the efforts of committed and prominent individuals who were able to organize the financial and political resources necessary to establish high-quality schools (Andersen & Reed, 2017; Quiroga, 1995). For various reasons, it was decided that a division of roles would be necessary with some reconstruction aides assigned to do orthopedic work, corrective exercise, and massage, whereas others, who became occupational therapists, provided handicrafts and support for "shell shock" which resulted from the stressful conditions of trench warfare, poisonous gas, and constant explosions from artillery (Low, 1992) (Figure 2-5).

FIGURE 2-5 Reconstruction aides in workshop preparing projects at base Hospital No. 9. Chateauroux, France, during World War I. (Photo credit: Image Archive, History of Medicine Collection, National Library of Medicine.)

Despite the success in recruiting and training qualified reconstruction aides for the war effort, the initial placement of these trained aides proved to be difficult because some physicians continued to view OT as a fad, failing to appreciate that it could have a worthwhile role in the treatment of wounded soldiers. However, after OT reconstruction aides achieved success at base hospitals in France, attitudes began to change (Andersen & Reed, 2017; Low, 1992; Quiroga, 1995).

By November 1918, when Germany and its allies surrendered, at least 200 reconstruction aides were serving in 20 base hospitals in France (Quiroga, 1995). The war ended on November 11, 1918. Between 1917 and January 1, 1920, nearly 148,000 sick and wounded men were treated upon their return to the United States at 53 reconstruction hospitals (Office of the Surgeon General, 1918). The military specifications governing OT for returning soldiers declared that it should have a purely medical function and be prescribed for the early stages of convalescence to occupy the soldier's minds. Even at this early date, there was a lack of clarity and considerable ambiguity in the roles and functions of the reconstruction aides providing OT. However, leadership in the newly formed professional association for OT, which was now known as the AOTA, provided wise advocacy for the recruitment of high-quality trainees. Dr. William Rush Dunton, Jr., succeeded George Barton as president of AOTA in 1917, and his friend Eleanor Clarke Slagle later succeeded him in the role. This provided a period of thoughtful and successful leadership that helped the new profession gain momentum and legitimacy after the war (Quiroga, 1995). See Box 2-2 for a summary of important influences and social movements from this period that impacted OT's development.

1920 to 1939

Historical Context

As the Treaty of Versailles following WWI was negotiated by the allies, President Woodrow Wilson proposed a League of Nations to prevent such wars from recurring. Wilson was successful in getting these terms into the treaty, but he suffered a severe stroke and the U.S. Congress never ratified them reportedly because Wilson refused to compromise on minor details of the ratification (Eubank, 2004). Ironically, the harsh conditions and reparations imposed on Germany at Versailles and the absence of U.S. leadership to organize the League of Nations contributed to political instabilities in Europe, economic shifts, and a rise in nationalism, which led to mistrust between various nations. Eventually, the rise of fascist leadership in Germany and Italy and additional

BOX 2-2 KEY POINTS: EARLY YEARS AND WORLD WAR I (1900–1919)

- A period of progressive movements in the United States brought political and social reform to improve working conditions, advance women's rights, and improve medicine and psychiatry.
- The arts and crafts and curative occupation movements, which were reactions to industrialization and modernization, led to the formation of a formal OT professional society in 1917.
- The U.S. entry into World War I created the need for services to reconstruct wounded soldiers, giving OT an early opportunity to advance its cause.
- Key people during the era included Herbert Hall, George Barton, Eleanor Clarke Slagle, William Rush Dunton, Jr., Susan Tracy, Adolf Meyer, and General J. J. Pershing.

tensions foreshadowed Hitler's decision to invade Poland in September 1939 and begin what was to become World War II (WWII) (Zaloga, 2004).

Within the United States, the period from 1920 to 1939 framed the continuation of significant societal transformations as women asserted their right to vote. The first decade of this period is sometimes called the "roaring twenties" because the advancements of the era in manufacturing, transportation, and communication encouraged a sense of optimism and excess (Cooper, 1990). Profits in industry allowed increased earnings for workers, and the introduction of installment buying led to a very high level of consumerism that fueled a robust economy. Yet, new wealth encouraged widespread and irrational speculation in the stock market, which contributed to the stock market crash of 1929 and a long period of hardship that followed, known as the *Great Depression*.

In rural areas, the economic situation was made more difficult by a persistent drought that was worsened in some areas by poor conservation (Egan, 2006). With unemployment at 25% and family incomes sliced in half, many people were desperate (McElvaine, 1993). President Herbert Hoover, an engineer, humanitarian, and respected administrator, was unable to contend with a crisis made worse by a financial disaster in Europe. In 1932, Franklin D. Roosevelt was elected to the first of four terms, and he quickly moved ahead with economic and social reform programs, collectively called the "New Deal." These included Social Security, higher taxes on the wealthy, new controls over banks and public utilities, and enormous work relief programs for the unemployed, including the Civilian Conservation Corps for rural conservation and environment projects and the Works Progress Administration focusing on constructing or repairing bridges, libraries, and public buildings (Kennedy, 1999). There were also efforts to support artists to create public murals, sculptures, and paintings and writers to produce books and plays. These government-sponsored programs contributed to the public's recognition that creative and productive activities were essential for both economic and social and psychological benefit.

People and Ideas Influencing Occupational Therapy (1920 to 1939)

The founders of the National Occupational Therapy Society had set events in motion for the rapid evolution of their new profession. After George Barton's abrupt resignation in 1917, **Dr. William Rush Dunton, Jr.**, (Figure 2-6) helped to advance the new society, which was then focusing

FIGURE 2-6 William Rush Dunton, Jr., MD, a physician at the Shepard and Enoch Pratt Hospital near Baltimore, was a founder of AOTA, an early president of the organization, and a strong proponent of OT. He was a prolific writer of articles and books and served as founding editor of the profession's first journal, *Archives of Occupational Therapy*. (Photo credit: Archives of the AOTA.)

on standardizing educational programs. Dunton embraced Adolf Meyer's theory of psychobiology, which provided a common sense approach to treating mental illness (Christiansen, 2007; Lief, 1948). Psychobiology was holistic and practical, emphasizing that mental disease was reflective of habit disorganization in the lives of those affected. Meyer believed that humans organized time through doing things and that a balance of activities involving work and rest was essential for well-being. More importantly, Meyer and Dunton shared the belief that occupational therapists had an important role in helping patients reorganize their daily habits and regain a sense of optimism. Meyer expressed these ideas in a paper given at the Fifth Annual Meeting of the AOTA held in Baltimore, Maryland, during October 1921 (Meyer, 1922).

Meyer's ideas were consistent with the emerging central beliefs of OT in that it recognized that forced idleness during convalescence was not only morally wrong but also disorienting and physically debilitating. Through engagement in occupations, Meyer asserted that patients could ward off depression and gain a sense of self-confidence that would help motivate them further (Christiansen, 2007). There were also economic motivations to normalize lives by enabling individuals to develop skills that would help them become economically independent of assistance by the state (Figure 2-7).

FIGURE 2-7 Dr. Adolf Meyer, a renowned psychiatrist and advocate for OT, shown at the Henry Phipps Clinic at Johns Hopkins University around 1915. (Photo credit: Meyer Collection, Alan Chesney Memorial Library, Johns Hopkins University.)

Within psychiatry, other theoretical perspectives, including the work of Sigmund Freud, overshadowed Adolf Meyer's theory of psychobiology. Freud's emphasis on unconscious drives captured the interest of many psychiatrists as well as the general public (Burnham, 2006). Freudian psychoanalysis remains a contentious topic (Brunner, 2001), and many historians view the distraction it created as a scientific setback (Eysenck, 1985). Moreover, the progress made in general medicine in treating common diseases during that era encouraged pursuit of biological explanations in the treatment of mental illness. One theory held that mental conditions were caused by focal infections in the body and led to unnecessary and sometimes harmful surgeries to some institutionalized mental patients because patient consent was not yet required for experimental procedures (Scull, 2005). Electroconvulsive treatments and lobotomies began to be used with both positive and negative consequences, and these treatments remain controversial (Fink & Taylor 2007; Pressman, 1998).

The trend toward medicalization in OT that occurred in the 1920s and 1930s was purposely influenced by strategic decisions of the profession's leaders. In their quest for professional legitimacy, OT leaders perceived that there would be benefit in allying more closely with organized medicine (Andersen & Reed, 2017). The rise of physical medicine and rehabilitation as a specialty of medicine and the leadership of **Frank H. Krusen, MD**, had a clear influence on the practice of occupational therapists in rehabilitation. Krusen believed that OT was simply a special application of physical therapy and that the two disciplines should merge (Krusen, 1934). This point of view had adherents in Canada, where training programs combined the theory and practices of both professions and produced graduates who could be dually credentialed (Friedland, 2011).

During the 1920s and 1930s, the principles of OT were also viewed as beneficial in the care of persons with tuberculosis, a disease stigmatized through its association with immigrants and poverty. Thomas B. Kidner, the Canadian vocational education expert who had been a member of the American Occupational Therapy Association founder's group at Clifton Springs, decided to remain in the United States after his temporary assignment to advise the surgeon general had concluded. Kidner, who served two separate terms as president of the AOTA, used his role as a vocational expert to plan facilities that included workspaces for OT and vocational training (Friedland & Silva, 2008). Kidner had a keen interest in the relationship between OT and vocational training, yet the formal relationship between these two important areas of social benefit remained distant well beyond his death in 1932. This unresolved issue would reemerge in an area of applied theoretical emphasis 30 years later known as "occupational behavior" (Kielhofner & Burke, 1977; Reilly, 1962).

Occupational Therapy (1920 to 1939)

In OT, the early part of this era was dominated by the continued "reconstruction" of wounded soldiers from WWI, which occurred at more than 50 hospitals established with reconstruction in mind (Quiroga, 1995). These facilities provided employment for occupational therapists in the early 1920s as did the curative occupation programs in place at mental hospitals (Hall, 1922).

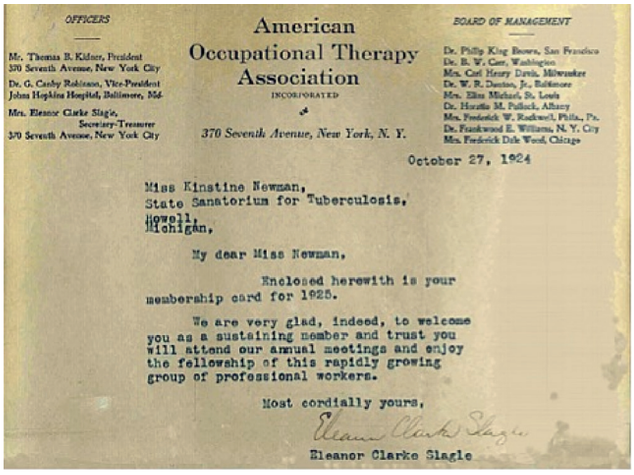
The AOTA became an effective organization for promoting the profession through its network of members, annual meetings, and the publication of a journal under three different names (*Archives of Occupational Therapy*, *Occupational Therapy and Rehabilitation*, and *American Journal of Occupational Therapy* [now *AJOT*]) between 1917 and 1925, at which time the association had nearly 900 members listed in its registry (Dunton, 1925) (Figure 2-8).

In order to continue the development and growth of the new profession during the 1920s, Eleanor Clarke Slagle, who served as president and later secretary-treasurer of the new society for 15 years, found creative ways to continue promoting the field through networking among women's clubs and the establishment of a national office in New York City (Figure 2-9) (Andersen & Reed, 2017; Metaxas, 2000; Quiroga, 1995). Attendance in the association and in the society grew steadily during this time so that by 1929, there were 18 state and local OT associations and approximately 1,000 members of the AOTA (Slagle, 1934). The association leadership continued to foster stability and quality in the profession by emphasizing standards for educational programs and their graduates. The profession worked to gain legitimacy through aligning itself with other professionals, especially physicians (Andersen & Reed, 2017; Quiroga, 1995).

In 1935, after several years of negotiation, the accreditation of OT programs was initiated in concert with the American Medical Association (Quiroga, 1995). During this period, male physicians dominated association leadership in OT; still, many more positions for occupational therapists were being created in specialized facilities for physical rehabilitation, mental health, and tuberculosis.

The emergence of physical medicine and rehabilitation in the mid-1930s, which had been influenced by physicians who used physical agents and practiced physical therapy, was reflected in many of the publications during this era (Slagle, 1934). Because occupational therapists assumed roles in rehabilitation units, they adopted goniometry and began adapting tools and equipment to enable patients to gain strength, endurance, and range of motion while doing crafts (Andersen & Reed, 2017).

During this period, polio epidemics and President Franklin Roosevelt's polio-related paralysis brought



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October 27, 1924

Miss Kinstine Newman,
State Sanatorium for Tuberculosis,
Howell,
Michigan,

My dear Miss Newman,

Enclosed herewith is your membership card for 1925.

We are very glad, indeed, to welcome you as a sustaining member and trust you will attend our annual meetings and enjoy the fellowship of this rapidly growing group of professional workers.

Most cordially yours,

Eleanor Clarke Slagle

FIGURE 2-8 Letter from Eleanor Clarke Slagle, secretary-treasurer of AOTA, acknowledging dues receipt to a new sustaining member from Michigan (October 27, 1924). (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-9 Eleanor Clarke Slagle. Her work as founder and tireless leader is recognized through a prestigious lectureship named in her honor. (Photo credit: Archives of the AOTA, Wilma West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-10 Franklin D. Roosevelt, president of the United States from 1933 to 1945, pictured with Ruthie Bie (a friend's grand daughter) and his dog Fala at the Roosevelt Cottage in Hyde Park, New York, in 1941. Roosevelt's legs became paralyzed at age 39 after an acute illness. Elected for four terms, he is known for many accomplishments, including the Social Security Act of 1935. (Photo credit: Franklin Delano Roosevelt Library, Library ID 73113:61.)

visibility and public awareness to the disease, leading to treatment facilities and research as well as specialized centers that employed occupational therapists and others for the care of patients (Figure 2-10). Polio epidemics peaked in 1952 and diminished after development of a vaccine by Jonas Salk a decade later (Oshinsky, 2005).

Aided by the advocacy of Thomas B. Kidner, tuberculosis hospitals had also become settings where many occupational therapists assumed roles providing recuperative, diversional, and vocational therapy for long periods of convalescence (Friedland & Silva, 2008; Kidner, 1922). The principle of activity graded to provide appropriate challenge and physical demand for patients was, by this time, a well-established part of the OT regimen in physical rehabilitation (Laird, 1923). See Box 2-3 for a summary of social challenges and the profession's responses during this period.

1940 to 1959

Historical Context

By 1940, Europe was well embroiled in major turmoil; with Germany having already annexed Austria, it invaded Poland and Czechoslovakia. Those events were followed quickly by declarations of war by Great Britain and France and the invasions of Denmark, Norway, Holland, Belgium, and France. The German army was so dominant that it devastated French and British forces and forced the cross channel retreat of forces from both countries at Dunkirk (Ward & Burns, 2007). Italy joined Germany, and the war soon spread to North Africa. Meanwhile, Adolf Hitler exploited his occupation of the European continent to pursue massive genocide against the Jewish people (Bergen, 2016). Japan then joined the axis powers, further expanding the theater of war to the Pacific (Spector, 1984).

Despite the Neutrality Acts of the 1930s designed to prevent the United States from entering another war, the United States opposed Hitler, and when the Japanese attacked Pearl Harbor in December 1941, the United States entered WWII. With the numbers of men drafted to armed service, the severe unemployment of the late 1930s gave way to a workforce shortage that plagued all areas of industry. This led to an influx of women into the workforce. Many hospitals were understaffed and ill-equipped to meet health care needs of those at home as well as soldiers returning from combat. Health challenges of returning veterans included diseases such as tuberculosis, hepatitis, and rheumatic fever but also war injuries, including amputations and chemical wounds (Richards, 2011).

BOX 2-3 KEY POINTS: POSTWAR GROWTH AND ADVANCEMENT (1920–1939)

- In the aftermath of the treaty ending World War I, advances in manufacturing and great optimism led to consumerism and speculation, leading to a stock market crash and the Great Depression.
- The AOTA, led by wise leaders, focused on allying itself with physicians and hospitals and developing and standardizing its educational programs while distinguishing itself from vocational and medical rehabilitation.
- Occupational therapy practice expanded into specialized hospitals treating tuberculosis and polio.
- Key people during the era included Eleanor Clarke Slagle, William Rush Dunton, Jr., Thomas Kidner, and Adolf Meyer.

According to the U.S. Department of Veterans Affairs (2015), WWII killed more people, destroyed more property than previous wars, and was among the most devastating in history, with more than 16 million serving in the armed forces and more than 291,000 American deaths. Total estimates of global fatalities vary, but it is generally accepted that they exceeded 60 million. The economic and social effects of WWII brought changes in health care and the passage of a number of U.S. legislative acts to fund research and services to returning veterans.

The Public Health Service Act gave the National Institutes of Health (NIH) permission to grant awards for nonfederal research, the GI Bill of 1944 funded efforts to aid veterans to transition back to civilian life, and in 1946, President Harry Truman signed the Mental Health Act, which was designed to provide funding for mental health services and research (Harlow, 2007). Rehabilitation expanded to assist veterans to return to work as the amendments in 1943 and 1954 of the Vocational Rehabilitation Act emphasized physical and mental restoration leading to a rise in the development of curative workshops (Gainer, 2008).

The post-WWII era saw the start of the Cold War marked by tensions with Russia that were caused by the conflicting ideals of the democratic philosophies of the United States and the communist beliefs of Russia. Globally, as Japan started to rebuild post-WWII, the Korean War again brought armed forces from the United Nations (including the United States) to support the Republic of Korea (now South Korea). Domestically, post-WWII brought economic growth, and although the United States had only 6% of the world's population, it was producing half of the world's goods (American Machinist, 2000). Yet, despite the economic affluence, more than 36 million Americans remained impoverished, and social concerns were given new political emphasis (Huret, 2010).

As new economic growth and postwar social concerns marked the 1950s, major health care advances took place, including triumph over polio, the discovery of the DNA double helix, the development of the pacemaker, and the formation of the Joint Commission on Accreditation of Health Care Organizations (Gerber, 2007). Yet, despite these advances, there were still areas of health care in dire need of change. Mental health institutions were overcrowded and the rate of alcoholism and juvenile delinquency skyrocketed (Dworkin, 2010). As the stigmatizing effects of mental illness plagued the decade, patients and their families began organizing, and efforts were made to address concerns not only of the clients but also of their families (L. D. Brown, Shepherd, Wituk, & Meissen, 2008). This, paired with the discovery of the antipsychotic effects of chlorpromazine (Thorazine), ushered in a new era of psychiatric treatments for those with mental illness. Although, perhaps helpful, the reliance on pharmaceutical interventions and deinstitutionalization brought a new set of social and health care challenges.

Occupational Therapy (1940 to 1959)

Although occupational therapists didn't serve overseas in WWII, United States-based consultant positions were created along with emergency training programs to provide therapists for the treatment of veterans returning from war (Andersen & Reed, 2017; Hartwick, 1993). This was a time of immense growth and change in OT (Gordon, 2009) because the focus shifted from the use of arts and crafts toward rehabilitation techniques based on scientific methods. Emphasis was placed on reintegrating veterans into society, and therefore, the use of activities of daily living (ADL), ergonomics, and vocational rehabilitation gained favor in therapeutic communities (Gainer, 2008). With battlefield medicine focused on saving severely wounded soldiers, the development of prosthetics and orthotics gained momentum during this period (Ott, Serlin, & Mihm, 2002). Occupational therapists became involved in prosthetic training, which often entailed the use of adapted tools and involved strengthening and conditioning (Figure 2-11).

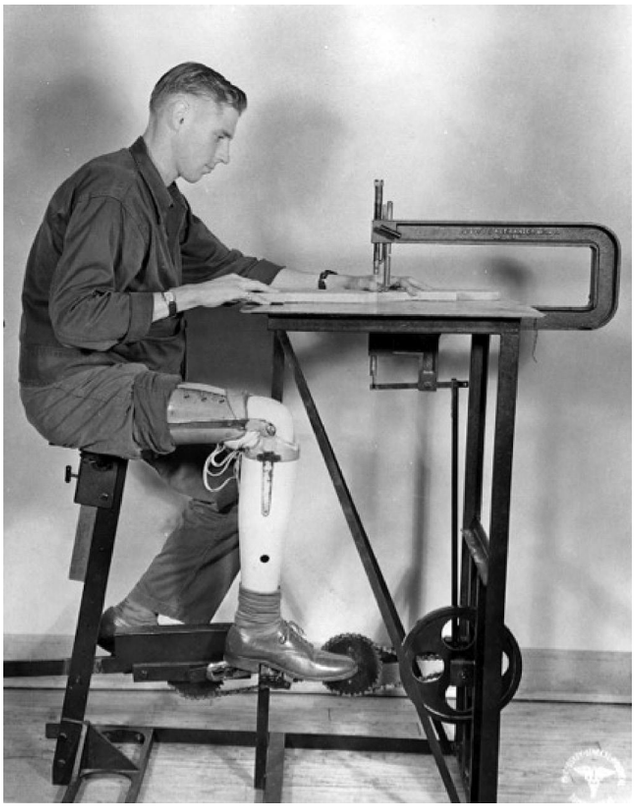

FIGURE 2-11 Bicycle jigsaw, common in physical rehabilitation OT clinics from the 1940s through the 1960s. (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

With the shift toward hospital-based therapy and the growth of rehabilitation, OT educational programs reorganized their curricula supported by the publication of the first OT textbook written in 1947 in the United States and edited by Helen Willard and Clare Spackman (Mahoney, Peters, & Martin, 2017; Willard & Spackman, 1947). That same year, the first woman and registered occupational therapist, Winifred Kahmann, became president of AOTA (Andersen & Reed, 2017). In 1949, guidelines for OT education were expanded through the Council on Medical Education and Hospitals and the *Essentials of an Acceptable School of Occupational Therapy* were established (Council on Medical Education and Hospitals, 1949).

In 1956, the OT assistant was created to help meet workforce needs, and in 1958, the AOTA took responsibility for accrediting assistant level OT programs (AOTA, 2009). Although the term *certified occupational therapy assistant* did not take hold internationally, countries such as Canada, Australia, and the United Kingdom developed positions similar to the OT assistant in order to augment the workforce demands of the profession (Nancarrow & Mackey, 2005; Salvatori, 2001).

Globally, the number of occupational therapists continued to increase as educational programs expanded, and by 1950, there were seven OT educational courses in England and one in Scotland (Oxford Brookes University, 2011). In 1952, preliminary discussions took place for the eventual formation of the World Federation of Occupational Therapists (WFOT) recognized in 1959 by the World Health Organization, which was at that time just over a decade old (WFOT, 2011). See Box 2-4 summarizing important challenges and the profession's responses from 1940 to 1959.

People and Ideas Influencing Occupational Therapy (1940 to 1959)

Influences on the profession during this period came from OT leaders in the Army as well as from therapists working with individuals having motor paralysis. Here, we include the Bobaths (physiotherapists practicing in England), Ruth Robinson, and Margaret Rood.

Karel and Berta Bobath: Berta Bobath was a German physiotherapist and her husband Karel was a Czech neuropsychiatrist. Together, they jointly developed a popular neurodevelopmental treatment (NDT), originally designed for persons with cerebral palsy but later applied to individuals with stroke or neurodevelopmental conditions. Although the approach originally used manual techniques to control tone and movement patterns, once they noticed a lack of generalization, the Bobaths expanded NDT to use normal play environments and natural contexts to encourage neurological development (Patel, 2005). Although studies question the effectiveness of NDT for various populations, the Bobaths' techniques are still used by occupational and physical therapists throughout the world, and their work encouraged study of the sensory links to motor output (Levin & Panturin, 2011).

Col. Ruth A. Robinson of the U.S. Army helped create OT educational programs for those preparing to serve in the military. Robinson proposed an accelerated training program to meet the needs for expansion during the Korean War (U.S. Army Medical Department, 2012). She continued in leadership positions, serving as the president of AOTA from 1955 to 1958 (Figure 2-12) (Peters, 2011b). During her time in the Army, Col. Robinson became chief of the Army Medical Specialists Corps and served as mentor to Wilma West and Ruth Brunyate (later Ruth Brunyate Wiemer), who later became colleagues and leaders in the AOTA.

Margaret Rood was an occupational and physical therapist credited as one of the earliest theorists on motor control. Rood stressed the importance of reflexes in early development and emphasized the use of facilitation and inhibition techniques, which were soon after used and expanded on by the Bobaths. In addition to clinical work, Margaret Rood took on leadership and educational positions including the development of the Occupational Therapy Department of the University of Southern California (USC), where she served as the first chair (USC, n.d.).

BOX 2-4 KEY POINTS: WORLD WAR II AND CONTINUED DEVELOPMENT (1940–1959)

- World War II, fought in European and Pacific theatres, causes the mobilization of men and material as the United States enters the war in 1941 following the attack on Pearl Harbor.
- Occupational therapy, still influenced greatly by its ties to medical rehabilitation, once again plays a key role in the care of wounded soldiers.
- Developments in prosthetics, assistive technology, neurodevelopmental care, and compensatory techniques for therapy accelerate as part of the war effort.
- Key personalities of the period include Ruth Robinson, Margaret Rood, and Karel and Berta Bobath.

FIGURE 2-12 Col. Ruth A. Robinson. Robinson established accelerated programs in the U.S. Army to train therapists for the Korean War and served several leadership roles in the AOTA, including that of president from 1955 to 1958. (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-13 Lyndon B. Johnson signing the 1965 Medicare and Medicaid Legislation with former President Harry S. Truman, Mrs. Truman, Mrs. Lady Bird Johnson, and members of Congress. (Photo credit: National Archives, photograph collection.)

1960 to 1979

Historical Context

During this time frame, Martin Luther King's famous speech, "I Had a Dream," (M. L. King, 1963) symbolized decades of the civil rights movement seeking equality and justice for African Americans. This was also an era of unrest and change marked by the "cold war," a prolonged period of distrust between the Soviet Union (Union of Soviet Socialist Republics [USSR]) and the United States. This political tension led to continued division of Germany and the construction of the Berlin wall, advancements in space science as the two superpowers developed their defense technologies, the Cuban Missile Crisis, and ultimately, a controversial war in Vietnam War. Kennedy's decision to pursue civil rights legislation provided the foundation for President Johnson to sign the **Civil Rights Act** into law in 1964, protecting individual rights and freedom from discrimination in areas such as voting, education, and employment (Andrews & Gaby, 2015). Concerns were raised regarding poverty, access to health care, and quality education for all, leading President Johnson to institute a number of other domestic programs commonly known as the "Great Society" aimed at reducing poverty and providing increased funding in areas such as education and health care (Warner, 2012). Perhaps foremost among these was legislation in 1965, establishing Medicare and Medicaid (Figure 2-13), which provided health care access to millions of seniors and disabled and impoverished American citizens, many of whom previously did not have access to such care (Bakken, 2009). Similar efforts took place elsewhere during this period, with Canada instituting its federal-provincial universal coverage health care system in 1962 and many Western European countries instituting forms of social health insurance in the 1960s and 1970s (Saltman & DuBois, 2004).

By the 1960s, American health care had been modernized greatly with updated equipment, electric beds, advanced communication systems, and innovative laboratories. The demographics of hospitalization shifted because new medicines were discovered and medical advances escalated. With the mass production of antibiotics and other pharmaceutical treatments for physical and mental health conditions, there was a move away from the treatment of acute epidemic illness (e.g., polio and smallpox) toward increased need for care of chronic conditions such as rheumatism, arthritis, and heart conditions (U.S. Department of Health, Education, and Welfare, 1965). The rise of feminism also brought changes domestically and globally bringing new emphasis to women's health and increased representation of women in medical schools (Rosser, 2002). Health planning is increased in order to reduce duplication (Melhado, 2006), and private health insurance was widely provided by employers to compete for workers. Typically, these insurance plans had low deductibles and required little out-of-pocket cost by

beneficiaries (Thomasson, 2002). This, alongside the legislation providing government payments under Medicare and Medicaid, contributed to an overuse of services and further stimulated the growth and cost of health care.

A move to close state institutions for the infirmed, particularly those with mental illness, caused additional challenges. The emergence of psychotropic medications paired with the overcrowding and deplorable conditions of many state hospital systems led to the deinstitutionalization movement and subsequent closure of state and psychiatric hospitals both in Canada and the United States (Koyangi, 2007; Sealy & Whitehead, 2004). Although the aim was to contain costs and provide improved care in the community, the development of community mental health services was inadequate to address the demands (Koyangi, 2007). Many of those affected by deinstitutionalization wound up homeless or in the criminal justice systems (McGrew, Wright, Pescosolido, & McDonel, 1999). Efforts to shift the care for those with mental illness to the community have continued globally to the present day, yet challenges remain to provide adequate long-term care and housing.

Occupational Therapy (1960 to 1979)

The decades from 1960 to 1979 brought significant change to OT practice (Box 2-5). During the reorganization of the AOTA in 1964 under the presidency of Wilma West, renewed emphasis was placed on supporting scientific endeavors in OT (Yerxa, 1967b). The board supported the idea of reorganization and expansion, and in 1965, the American Occupational Therapy Foundation (AOTF) was established to advance the science of the field and improve its public recognition (AOTA, 1969). Efforts to emphasize science and theory development led to increased graduate education in the field and later led to a proliferation of models, theories, and frames of references for practice. Continued emphasis on the legitimacy of the profession increased efforts to regulate practice through state licensure legislation as the U.S. government, concerned about costs for outpatient therapy services, initiated the first caps on payments for services in 1972.

The practice of OT during this period was heavily influenced by medical rehabilitation, which continued the post-WWII mechanistic paradigm emphasizing neuromotor and musculoskeletal systems and their impact on function (Kielhofner, 2009). Advances in neuroscience motivated A. Jean Ayres to expand on the work of the Bobaths and Rood. Ayres used neuroscience to study perceptual motor issues in children and develop and apply a theory of sensory integration (Ayres, 1966, 1972). Influences on practice shifted from the holistic mind–body occupation-based philosophies to those with bottom–up approaches focusing on the underlying source of the problem, often with emphasis on reflex integration and motor function (Figure 2-14).

Various Great Society programs and the *Education for All Handicapped Children Act* (*1975*) expanded the scope and areas of practice for occupational therapists. Medicare and Medicaid laid the foundation for expanded services to the elderly, those with disabilities, and the poor, and the Education for All Handicapped Children Act mandated access to education for all children, including those with disabilities. These laws, governing provision for health care and educational services to expanded populations, led to expansion of work areas for occupational therapists as the need for therapists in educational systems continued to grow (Coutinho & Hunter, 1988). In 1965, new guidelines were developed for accredited OT programs in the United States, and in 1967, AOTA celebrated the 50th year of OT (Andersen & Reed, 2017).

Internationally, OT was guided by theory-driven clinical models but, similar to the United States, was also driven by the medical profession and the social and health care institutions because these were the main employers of

BOX 2-5 KEY POINTS: FURTHER EVOLUTION OF THE PROFESSION (1960–1979)

- The civil rights movement and the Great Society lead to historic legislation that influences health care and social justice.
- In OT, educational programs continue to mature and school-based practice gains great momentum with passage of the Education for All Handicapped Children Act; large mental institutions begin to close, affecting the number of therapists employed in longer term mental health settings; and the American Occupational Therapy Foundation (AOTF) is founded to foster scientific development.
- Increased emphasis is placed on sensorimotor therapies, particularly driven by neurodevelopmental theorists, and occupational behavior emerges as a counterbalance to the medicalization of therapy.
- Key personalities of the period are A. Jean Ayres, Mary Reilly, Gail Fidler, and Wilma West.

FIGURE 2-14 Therapy for developmental disabilities grew rapidly in the 1980s because therapists applied theories of reflex integration from the neurosciences. In this undated photo from the period, an unidentified therapist works with a young child. (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

occupational therapists (Clouston & Whitcombe, 2008). The ADL tools and adaptations were developed to accommodate for dysfunctions (Hocking, 2008), and the profession continued to emphasize scientific endeavors. There was also an increase in educational programs throughout the world, fostered in part by international efforts of representatives to the WFOT (Cockburn, 2001).

People and Ideas Influencing Occupational Therapy (1960 to 1979)

Mary Reilly became a distinguished clinician in the U.S. Army Medical Corps during the war (Figure 2-15) (E. J. Brown, 1996) and went on to earn her doctorate in education, serving as the chief of the Rehabilitation Department at the Neuropsychiatric Institute at the University of California, at Los Angeles. She later served as professor and chair in OT at USC, where she became an influential, if controversial, academician. Through her graduate students, she is credited with evolving a theoretical framework known as the "occupational behavior" frame of reference, which emphasized the development of work skills and the societal importance of productive occupations. This work influenced the development of the Model of Human Occupation (MOHO) originally advanced by a team of scholars led by Gary Kielhofner, Janice Burke, and others (Kielhofner & Burke, 1980). In her 1961

FIGURE 2-15 Dr. Mary Reilly created a frame of reference known as occupational behavior. She was the Eleanor Clarke Slagle lecturer in 1961 and a charter member of the Academy of Research of the American Occupational Therapy Foundation (AOTF). (Photo credit: Archives of AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

Eleanor Clark Slagle lecture, Reilly challenged the profession to reclaim its roots in occupation and famously proclaimed, "Man [sic], through the use of his hands as they are energized by mind and will, can influence the state of his own health" (Reilly, 1962, p. 2).

A. Jean Ayres, an occupational therapist and licensed educational psychologist, applied neuroscience to practice (Figure 2-16). Dr. Ayres was educated at USC, where she served as a student, scientist, practitioner, and educator. Within her research, Ayres developed tools for practice, including assessments of integrated sensory processing, later forming a battery known as the Sensory Integration and Praxis Tests (Ayres, 1989). In 1976, Ayres founded the Ayres Clinic, in which she combined teaching, research, and practice to develop her practice model of sensory integration (Kielhofner, 2009). Her theories and influence continue to present day.

Gail Fidler emphasized the use of occupation as a means for emotional expression (Figure 2-17). Fidler, a teacher and occupational therapist with a background in psychology, was influenced by her studies of interpersonal theory, self-esteem, and ego development (Miller & Walker, 1993). Gail Fidler became a leader in mental health

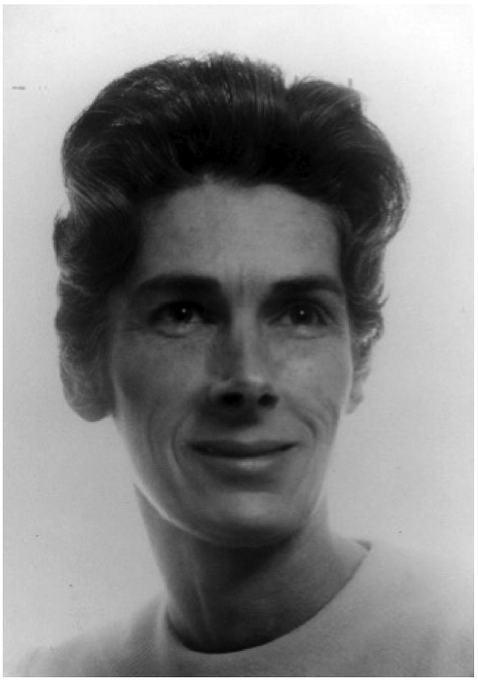

FIGURE 2-16 A. Jean Ayres, PhD, was one of the first occupational therapists to use basic science to develop applied theory in OT. Her area of interest was sensory processing in children with developmental disorders. (Photo credit: Archives of AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-17 Gail Fidler was a leading spokesperson for the application of psychodynamic theory in OT, publishing (with her husband, a psychiatrist) one of the first textbooks in the field dedicated to practice in mental health. (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

OT, studied with her mentor Helen Willard, and worked in a settlement house while a student at the Philadelphia School of Occupational Therapy (Peters, 2011a). She and her husband wrote *Introduction to Psychiatric Occupational Therapy* (Fidler & Fidler, 1954), a groundbreaking book that promoted the application of ego theory and therapeutic use of self in practice. Fidler's contributions include 13 books, numerous articles and service on the executive board of AOTA (Gillette, 2005).

Ann Mosey advanced Fidler's ideas through development of the object relations/psychodynamic frame of reference, which offered concepts integral to understanding the use of activities and groups in therapy (Figure 2-18) (Mosey, 1973). Other prominent theorists emerged at the time, increasing the theory base of OT. *Lorna Jean King* (1974) applied sensory integrative theories to persons with schizophrenia, *Claudia Allen* developed theories of cognition to guide therapy for persons with chronic mental illness (Allen Cognitive Network, 2011), and Kielhofner and Burke (1977) advocated an OT paradigm to refocus on human adaptation and occupation. The core concepts of this work later became the foundation of a widely adopted MOHO (Kielhofner & Burke, 1980).

Wilma L. West, a retired Army colonel who had served with Ruth Robinson during WWII, worked as executive director of the AOTA from 1947 to 1952 and became a powerful influence on the advancement of OT (Figure 2-19). She was a respected and passionate advocate for OT (Gillette, 1996; West, 1991) and served as the president of the AOTF during its key formative years from 1972 to 1982. Among her earnest goals was the promotion of research, and she presided over the creation of the profession's first research journal, *The Occupational Therapy Journal of Research* (*OTJR*), now *OTJR: Occupation, Participation and Health*. The foundation board designated her as its only president emerita, and the Wilma West Library at AOTF is named in her honor (Foto, 1997).

Elizabeth Yerxa, a successor to Mary Reilly, emphasized the importance of advancing theory to the benefit of practice (Figure 2-20). In her 1966 Eleanor Clark Slagle lecture, she asserted the need for occupational therapists to take steps toward professionalism, produce research, and focus on the unique assets of the profession, including purposeful activity and the practice of authentic OT (Yerxa, 1967a). Yerxa later became involved in active promotion of research efforts and in promoting the development of

FIGURE 2-18 Ann Mosey, PhD, a widely respected scholar and professor of OT at New York University, published frequently on topics related to the evolution of theory in the field of OT as well as on topics in mental health. (Photo credit: Archives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-19 Wilma West, an Army officer in WWII, served in many important leadership roles in the AOTA and the AOTF. The official library, housing AOTA's archives, is named in her honor, as is a prestigious joint commendation award given by the presidents of the two organizations. (Photo credit: Achives of the AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

occupational science as an academic discipline and foundation for practice. Yerxa retired in 1988 and is recognized as a distinguished professor emerita at the USC.

Lela A. Llorens became the first person of color awarded the Eleanor Clarke Slagle lecture (Figure 2-21). Her 1970 lecture (Llorens, 1970) emphasized a theory for OT emphasizing the importance of development and its influence on physical, psychosocial, neurophysiological, and psychodynamic facets of development (AOTA, 2017a). Llorens later went on to chair the AOTA–AOTF Research Advisory Council. See Box 2-5 for a summary of the key events and professional developments of this period.

1980 to 1999

Historical Context

The onset of the 1980s brought international change with the end of the Cold War, the collapse of the Soviet Union, and the removal of the Berlin Wall. Internationally, the Treaty of Maastricht was signed in formation of the European Union, later paving the way for the development of the European Free Trade Association. Within the United States, Ronald Reagan took office, and the era of the space shuttle began along with the initiation of an initiative to defend against missile attacks. With the advancement of the scientific age, perhaps one of the most pronounced shifts was the beginning of what was to become a dramatic new era of digital technology.

On January 3, 1983, after a variety of companies, including Commodore, IBM, and Apple, had released versions of interactive personal computers, *Time Magazine* featured a cover naming the home computer the "Machine of the Year" for 1982. Thus, began an era where computer languages and new digital inventions proliferated (Bergin, 2007). As computer use extended to the World Wide Web, the Internet grew in popularity and use, affording unprecedented opportunities for cross-cultural communication and knowledge (Palfrey, 2010). By the late 1990s, computers were becoming integral to all areas of society, including business, education, and health care.

Driven by technological advances, Medicare funding, and the prevalence of chronic diseases, the health

FIGURE 2-20 Elizabeth J. Yerxa led the initial development of the academic discipline of occupational science. Dr. Yerxa received many awards for her work, including the AOTA Award of Merit for her leadership in the profession. (Photo credit: Archives of AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-21 Lela Llorens served as an educational leader in Florida and California and also provided important leadership within the American Occupational Therapy Foundation (AOTF). Her Eleanor Clarke Slagle lecture on facilitating growth and development provided one of the first comprehensive frameworks for organizing knowledge about OT. (Photo credit: Archives of AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

care industry expanded greatly. Trends in health concerns shifted during the era as the World Health Organization declared small pox eradicated and the first case of HIV was identified (Hospitals and Health Networks, 2012). Advanced digital imaging technology (such as computed tomography [CT] and magnetic resonance imaging [MRI]) brought increased diagnostic capabilities and costs. Between 1980 and 2000, annual age-adjusted costs per person for health care in the United States nearly tripled (Centers for Medicare & Medicaid Services, 2012).

Hospital stays grew shorter, telemedicine emerged, and increased emphasis was placed on patient choice and participation in health care decisions. Not only did telemedicine provide health professionals the opportunity to extend medical care, but also other digital advances evolved to maintain records and efficiently transfer information from one provider to another. These developments gave rise to concerns about privacy and access to personal health information which could be used by health insurers to deny or restrict coverage, leading to enactment of legislation in 1996 known as the Health Insurance Portability and Accountability Act (known as HIPAA) (Choi, Capitan, Krause, & Streeper, 2006). The public began increasingly to use the Internet to gather information on health care and medical conditions, providing yet another significant social influence on the delivery of health care (Hernandez, 2005).

Outside of physical medicine, advances in psychiatric rehabilitation were influenced by a paradigm shift away from an expert model toward inclusion of the consumer in treatment decisions. Within mental health, the recovery model emerged (W. A. Anthony, 1993), highlighting the importance of skill training, consumer empowerment, and the development of cooperative alliances in psychiatric rehabilitation. Within this model, concepts of self-determination are emphasized along with empowerment, consumer rights, and community involvement (Tilsen & Nylund, 2008). Goals of mental health recovery included reduced symptoms; enhanced quality of life; and emphasis on personal meaning, purpose, and values (Gagne, White, & Anthony, 2007).

The changing nature of the health care system, along with the renaming and reformulation of the Education for All Handicapped Children Act to the Individuals with Disabilities Education Act (IDEA) and President H. W. Bush's signing of the Americans with Disabilities Act (ADA) in 1990, focused attention on rehabilitation and independent living. Overall, the legislation and trends affecting health care and education during this period influenced areas of OT practice, as increasing numbers of occupational therapists sought employment in school systems (AOTA, 2006b).

Occupational Therapy (1980 to 1999)

During this period, significant public attention was given to health care, especially following the election of William Jefferson Clinton as president. Clinton's health care reform agenda created much discussion but did not result in significant action, primarily due to heavy lobbying by the private health insurance industry, the complexity of the administration's plan, and lack of consensus among members of the majority party in Congress (Birn, Brown, Fee, & Lear, 2003).

In OT, state professional associations continued their lobbying for legislative acts and licensure to regulate the practice of OT and increase the public safety, visibility, and legitimacy of the profession. During this period, emphasis was placed on research, efficacy, and defining the scope of practice for occupational therapists. For example, one significant controversy related to the appropriate use of physical agent modalities by occupational therapists, with some leaders arguing that use of these procedures blurred the distinction between physical therapy and OT (West, 1991).

Also during this time, the AOTF, under the leadership of President Wilma West and Executive Director Martha Kirkland, began a thoughtful series of programs recommended by the Research Advisory Council to advance research and education. The most significant initiatives included the founding of a professional journal *The Occupational Therapy Journal of Research* in 1980 (renamed *OTJR: Occupation, Participation and Health* in 2002) (Classen, 2017) and the creation of the Academy of Research in 1983, an honorary body to recognize outstanding scientists in OT (AOTF, 2012; Christiansen, 1991).

Within the professional association (AOTA), discussions took place regarding the governance of certification activities. In 1986, the AOTA board of directors determined that certification activities and membership functions were not sufficiently independent to avoid potential liability under antitrust legislation. Accordingly, the board voted to create the American Occupational Therapy Certification Board, which later became known as the National Board for Certification in Occupational Therapy (Low, 1997). This action eventually led to a decline in the membership of the AOTA because membership was no longer required for certification purposes.

In addition to activities of the professional association, legislation of the period affecting practicing therapists in the United States included the IDEA (1997), the ADA (1990), and the Balanced Budget Act, enacted August 5, 1997.

In 1997, the IDEA Amendments were signed into law providing strength and accountability for the education of children and adolescents with disabilities. Occupational therapy was one of the specialized services provided for under this Act. The provisions for rehabilitation services in the law gave rise to an increase in therapists practicing in the school system such that by the mid-2000s, education and early intervention was the area with the highest number of practicing therapists (AOTA, 2006b).

The ADA of 1990 became the most comprehensive piece of legislation in U.S. history to provide protection against discrimination for persons with disabilities (Karger & Rose, 2010). The law defined disability and addressed issues of employment accommodation and ensured that persons with disabilities could access public services, transportation, and telecommunications (Hein & VanZante, 1993). The ADA was amended in 2008 to strengthen its provisions and clarify the scope of disabilities protected under the act. Many occupational therapists were well qualified to advocate for clients and consult with organizations seeking to comply with ADA mandates (AOTA, 2000). Yet, despite legislation providing opportunities during this era (such as IDEA and ADA), OT employment growth slowed because of legislation to contain health care costs. The *Balanced Budget Act of 1997* was enacted largely to control Medicare's subacute care costs (Qaseem, Weech-Maldonado, & Mkanta, 2007). However, it reduced positions and led to a decrease in applicants to OT programs, a few of which were eventually closed as a result of low enrollment.

During this era, occupational science was proposed as an academic discipline to provide an underlying foundation for OT (Yerxa, 1990). In 1989, Elizabeth Yerxa and colleagues developed the first occupational science PhD program at USC (Gordon, 2009). Occupational science was developed as a scientific discipline to generate foundational knowledge to inform practice (Clark, Wood, & Larson, 1998; Gordon, 2009). Shortly thereafter, the "occupational science movement" expanded steadily and globally with many academic units changing their names to "occupational science and OT." In Australia, Ann Wilcock and colleagues launched the *Journal of Occupational Science* in 1993 to be followed over the next decade by the creation of societies in several countries dedicated to the study of occupation. In the United States, this body is known as The Society for the Study of Occupation: USA (SSO:USA). There are also Canadian and international societies similarly organized. Refer to Box 2-6 for a summary of important trends during this era.

Individuals during this period who were influential in advancing the study of occupation included Ann Wilcock and Gary Kielhofner. In 1980, Kielhofner and his colleagues published a series of articles on the MOHO (Kielhofner, 1980a, 1980b; Kielhofner & Burke, 1980). Influenced by Mary Reilly's work in occupational behavior and general systems theory, MOHO emphasized motivation, performance, and patterns or routines. Wilcock's book, *An Occupational Perspective of Health*, emphasized the need for promoting health globally through a focus on the occupational nature of humans (Wilcock, 1988). Wilcock's work

BOX 2-6 KEY POINTS: DRAMATIC GROWTH AND OCCUPATIONAL SCIENCE (1980–1999)

- The aftermath of the Vietnam War leads to a period of dramatic growth for OT, and the Americans with Disabilities Act extends civil rights to persons with disabilities.
- The demand for therapists increases dramatically, only to be interrupted by the Balanced Budget Act; key changes regarding the regulation of practice through licensure and certification characterize the era.
- Graduate education in the field develops and theory-driven practice further evolves, with several new conceptual models emerging to influence practice. The idea of a core discipline to provide a foundation for applied science begins with the development of occupational science. Client-centered practice gains emphasis.
- Key people during the era include Gary Kielhofner, Elizabeth Yerxa, and Florence Clark.

led to an improved recognition that if engagement in meaningful occupation is necessary for health, a truly just world must ensure human opportunities for such engagement (Stadnyk, Townsend, & Wilcock, 2010).

Additional occupation-based models such as the Person-Environment-Occupational Performance Model (PEOP) (Baum, Christiansen, & Bass, 2015; Christiansen & Baum, 1997), the Ecology of Human Performance Model (Dunn, Brown, & McGuigan, 1994), the Occupational Performance Process Model (Fearing, Law, & Clark, 1997), and the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists [CAOT], 1997; Townsend, 2002) laid a foundation for the growth of occupation-based practice.

In Canada, the government began programs to help older adults remain independent. In the early 1990s, a 30-month project began to emphasize health prevention and promotion in OT (CAOT, 1993). Soon after, a collaborative group from CAOT, the Client-Centered Practice Committee, met to develop guidelines on consulting, research, education, and practice. Initial representatives included Helene Polatajko, Tracey Thompson-Franson, Cary Brown, Christine Kramer, Liz Townsend, Mary Law, Sue Stanton, and Sue Baptiste. The eventual work resulted in publication of the monograph, *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 1997; Townsend, 2007).

People and Ideas Influencing Occupational Therapy (1980 to 1999)

Florence Clark completed her PhD in Education at USC and went on to serve as a faculty member, chair, and administrator (Figure 2-22). Clark is a respected scientist in OT and was among a group of faculty who argued that occupational science, the study of humans as occupational beings, is an appropriate academic discipline to serve as a foundation for OT practice. Clark and colleagues have gained recognition for studying the effect of lifestyle-oriented activity programs for maintaining health and preventing cognitive decline in elders with an aim of helping them remain in their homes and communities (Clark et al., 1997; Clark et al., 2012). Clark was elected president of AOTA in 2012.

FIGURE 2-22 Florence Clark, scientist, scholar, and association leader, is a strong proponent of science-driven, evidence-based practice. Clark, from the University of Southern California, is a member of the Academy of Research of the American Occupational Therapy Foundation (AOTF). (Photo courtesy of Archives of AOTA, Wilma L. West Library, AOTF, Bethesda, MD. Used with permission.)

FIGURE 2-23 Gary Kielhofner (1949 to 2010) worked with colleagues in graduate school to develop a Model of Human Occupation, which amalgamated knowledge from the social and behavioral sciences to provide an occupation-based approach to OT practice. During his career, Kielhofner's lectures and publications became internationally known and had a significant influence on practice in Europe, Asia, and South America (Kielhofner, 2008, 2009). (Photo credit: Renee R. Taylor, PhD. Used with permission.)

FIGURE 2-24 Mary Law, a Canadian occupational therapist, co-founded an important center in Canada for childhood disability and was co-author of a popular outcome assessment instrument in OT known as the Canadian Occupational Performance Measure (COPM). (Photo courtesy of Mary Law.)

Gary Kielhofner, a graduate of the USC who was influenced by Mary Reilly's occupational behavior model, studied public health at University of California, Los Angeles. He worked with others to propose a MOHO that focused on understanding humans as occupational beings (Figure 2-23). Kielhofner was a prolific writer, publishing more than 19 books and 140 articles (Suarez-Balcazar, 2010). He spent most of his academic career as head of the Department of Occupational Therapy at the University of Illinois at Chicago. Kielhofner spoke and consulted widely and assisted therapists in Sweden, England, and other countries to implement the MOHO in practice. Kielhofner died in 2010 after a brief illness and was described by his colleagues as "extraordinary" in his impact (Christiansen & Taylor, 2011, p. 4) and one of the most "influential and multifaceted OT scholars of the past 30 years" (Braveman, Fisher, & Suarez-Balcazar, 2010, p. 828). For a summary of key events and people during the period 1980 to 1999, see Box 2-6.

Mary Law, a prominent OT clinical scientist in Canada, (Figure 2-24) co-founded the CanChild Centre for Childhood Disability Research at McMaster University in Hamilton, Ontario, and has been a prolific theorist, researcher, and scholar. Recognized by the AOTF Academy of Research, Law was instrumental in co-developing the Canadian Occupational Performance Measure (COPM) (Law et al., 1990), a widely used outcome assessment tool, and the Person-Environment-Occupation Model (Law et al., 1996), a practice framework used widely in Canada and elsewhere. Law received prestigious recognition from the Canadian government for her career accomplishments when she was named an Officer of the Order of Canada in 2017.

2000 to Present

Historical Context

The dawn of the twenty-first century marked only the second recorded millennium change in documented history, and the transformations that were occurring in the world as the third millennium began were worthy of the occasion. As Thomas Friedman (2006) pointed out, global economic transformation, spawned by digital technology and

the Internet, had created a new world that truly was connected economically, so that China, India, and other countries could become significant players in world commerce, both for goods and for services. This increased global connectivity not only created rising middle classes in China and India but also enabled social transformations through the rapid sharing of ideas on social media platforms. The Internet had the potential of influencing large numbers of people in unprecedented ways and at remarkable speed.

Ironically, in the United States, the twenty-first century began with remarkable events that were not related to the Internet. In 2000, the outcome of a historically close presidential election was decided by the Supreme Court, and George W. Bush became the 43rd president under contentious circumstances. Then, on September 11, 2001, during the first year of his presidency, the United States experienced a dramatic terrorist attack on the World Trade Center in New York City. This unprecedented event dominated the news for nearly a year and led to widespread efforts to increase security in ways that permanently changed the way people live their lives. These changes began with passage of the Patriot Act, which suspended some individual liberties in the service of national defense, and extended to creation of a Department of Homeland Security, and the prosecution of controversial wars in Afghanistan and Iraq aimed at eradicating terrorists overseas.

In 2003, President George W. Bush signed legislation that expanded Medicare through provision of a prescription drug plan, known as Medicare Part D (117 Stat. 2066 Pub. L. 108-173).

In his second term in 2008, speculative and unregulated real estate investment led to an economic collapse, which, because of the new global economics, resulted in a serious international market crisis that had profound economic consequences for the United States and most other countries in the world (U.S. Government Printing Office, 2011).

Barack H. Obama, the country's first African-American president, was elected in 2008, inheriting this difficult economic and political situation which required unprecedented legislation to restore market confidence (American Recovery and Reinvestment Act of 2009). In 2010, a significant health care reform bill called the Patient Protection and Affordable Care Act (popularly known as Obamacare) passed without bipartisan support. In addition to its provisions to subsidize premiums so that more people could afford health insurance (resulting in coverage of 30 million more people), the legislation also provided funding for research to promote patient-centered care through creation of the Patient-Centered Outcomes Research Institute, or PCORI (2017). Mr. Obama was elected to a second term, but a divided and partisan Congress continued a legislative stalemate that precluded significant progress on key national issues.

Donald W. Trump, a real estate businessman, was elected president in 2016. Mr. Trump proposed various measures, including immigration restrictions and a repeal of the Affordable Care Act, which was not successful. The Republican-controlled Congress was successful in passing significant tax reform legislation, and the status of health care reform remained uncertain at the end of 2017.

The growth of digital communication accelerated through sales of digital devices such as smartphones, tablets, and e-readers, which made use of cellular and wireless broadband networks. The growth of social networking Websites and Web-based commerce ushered in significant changes in communication and marketing.

Occupational Therapy (2000 to Present)

In the millennium's first two decades, OT practice continued to be influenced in the United States by federal and state legislation and policy changes aimed at achieving cost containment and increasing quality, as determined by measurable outcomes and demonstrated effectiveness. In 2004, the NIH introduced a strategic plan to guide biomedical research called the NIH Roadmap (Zerhouni, 2003). Its purpose was to focus and coordinate biomedical research efforts toward areas deemed important to the health of the nation. This eventually led to the creation of an NIH strategic plan specifically aimed at rehabilitation (Frontera, et al., 2017). Research development in OT was bolstered in this period through NIH-funded training programs aimed at developing clinical scientists in physical and OT.

Increasingly, the federal Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality (AHRQ) began to exert influence on health care practices and research by linking clinical studies of effectiveness to reimbursement through its Effective Health Care Program (Slutsky, Atkins, Chang, & Sharp, 2010).

Increased emphasis of the federal government and private health insurers on cost containment and evidence-based practice led to greater emphasis on research within organized OT. Because hospitals experienced pressures to reduce patient lengths of stay in order to contain costs, the types of procedures offered to inpatients began to focus more on those needed for discharge. More therapy was offered on an outpatient basis or in the home as part of home health services.

Because OT developed globally, existing conceptual models were examined and challenged by the growing numbers of professionals outside North America, particularly in the Asia Pacific region, South America, and the European Union. A key development was the Kawa Model (Iwama, 2006; Iwama, Thomson, & Macdonald, 2009), which offered an alternative view of OT through the lens of Asian Pacific and other collectivist cultures. The influence

of international perspectives was also fostered through the emergence of international societies for occupational science. The inaugural organizing meeting of the first SSO:USA was held in Galveston, Texas, in 2002; this was followed by developments in the Asia Pacific region as well as in Canada and the European Community.

In 2004, the AOTA board, under the leadership of Carolyn Baum, charged the vice president, Charles Christiansen, to lead a strategic planning initiative aimed at establishing a Centennial Vision. The aim was to identify goals necessary to position the profession for success beyond 2017 (the 100th anniversary of OT). The Centennial Vision, developed with significant AOTA member input, served as an ongoing goal-setting framework for the AOTA until 2017, emphasizing visibility, influence, research, evidence-based practice, diversity, global connectivity, and attention to the occupational needs of clients as key areas of focus (AOTA, 2006a).

In 2007, the AOTA and the AOTF published the Research Agenda for Occupational Therapy, recommended by a joint panel of OT scientists serving the two organizations (AOTA/AOTF Research Advisory Panel, 2011). This agenda emphasized the importance of providing a strong infrastructure for supporting research in OT that demonstrated the efficacy of services. In 2013, AOTF, in partnership with AOTA, launched a bold research grant program, providing significant funding for projects undertaken by promising emerging scientists with a focus on providing evidence for OT interventions (AOTF, 2014). This initiative was augmented with joint initiatives related to training OT scientists, including workshops and institutes (AOTF, 2015).

Key areas of practice in the United States during 2010 as reflected in association membership data include school-based services and early intervention (27%), hospitals (28%), long-term care facilities (16%), and home health and community (7%), whereas the number of therapists practicing in the United States that reported their primary and predominate area of practice as mental health decreased to 3% (AOTA, 2010). This compares with the 2010 demographics in Canada, where 9,827 occupational therapists held registrations across the provinces, with 11% working in mental health, 46% in hospitals, and 32% working in the community with slightly over 4% employed by residential or assisted living facilities (Canadian Institute for Health Information [CIHI], 2011). By 2014, in the United States, school-based services, mental health, hospitals, home health, and community health settings all showed continued declines, whereas academic settings, freestanding outpatient facilities, early intervention, and long-term care/skilled nursing facilities showed increases (AOTA, 2015). In contrast, across Canada, slight increases in the employment of occupational therapists in mental health, and community settings occurred, whereas there was a slight decline in hospital settings (CIHI, 2015).

During this period, the wars abroad resulted in significant and challenging injuries for many survivors of combat. These returning wounded warriors led to innovations in military OT and called attention to the need for services to reintegrate soldiers sustaining blast injuries that resulted in polytrauma, including brain injuries, severe burns, and amputations (Howard & Doukas, 2006).

In OT education, the growth of clinical doctorate programs escalated during the period. Online and hybrid educational programs also increased, offering a significant portion of curricular content to be delivered over the Internet. This trend accelerated with the growth of online social networking and the development of new digital learning technologies and the advent of mobile wireless smartphones and tablet computing devices.

People and Ideas Influencing Occupational Therapy (2000 to Present)

Ann Wilcock of Australia, one of the first scholars to emphasize the idea of OT as a key contribution to population health (Figure 2-25), and **Elizabeth Townsend**

FIGURE 2-25 Ann Wilcock, PhD, DipCOT, BAppSCiOT, GradDipPH of Australia. Dr. Wilcock is the author of *An Occupational Perspective of Health* and other works and is a developer of the concept of occupational justice. (Photo courtesy of Ann Wilcock.)

FIGURE 2-26 Elizabeth Townsend, PhD, OT(C), FCAOT, professor emerita of Dalhousie University, Halifax, Nova Scotia, Canada. Dr. Townsend is a coauthor of the Canadian guide to practice known as *Enabling Occupation* and a developer, with Ann Wilcock of Australia, of the concept of occupational justice. (Photo courtesy of Elizabeth Townsend.)

(Figure 2-26), a Canadian who partnered with Wilcock to develop and advance the concept of occupational justice (Townsend & Wilcock, 2004), jointly had a significant global influence on OT. The concept was grounded in the belief that opportunities to engage in meaningful occupation are a prerequisite to health and well-being. Their concept was given additional impetus when the World Health Organization's International Classification of Impairment, Disability, and Handicap was revised to become the International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001).

M. Carolyn Baum (Figure 2-27) served as president of the AOTA (for the second time) from 2004 to 2007, emphasizing the important links between practice, education, and research and the need for studies to support evidence based-practice. Baum, a well-recognized leader and scientist, worked with Charles Christiansen to create the PEOP Model in the 1980s and later, as professor and director of OT at Washington University in St. Louis, organized a successful research program, developing innovative assessment tools that focused on cognitive function. As chair of the Research Commission of AOTF, Baum played a key role in advising an important intervention research program.

In 2016, Hawaii became the 50th state to enact the licensure of OT practitioners. In the Spring of 2017, under the leadership of President Amy Lamb, the AOTA board undertook a strategic planning effort to determine goals beyond the Centennial year (AOTA, 2017b, 2017c). These were focused on advocating for the importance of the association and promoting the distinct value of OT. These objectives were undertaken as part of the AOTA board's Vision 2025 initiative, which stated, "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living" (AOTA, 2017b).

In August 2017, the Accreditation Council for Occupational Therapy Education voted to mandate that the level of entry for occupational therapists and OT assistants be at the clinical doctorate (OTD) and bachelor's degree (BS), respectively, by 2027 (AOTA, 2017d).

The international community came together in 2017 as the AOTA hosted the centennial celebration in Philadelphia. It was the largest gathering of occupational therapists in history. Events were hosted throughout the world commemorating the 100th anniversary of OT, and a dedicated Website highlighted OT's history (www.otcentennial.org). For a summary of significant events and people during this era, see Box 2-7.

FIGURE 2-27 Carolyn Baum, PhD, is a professor and Elias Michael Director of the Program in Occupational Therapy at Washington University in St. Louis. As a widely recognized leader and scientist, Baum has advocated strongly for the important links between practice, education, and research. (Photo credit: Washington University in St. Louis. Used with Permission.)

CENTENNIAL NOTES

The History of Our History

For much of its first 60 years, records of historical significance were kept in personal files of successive AOTA presidents. When Eleanor Clarke Slagle, AOTA's third president, secured office space in New York City's Flatiron building in 1925, a central file of historical documents was kept. Yet, some documents were likely lost in later office moves.

William Rush Dunton, Jr., MD (1868–1966), a founder and AOTA's second president, wrote many editorials, reports, and obituaries as editor of *the Archives of Occupational Therapy*, the profession's first journal. These writings provide valuable information to historians. Thirty years later, Wilma L. West and Florence Cromwell helped establish the American Occupational Therapy Foundation (AOTF) and encouraged creation of an AOTF library in 1981 (now known as the Wilma L. West Library) to organize and house relevant publications and archival materials. As early as the 1950s, the writing of an official history was discussed, but it was not until historian Virginia Metaxas Quiroga was hired in 1987 that the profession's first official history was started. The first document was published in 1995, nearly 80 years after the profession was founded, and covered only the years from 1900 to 1930 (Figure 2-28).

Dr. Robert K. Bing, who later became an AOTA president, provided personal caretaking for William Rush Dunton, Jr., between 1959 and 1961. During those years, Bing gained access to interviews and personal records for his doctoral dissertation about Dunton. After the association moved its headquarters from New York City to Rockville, Maryland, in 1972, Bing, a devoted historian, was asked to chair a history committee and was able to persuade the association's board to move its aging and poorly organized historical documents and records to the Blocker History of Medicine collection at the University of Texas Medical Branch at Galveston in 1978. There, it could be indexed and preserved under the skillful guidance of dedicated curator Inci Bowman.

The impracticality and cost of maintaining OT's history in Texas led to the return of the archives to AOTA's headquarters in 1992. Since that time, the AOTF has maintained and further developed the collection in the Wilma L. West Library, now in Bethesda, Maryland. Documents are accessible to scholars on site or online through OT Search and the AOTF Website. Access to the archives and official publications has helped support the writing of numerous historical articles and several books, including those by Andersen and Reed (2017), as well as by authors outside the United States, such as Friedland (2011) in Canada and Wilcock and Hocking (2015) of Australia. Access to the archives and official publications has helped support the writing of numerous historical articles and several books. No strategic plan has yet been approved by the profession's leaders that will assure the preservation of historical documents for future scholars and historians.

Note: Material in this note was compiled through personal correspondence with Lori Andersen, Mary Binderman, Mindy Hecker, Christine Peters, Kathlyn Reed, Ruth Schemm; from various news accounts in AOTA periodicals; and from a January 1998 article by Joel Berg entitled "From Chaos to Archives: The Records of the American Occupational Therapy Association" published in *Perspectives on History*, the news magazine of the American Historical Association.

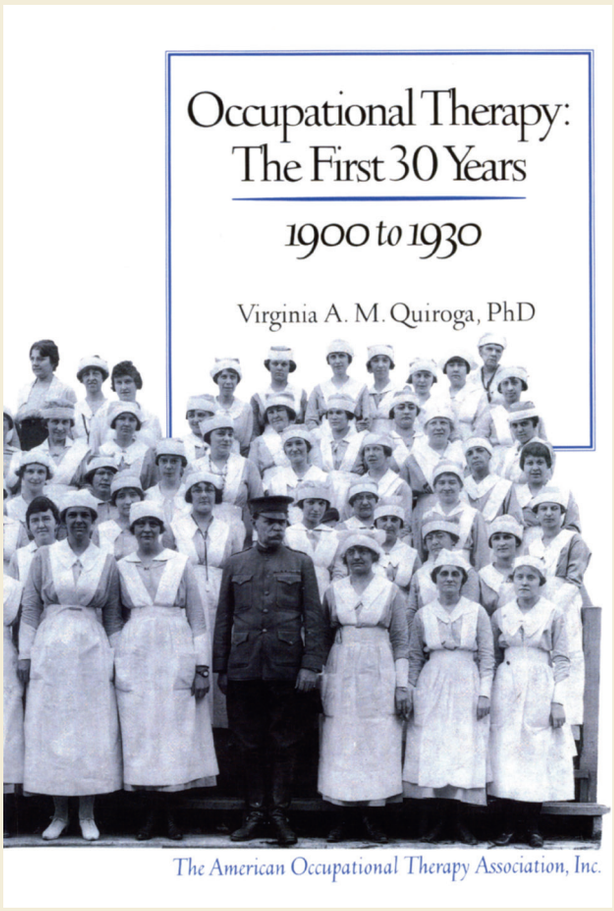

FIGURE 2-28 Cover of the first official history of OT in the United States. The work documented the profession's first 30 years and was published by the AOTA in 1995. The author was Virginia Metaxas Quiroga. (The photo used in the cover is of reconstruction aides posing with the Army Surgeon General, Major General W. C. Gorgas in 1918. The photo used on the cover is from the Archives of the AOTA, housed in the Wilma West Library of the AOTF.)

BOX 2-7 KEY POINTS: THE NEW MILLENNIUM (2000–PRESENT)

- Terrorism, globalization, digital technologies, and economic turbulence characterize the early part of the era, leading to dramatic societal changes and political upheaval.
- Occupational therapy expands dramatically in emerging regions, augmented by digital technologies; this leads to models based on different cultural perspectives, the development of online education, and the emergence of clinical doctorates.
- In the United States, practice is increasingly driven by federal reimbursement regulations influenced by cost containment and evidence-based practice, a Centennial Vision is created to guide organized national efforts, research begins to mature.
- Key people during the era included Carolyn Baum, Elizabeth Townsend, and Ann Wilcock.

Summary

In this chapter, more than a century of OT history has been reviewed, beginning with a description of important ideas and personalities prior to the twentieth century that influenced the birth of the profession. For each of five eras, a contextual backdrop was provided to describe the historical circumstances under which different events occurred, with the aim of emphasizing that professions, like individuals, are best understood in situational contexts.

Occupational therapy began during a progressive era that was auspicious for bold ideas and new approaches. Motivated by his own recovery experience and his interest in "the work cure," an ambitious architect and consumer (George Edward Barton) assembled an interdisciplinary group of like-minded advocates together to begin what is now the profession of OT. Within weeks of that meeting, a nation's preparations for war provided a rare opportunity for the fledgling profession to organize around a patriotic cause and demonstrate its value. Because women were just emerging as a political force in the country and still lacked the right to vote, the recruits to OT were uncertain about how to manifest their opportunities. Occupational therapy competed with medical specialties, vocational educators, nurses, and others who believed that they were equally entitled to the use of curative occupations as part of their treatment regimens.

For much of its history, OT practitioners were doers, perhaps insufficiently interested in explaining or proving the theoretical ideas and practical benefits of their actions. This inattention placed the profession at a disadvantage to medicine and other disciplines, where science-based practice had received greater emphasis, until the Centennial Vision led to significant intervention research efforts (AOTF, 2014). Yet, the inherent flexibility of occupations as a therapeutic medium continued to offer creative opportunities for benefiting a wide range of patients and clients. As daunting health problems served by occupational therapists (e.g., tuberculosis, polio) faded into the history books of biomedical success, occupational therapists were able to mobilize in the service of emerging health problems and concerns deemed important by consumers (such as dementia and autism spectrum disorders). Moreover, the cooperative nature of the therapeutic relationship afforded a bridge to connect the body and mind—providing occupational therapists with a rare, important, and enduring place in the lives of their patients—serving as healers as well as technologists.

As OT moves ahead into the twenty-first century, one must ask if these themes will continue to shape the story of the profession. Will the importance of science and theory experience a renaissance? Will therapists reinvent new approaches for serving the emerging diseases of the twenty-first century, and will they preserve and capitalize on their unique position as both technologists and custodians of meaning (Engelhardt, 1983)? Only the histories yet to be written will tell.

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CHAPTER 3

The Philosophy of Occupational Therapy

A Framework for Practice

Barbara Hooper, Wendy Wood

OUTLINE

LEARNING OBJECTIVES

After reading this chapter, you will be able to:

1. Describe elements of a philosophical framework and their transactions.
2. Explain how a philosophical framework guides practice.
3. Using a comprehensive philosophical framework, articulate occupational therapy's basic philosophical assumptions and their transactions.
4. Given a practice scenario, evaluate the fit of occupational therapy's philosophy with practice.
5. Given a practice scenario, create one or two strategies that could strengthen the congruence between occupational therapy's philosophy and practice.

Introduction

Occupational therapy (OT) has a philosophy, and it may be the most basic element of practice. The profession's philosophy is the foundation upholding all that practitioners, educators, and researchers do; it helps members of the profession to (1) develop clear and coherent professional identities as *occupational* therapists, (2) hone a practice that is unique among health care providers, and (3) explain the hidden and often underestimated complexity of the profession both to themselves and others. Emphasizing how basic philosophy is, Wilcock (1999) stated that "the first essential for each individual in any profession is the acceptance of a philosophy that is the profession's keystone" (p. 192).

Specific influences of many formal philosophies on the field have been carefully detailed elsewhere (Table 3-1) and are beyond the scope of this chapter. Yet, many beliefs, values, principles, and perspectives originally imported from these formal philosophies have melded into a compelling profession-specific philosophy, which is the focus here.

Influential writers have elaborated single elements within this profession-specific philosophy such as beliefs about humans, knowledge, values, and principles for best practice. To our knowledge, however, these elements, often addressed apart from one another, have yet to be assembled into a philosophical framework. Thus, our purpose in this chapter is

TABLE 3-1 Select Resources on the Influences of Formal Philosophies on Occupational Therapy

Formal Philosophy	Select Resources
Pragmatism	Breines, 1986, 1987; Cutchin, 2004; Hooper & Wood, 2002; Ikiugu & Schultz, 2006
Arts and crafts movement	Friedland, 2003; Hocking, 2008; Levine, 1987; Reed, 1986, 2005
European enlightenment	Ikiugu & Schultz, 2006; Wilcock, 2006
Structuralism	Hooper & Wood, 2002
Existentialism	Yerxa, 1967
Humanism	Bruce & Borg, 2002; Devereaux, 1984; Nelson, 1997
Holism	Finlay, 2001
See also	Peloquin, 2005; Punwar & Peloquin, 2000; Reed & Sanderson, 1999; West, 1984

to describe the profession's philosophy using a comprehensive philosophical framework. To do so, we introduce the meaning of philosophy and three elements of a philosophical framework: ontology, epistemology, and axiology. We explore the profession-specific philosophy of OT in relation to these elements, each of which suggests a question as captured in the chapter's headings:

- Ontology: What Is Most Real for Occupational Therapy?
- Epistemology: What Is Knowledge in Occupational Therapy?
- Axiology: What Is Right Action in Occupational Therapy?

We conclude the chapter with a comparison of philosophical and nonphilosophical thinking and practice scenarios to apply the philosophical framework.

The Meaning, Structure, and Use of Philosophy

At its root, the word *philosophy* refers to "love (philo) of knowledge or wisdom (sophia)" ("Philosophy," n.d.). Philosophy is built from a "network" of assumptions and beliefs (Paul, 1995). Assumptions are ideas or principles that are "taken for granted as the basis for argument and action" (http://www.oed.com). **Assumptions** are sometimes referred to as "first principle" that form a bedrock for beliefs (Ikiugu & Schultz, 2006). **Beliefs** are convictions about what is true (Rogers, 1982b; Yerxa, 1979). When assumptions and beliefs are consciously examined and organized, they form a philosophy, which is then used as a ***framework for thinking*** and a ***mode of thinking***. We thus define **philosophy** as (1) a conscious framework of assumptions and beliefs that guides actions and (2) a mode of thinking that actively relies on the framework for processing and responding to experience. A philosophical mode of thinking refers to "thinking with a clear sense of the ultimate foundations of one's thinking" (Paul, 1995, p. 436).

A Philosophical Framework: Ontology, Epistemology, and Axiology

A philosophical framework has at least three categories of assumptions and beliefs. One category, known as ontology, contains beliefs about reality. A second category, epistemology, contains beliefs about knowledge, and the third category, axiology, contains beliefs about appropriate actions (Lincoln, Lynham, & Guba, 2011; Ruona & Lynham, 2004; J. W. Schell, 2018a; Yerxa, 1979). In this section, we define and describe each category and how the three function as a dynamic framework for thinking.

Ontology is concerned with the question *What is most real*? Ontology is defined as the "science or study of being; that branch of metaphysics concerned with the nature or essence of being or existence" (http://www.oed.com). Occupational therapy's ontology can be discerned by examining how the field's scholars and practitioners have addressed the following questions:

- What is OT's view of the human?
- What are the *most* real dimensions of life from an OT perspective?

Yerxa (1979) phrased the question "What is 'really' real in the world?" (p. 26). Other philosophers (e.g., Sire, 2009) have phrased the question "What is prime reality—the really real?" (p. 18). In other words, what aspects of reality are illuminated and foregrounded by one's perspective? Those dimensions of reality that are in the foreground of an OT perspective constitute what is "most" real.

Epistemology asks the question *What is knowledge*? Epistemology is defined as the theory of knowledge (http://www.oed.com). Occupational therapy's epistemology can be discerned by examining how the field's scholars and practitioners have addressed the following questions:

- What knowledge is most important to know and to demonstrate in OT?
- How is knowledge in OT organized?

- How is knowledge acquired and used?
- What is an OT view of the essence or nature of knowledge?

Axiology asks the question *What are right actions*? Axiology is defined as "the study of values including what is good, beautiful, and morally desirable" (Yerxa, 1979, p. 26). Values in turn help "make explicit how we ought to act" (Ruona & Lynham, 2004, p. 154). Thus, axiology entails observable actions that manifest values; such actions are referred to as *methodologies and methods in service to one's values*. A **methodology** is a general approach to practice. **Methods** are the actual processes and procedures used when working within a given methodology. Occupational therapy's axiology can be discerned by examining how the field's scholars and practitioners have addressed the following questions:

- What are OT's enduring values?
- What are the core methodologies and methods that practitioners use in practice that manifest its enduring values?

All three categories of belief—ontology, epistemology, axiology—are fluid, mutually influential, and continually interacting. Ruona and Lynham (2004) accordingly argued that through their dynamic interactions, these categories form "a guiding framework for a congruent and coherent system of thought and action" (p. 154).

To illustrate, we borrow a visual representation from Parker Palmer (2009). Figure 3-1 uses a Möbius strip to depict the dynamic nature and ongoing transactions among OT's ontological, epistemological, and axiological premises. Beliefs about reality and knowledge are commonly more internal to the profession and individual practitioners, sometimes held without full conscious awareness; they are, therefore, depicted on what seems to be the "inside" of the Möbius strip. Beliefs about what actions to take, which are expressed in observable methodologies and methods, are depicted on what seems to be the "outside" of the strip. On closer examination, however, there is no dichotomy between an inside and outside on a Möbius strip. Rather, according to Palmer, the two sides keep coacreating each other.

If Figure 3-1 were made into a three-dimensional object (we encourage readers to do so using instructions found in the Web content), one's finger could continuously move from ontology to epistemology to axiology and so on, indicating that these three elements can be considered one whole. That is, professional beliefs about reality flow into and shape beliefs about knowledge, which flow into and shape actions manifest in practice. In reverse, professional actions and values flow into, reflect, and shape one's beliefs about reality and continue around the Möbius strip.

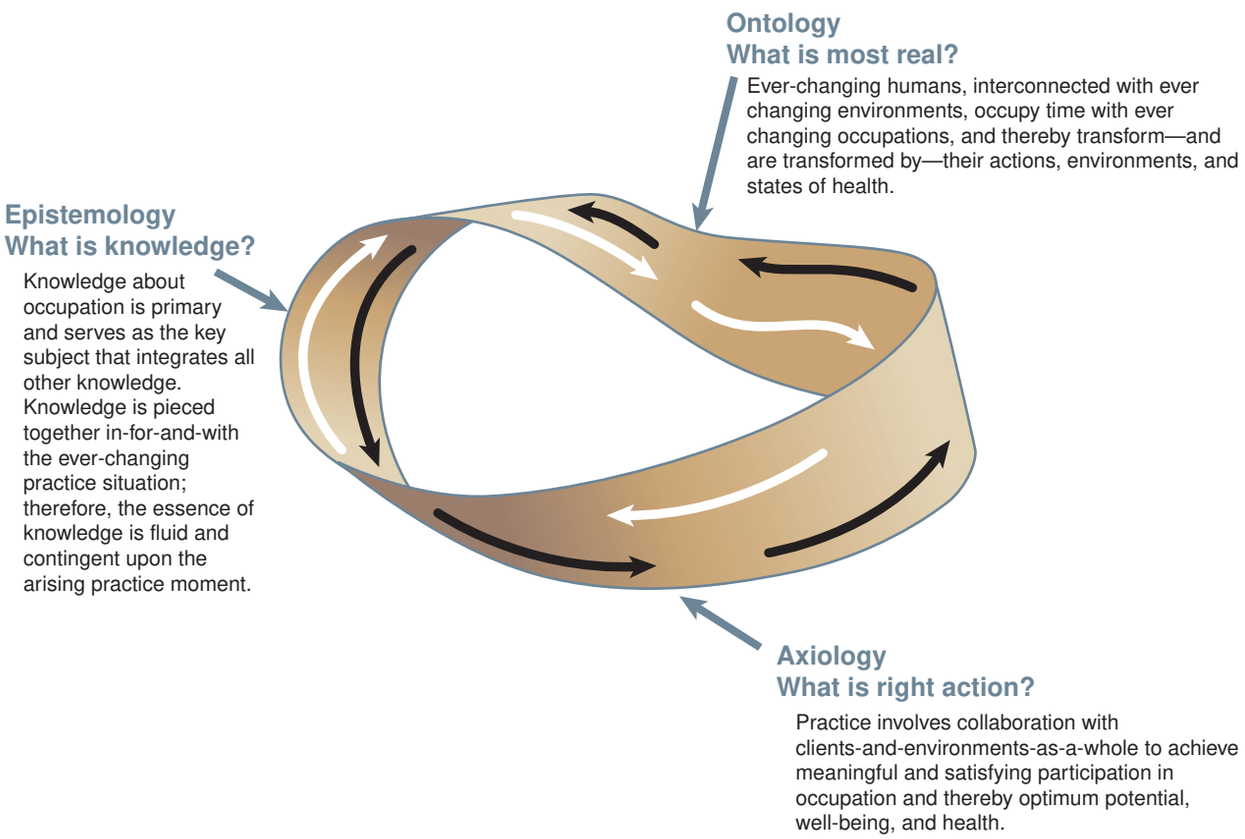

FIGURE 3-1 An occupational therapy philosophical framework for practice.

The Relationship of Philosophy to Theory

As argued in Chapter 41, theories help people understand and address something in the world. Theories are, therefore, inextricably linked to ways of seeing the world (ontology), constructing knowledge about the world (epistemology), and acting in the world (axiology) (Ruona & Lynham, 2004). A profession's philosophy consequently underpins its theories. Theory is like an intermediary that helps bind philosophy to practice and research.

The Philosophy of Occupational Therapy

Ontology: What Is Most Real for Occupational Therapy?

In her 1961 Eleanor Clarke Slagle lectureship, Mary Reilly (1962) posed that the most central belief of the profession could be stated in the form of this hypothesis: "That man, through the use of his hands, as they are energized through mind and will, can influence the state of his own health" (p. 6). Influenced by Reilly's hypothesis, and also having considered ideas that have been more recently refined or introduced (as elaborated later), we propose that OT's most central ontological premises can be summarized today as follows (see Figure 3-1):

> Ever changing humans, interconnected with ever changing environments, occupy time with ever changing occupations, and thereby transform—and are transformed by—their actions, environments and states of health.

We next elaborate on each element in this statement, beginning with the ever-changing occupational human.

The Nature of Humans, Ever-Changing Occupational Beings

A profound view of human beings has served as a cornerstone of OT since its inception: Human beings are infused with an innate, biological need for occupation; as humans engage in daily occupations, they seek to meet needs for survival, growth, development, health, and well-being (Wilcock, 2006; Wood, 1993, 1998a; Yerxa, 1998). Dunton (1919) described humans' biological need for occupation quite simply, "Occupation is as necessary to life as food and drink" (p. 17). Reilly (1962) described humans' biological requirement for occupation in neurological terms. If the human organism is to grow and become productive, then there is a vital need for occupation; indeed, in her view, the central nervous system "demands the rich and varied stimuli that solving life problems provides" (Reilly, 1962, p. 5). Wilcock (2006) likewise argued that occupation activates the integrative functions of the central nervous system, making it possible not only for individuals to develop and experience health and well-being but also for the species to survive. Wilcock and Hocking (2015) further summarized that as humans engage in occupation, they simultaneously meet needs for doing, being, becoming, and belonging.

Embedded in these descriptions of humans' need for occupation is another long-standing belief: Humans are an indivisible whole who possess an "inextricable union of the mind and body" (Bing, 1981, p. 515; Damasio, 1994). Mind, body, and spirit can be united in humans' pursuit of and engagement with occupation (Bing, 1981; Reed & Sanderson, 1999). A core philosophical assumption of the profession, therefore, is that by virtue of our biological endowment, people of all ages and abilities require occupation to survive, grow, thrive, and belong; in pursuing occupation, humans express the totality of their being, a mind-body-spirit union. Yet as noted by Wilcock (2000), saying that humans are occupational beings, or that occupation is indispensable to survival and health, or that mind, body, and spirit are inextricably linked, is much easier than grasping what these complex articles of faith mean. Stopping there, it would be easy to conclude erroneously that these human qualities solely reside within the individual. As next discussed, one must also, therefore, consider how the environment calls forth, develops, and sustains the occupational essence of humans.

The Nature of Humans as Interconnected with Ever-Changing Environments

Being interconnected with the environment does not denote either being in harmony with the environment or being fully determined by the environment. Occupational therapy's view of reality includes simply the belief that human beings, as indivisible wholes, are part and parcel of their daily living environments (Reed & Sanderson, 1999). Kielhofner (1983) posited, for example, that "unity of the human system with the social environment is not a platitude but is an essential part of the human condition" (p. 76). In Yerxa's (1998) words, people are "complex, multileveled (biological, psychological, social, spiritual) open systems who interact with their environments" (p. 413). She maintained that just like "water cannot be reduced to hydrogen and oxygen and still be wet and drinkable," neither can human beings be viewed as separate from their environments nor "be reduced to a single level, say that of the motor system, and retain their richness or identity" (p. 413).

Although an enduring belief of OT is that human beings are best understood in the context of their environments, beliefs about the person–environment relationship have evolved. Earlier conceptions of this relationship have been critiqued for separating the person and environment

too much. According to Cutchin (2004), OT historically embraced a view of the environment "as a container" in which an individual carries out occupation. The individual was the focus; the environment the background. This view allowed understandings of people to be too easily separated from understandings of environments as eliciting people's actions and influencing how they perform and experience occupation. As an alternative, scholars advocate for a closer adherence to Dewey's transactionalism, in which the human is viewed as an "organism-in-environment-as-a-whole" (Dickie, Cutchin, & Humphry, 2006, p. 83). Or, as expressed in this chapter, human beings are interconnected with their environments.

The Nature of Transformation and Health

As humans, interconnected with their environments, enact their biological need for occupation, they continuously change. Thus, through occupation, people transform and are transformed by their actions and their environments. Transformation refers to change on both small and grand scales, change for both better and worse, and subtle change such as new manifestations of an unchanging essence. On a small scale, for example, recall a time when participating in a favorite occupation transformed your outlook, emotional state, and body sense. For me (Barb), I can be in the throes of anxiety, feeling out of shape and out of time. Yet, if I can convince myself to go for a bike ride, I am, almost immediately, transformed. My anxiety falls away, joy emerges, strength returns, and time opens. In such fashion, consider how often clients express that they feel much better after working in OT to wash their face and brush their teeth for the first time after surgery. As Hasselkus (2011) persuasively illustrated, these taken-for-granted experiences and interactions reflect small-scale, yet still very important, transformations through occupation; they can even be epiphanous.

Especially prominent in OT is the more grand-scale belief that people's health changes as a function of their occupations over time (e.g., Blanche & Henny-Kohler, 2000; Friedland, 2011; Hasselkus, 2011; Kielhofner, 2004; Meyer, 1922; Peloquin, 2005; Quiroga, 1995; Reed & Sanderson, 1999; Reilly, 1962; West, 1984). In OT, health is not viewed as the absence of disease or pathology but rather as being able to engage in valued occupations. Consequently, health encompasses a dynamic state of thriving and well-being, considerations of human dignity, realization of potential, optimal functional capacities, a good quality of life, and finding meaning and satisfaction in life (Hasselkus, 2011; Peloquin, 2005; Rogers, 1982a; Wood, Lampe, Logan, Metcalfe, & Hoesley, 2017; Yerxa, 1983, 1998). People are viewed as being able to favorably influence these states of their health through occupation. Thus, OT's ontological view of human beings is an optimistic view.

This is not to say that the occupations in which people engage are seen as inevitably positive in either their subjective experiences or consequences. Because engagement in occupation is a biological necessity, when people are blocked from using—for whatever reasons—their powers to act, when they are unable to develop their potentials, when they are thwarted in being able to express their capacities for doing, then the change is toward states of dysfunction, dissatisfaction, poor health, and ill-being. What people do each day can lead to boredom, anxiety, depression, alienation, dysfunction, and ill health. So, too, can what they do lead to excitement, happiness, satisfaction, competence, and good health.

To be clear, we are not claiming a universal, theoretical consensus about occupation, which Hammel (2011) cautioned as "theoretical imperialism" (p. 27). Rather, as Watson (2006) claimed, the profession "unifies around a belief in the power and positive potential of occupation to transform people's lives. This is the profession's 'essence'" (p. 151) even as this belief must be developed in and for people in specific cultural contexts.

Ultimately, changes on a grand scale over time, whether for better or worse, can be understood to result from transformations that occur on a small scale each day. Furthermore, people's persistent "doings" can change not only themselves for both better and worse, but their doings can also change communities, societies, and the health of the planet for both better and worse (Wilcock & Hocking, 2015). Although OT's optimistic view of humans does not deny these realities, it does foreground attention to the inherent potential of all people to experience and cultivate, through occupation, a good life for themselves and others. As well summarized by Peloquin (2005), a core belief of OT is that there is, in occupation, a "capacity to help individuals become hale and whole" (p. 614).

Epistemology: What Is Knowledge in Occupational Therapy?

Occupational therapy's dominant perspective of reality and the nature of humans "sets priorities for knowledge" (Kielhofner & Burke, 1983, p. 43). As shown in Figure 3-1, we propose that the profession's most central epistemological premises today can be summarized as follows:

> Knowledge about occupation is primary and serves as the key subject that integrates all other knowledge and clarifies the desired consequences of action. Toward that end, knowledge is pieced together in-for-and-with the present practice situation that is continuously changing; therefore, the essence of knowledge is both bound and fluid, contingent upon the arising practice moment.

We elaborate on this epistemological premise by discussing each of its elements.

CENTENNIAL NOTES

Adolf Meyer and the Philosophy of Occupation Therapy

Proponents of OT have long been dedicated to articulating and promoting the profession's philosophy, often drawing from established formal philosophies. For example, Adolf Meyer, a psychiatrist, first published "The Philosophy of Occupation Therapy" in 1922 (Figure 3-2). The paper was based on a lecture Meyer gave at the fifth annual meeting of what would become the American Occupational Therapy Association (AOTA). In this classic work, Meyer described the young profession as "a very important manifestation of a very general gain in human philosophy" (p. 4). It is likely that Meyer was addressing how OT was influenced by pragmatism, a formal philosophy of his day that has shaped OT's philosophical foundations to the present day (Breines, 1986; Cutchin, 2004; Hooper & Wood, 2002; Ikiugu & Schultz, 2006).

However, OT historian, Kitty Reed (2017) studied the lecture using the historical research method, source criticism. Reed noted that Meyer did not name prominent pragmatist philosophers John Dewey or William James in his lecture even though they were likely important influences. He did, however, mention 21 other individuals, namely, people with whom he had worked and others whose philosophical ideas—energetics, behaviorism, the Montessori Method, and time-binding—compelled him. Meyer's interesting mix of chronicling his employment, the people he'd met along the way, and some loosely connected philosophical views has made this lecture a difficult read for students and scholars alike. Altogether, the paper is a curious depiction of the philosophy of occupation therapy.

Discussing Adolph Meyer at the 2017 meeting of the Society for the Study of Occupation: USA, Reed shared another finding that could explain the curious structure of Meyer's lecture as we inherited it. The title of the lecture was originally "Evolution and Principles of Occupational Therapy in Personal Reminiscence and Outlook" ("Source in Therapists' Program Ready," 1921). To date, Dr. Reed has not found any correspondence between Meyer and William Dunton, then editor of the *Archives of Occupational Therapy*, to explain the title change. Reed imagined that perhaps Dunton thought the title was too long. She also noted that the word "occupational" with the "al" on the end appears in the original title but in the *Archives of Occupational Therapy*, the word was spelled "occupation." Like the title change, no explanation for the change in spelling has been uncovered.

Nevertheless, Meyer's classic lecture remains a source whereby students first appreciate the philosophy of OT.

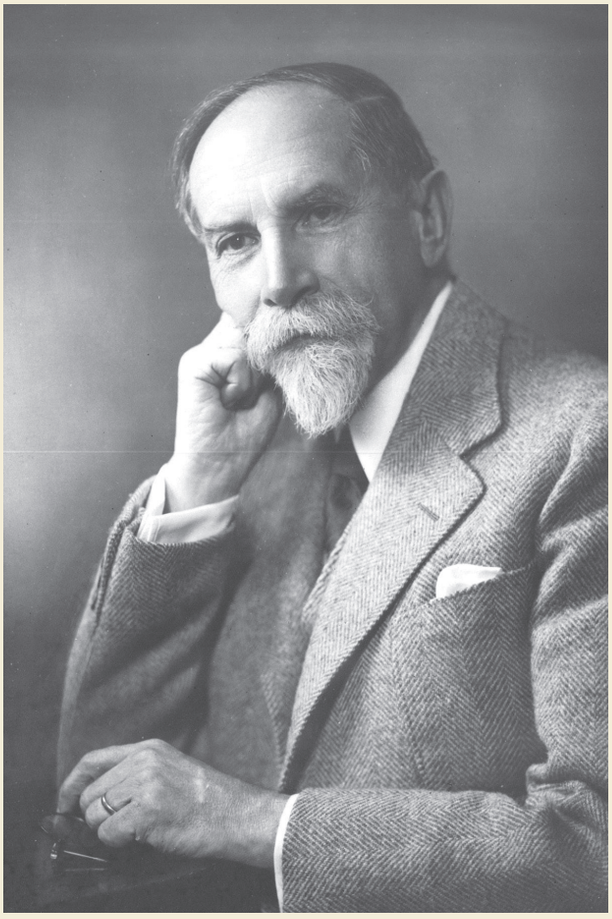

FIGURE 3-2 Adolf Meyer.

Knowledge of Occupation Is Primary for Occupational Therapists

Given OT's ontological premises, what is most important to know? Overwhelmingly, the answer is knowledge about occupation. As proclaimed by Weimer (1979), "Ours is, and must be, the basic knowledge of occupation" (p. 43). Reilly (1962) advised that knowledge about anatomy, neurophysiology, personality theory, social processes, and medical conditions that affect these functions, although relevant, are not our unique content. Rather, in Reilly's (1962, 1974) view, the unique knowledge of OT is a deep understanding of the nature of work and productive activity, including the play–work continuum, a belief that she believed aligned with what the founders of OT saw as most central to the new field. That occupation

continues to be held today as the foremost subject matter of OT has been corroborated extensively in the official documents of professional associations worldwide (AOTA, 2014, 2017; Craik, Townsend, & Polatajko, 2008; Hocking & Ness, 2002).

As the Primary Subject, Knowledge about Occupation Organizes and Integrates All Other Knowledge

In addition to what's most important to know, epistemology entails questions such as does knowledge have a structure? If so, then how is the structure to be conceptualized? Such questions are of particular interest because knowledge of occupation entails so many, and sometimes seemingly disparate, topics ranging from kinesiology to ethics and culture. Students can feel lost in the field's wide array of topics and, not seeing an organization among them, may mistakenly think that they can pick and choose based on personal interests. It is reassuring, therefore, that scholars have promoted the view that knowledge in OT has a structure.

For example, Kielhofner (1983) conceptualized OT knowledge as a matrix consisting of three integrated and hierarchical domains: biological, psychological, and social knowledge. Neuromusculoskeletal and kinematic knowledge was placed at the bottom of the biological hierarchy, not because it was considered basic knowledge for the field but because it was viewed as being influenced by knowledge at higher levels of the hierarchy, namely, the psychological, social, and symbolic dimensions of occupation. Given this structure, biological knowledge *works* for occupational therapists when it is understood to be regulated by the psychological, social, and symbolic dimensions of occupation. For example, although two people may have an identical injury, "A hand injury to an accountant is not the same as a hand injury to a clock maker" (Kielhofner, 1983, p. 79). In the same way, a hip fracture for a retired, married man is not the same as a hip fracture for a woman who is the caregiver for an ailing spouse. Each situation is unique because of the roles, values, goals, interests, and culture (i.e., psychological, social, and symbolic levels of Kielhofner's structure) into which the injury is introduced and for which it has consequences. Conversely, although two people may have disparate diagnoses, say, schizophrenia or spinal cord injury, they may both share the identical *occupational* diagnosis of limited occupational choice, again due to what is occurring at higher psychological, symbolic, and social levels of each person.

Kielhofner (2004) later modified the relationship between knowledge domains from hierarchical to heterarchical, yet the transactional structure among biological, psychological, social, and symbolic domains remained central to understanding human performance and participation. That is, the arrangements of musculoskeletal components during performance occur in spontaneous dynamic transaction with internal and external components such as intention and contours of an object.

As the Primary Subject, Knowledge about Occupation Clarifies Desired Consequences of Action

What is most important to know and how that knowledge is organized is often linked to a group's vision for society or a set of desired consequences that a group would like to see realized (MacIntyre, 1990). Pragmatist philosophers described knowledge as continually being developed and evaluated in light of "a coveted future" (Hooper & Wood, 2002, p. 42). Thus, knowledge about occupation and how it is structured reflects a future, a set of desired consequences toward which the profession aims. That future is the optimal participation of individuals and populations in health-promoting occupations (Wilcock & Hocking, 2015). This desired future serves as the beacon toward which practitioners aim their knowledge. The exact path for arriving at this distant beacon is discovered through active experimentation that involves piecing OT knowledge together for a given practice situation and evaluating the results in light of how well it contributed to the desired consequence of participation in occupation.

Knowledge Is Pieced Together In-for-and-with the Ever-Changing Practice Situation

Knowledge in OT is bound by subject, structure, and consequence. However, working within that boundary, practitioners continuously compose knowledge domains and modes of reasoning for each practice situation. For example, in Chapter 34, Schell illustrates how practitioners assimilate and use knowledge in multiple domains, including knowledge of (1) their own beliefs, values, abilities, and experiences; (2) professional theories, evidence, and skills; (3) clients' beliefs, values, abilities, and experiences; (4) clients' goals, expectations for therapy, and how health conditions impact their occupations; and (5) the practice culture and its influence on services. Additionally, practitioners shift rapidly among and integrate multiple modes of reasoning including scientific, narrative, pragmatic, ethical, and interactive reasoning (Mattingly & Fleming, 1994; B. A. Schell & Schell, 2018).

Practitioners not only integrate multiple knowledge domains through multiple reasoning processes but also do so again and again with each practice situation. Even if on the surface the situation seems routine, it is likely unique in subtle ways such as the emotional state of the therapist or client, a change in schedule, or a change in the social environment, all of which can make the present practice situation one of a kind. Practitioners recognize that each

practice situation is unique and changing even within a single therapy session. Thus, practitioners continuously assemble knowledge with and in response to each practice situation as it presents itself in each moment. Another way of saying this is: Practitioners use OT knowledge by configuring it for and with each practice situation.

The Essence of Knowledge Is Tentative, Fluid, and Contingent with the Arising Practice Moment

The earlier discussion culminates in the central consideration in epistemology: What is the nature of knowledge? In sum, knowledge in OT is bounded by its subject, occupation, and its desired consequence, health-promoting occupational engagement of individuals and populations. Additionally, there are structures for how knowledge about occupation relates to knowledge about its various elements. The subject, structure, and consequence of knowledge serve as boundaries for knowledge in the field. On the surface, these boundaries seem somewhat stable, yet they are always evolving in how we understand and talk about them. Thus, they are paradoxically enduring and tentative. On these seemingly stable foundations, OT knowledge is newly pieced together in-for-and-with each practice situation.

The essence of knowledge in OT is, thus, like a musical score. The practice of music is bounded by notes, music theory, and principles. These seemingly stable boundaries (understood and described in new ways over time) are continuously assembled into new pieces of music, and even the same pieces of music are experimented with and played with, given new interpretations in-for-and-with changing audiences and sociocultural situations.

That knowledge arises from the practice moment in a fluid and contingent manner is important for OT students to understand because it has everything to do with how students learn. That is, along with learning discrete content and skills, students need also to learn how to assemble knowledge, evaluate knowledge, and create knowledge in-for-and-with practice situations. To meet this epistemological challenge, some students find they have to dramatically shift how they have viewed themselves for many years, from a learner who receives knowledge from experts to a learner who thoughtfully and reflectively acquires and integrates knowledge in order to apply it flexibly according to what is needed for a practice situation. This shift can be life-changing (J. W. Schell, 2018b).

Axiology: What Is Right Action in Occupational Therapy?

The profession's axiology answers the questions *Given occupational therapy's central beliefs about reality and knowledge, how then shall we live day to day in practice? What do we value? What will we do?* As illustrated in Figure 3-1, views of reality and of knowledge "shape and direct how we *act* in the world . . . ." (Ruona & Lynham, 2004, p. 154). Coherence between how we act in practice and the other aspects of the field's philosophy is important to work out because as Wilcock (1999) cautioned,

> Skills without a philosophy can be a problem. It allows poaching outside a domain of concern, duplication of skills already available to those being served, the dropping of established skills for different ones when some other discipline changes its direction, or sticking to familiar skills because of no mandate to inform the direction to be taken. (p. 193)

To illustrate links between skills and philosophy, we discuss three key practice methodologies. We do not believe that these methodologies are comprehensive; for example, they do not encompass important values and actions outlined in the Occupational Therapy Code of Ethics (AOTA, 2015). We do believe, however, that these methodologies help to illustrate how actions flow from the field's ontological and epistemological premises as shown earlier in Figure 3-1. In accordance with those premises, we propose that OT's axiology can be summarized as follows:

> Practice involves collaboration with clients-and-environments-as-a-whole to achieve meaningful and satisfying participation in occupation and thereby optimal potential, well-being, and health.

Collaborative Practice

Because ever-changing humans, environments, and occupations are central to OT's beliefs about reality, it follows that entering into a personal collaboration with clients is a fundamental methodology for practice (Taylor, 2008). That is, through collaborative relationships, practitioners explore the occupations and environments with which clients seek to engage. Students will recognize this as client-centered practice but may not have considered how client-centered practice is an outward manifestation of a broader philosophical framework. Considering the philosophical framework in Figure 3-1, collaborative relationships express the profession's ontology. Similarly, if OT's central belief about knowledge involves piecing knowledge together in-for-and-with each situation, it follows that collaboration is necessary for the practitioner to determine which elements of knowledge and experience to assemble for the current situation. Thus, collaborative, relationship-centered practice constitutes a methodology that manifests OT values and beliefs about reality and knowledge.

By using the term, *methodology*, we do not mean to portray collaborative practice as a technical procedure; it

is, rather, a long-standing, normative way of practicing OT and exhibiting the profession's values. As Peloquin (2005) stated, "occupational therapy *is* [emphasis added] personal engagement." Watson (2006) elaborated, stating that if we are true to the field's philosophy,

> We will make a personal connection with people in a personal way. The people we are, who we have become . . . and our earnest desire to be of service, will lead us to reach out to the "being" of the "other." (p. 156)

This textbook has much to say about OT's use of collaboration as a methodology in practice. Our purpose here is to highlight how collaborative practice as a methodology stems directly from and manifests the field's views of reality, knowledge, and right action. Collaborative practice can, therefore, serve as a stimulus for reflecting on the congruence between philosophy and practice by asking the following:

- Does this assessment or intervention or my way of being with this client reflect collaborative, relationship-centered care?
- Is collaboration at the center of my actions as an occupational therapist?

Each practitioner will have to work out specific methods for collaborative practice within the parameters of client populations served, cultural contexts for services, and practice setting, among others. But whatever challenges present, collaborative, relationship-centered care is one methodology that naturally expresses the field's core values, ontology, and epistemology.

Occupation-Centered, Occupation-Based, and Occupation-Focused Practice

Because occupation is at the very center of an OT view of reality and what practitioners most need to know, it follows that a core methodology for practice is to help clients participate in meaningful, satisfying, and health-promoting occupations. Since the field's origin, practitioners have provided opportunities for people to engage in occupation and, in so doing, to develop and to transform their skills and potential (see, e.g., Christiansen, Baum, & Bass-Haugen, 2005; Kielhofner, 2004; West, 1984; Wood, 1998b). Students may associate these approaches with being occupation-centered and, therefore, with practicing in an occupation-based or occupation-focused manner. According to Fisher (2013), being occupation-centered means having adopted OT's profession-specific perspective, or "worldview of occupation and what it means to be an occupational being," as a guide to reasoning and action (p. 167). The methodology of occupation-based practice involves using occupation in evaluation and intervention, but this is a complex process that emerges from within each practice situation through collaborated relationships with clients (Price & Miner, 2007). The methodology of occupation-focused practice involves keeping one's immediate, proximal focus on occupation. From the start of care, therefore, practitioners seek to understand clients' occupations and use those throughout the therapy process. At all times, practitioners make explicit how their therapeutic approaches relate to the occupations that clients want and need to do. Therefore, like collaborative practice, practice that is grounded in occupation manifests beliefs about the occupational nature of humans and about knowledge as continuously being put together in-and-with each situation.

This textbook has much to say about the use of occupation-centered practice as a methodology. Our purpose here is to highlight how occupation-centered practice is a natural right action directly stemming from and manifesting the field's views of reality and knowledge. Occupation-centered practice can, thus, serve as a stimulus for reflecting on the congruence between philosophy and practice by asking the following:

- Does this assessment or intervention or my way of being with this client reflects occupation-centered practice?
- Is occupation at the center of my actions as an occupational therapist?
- Am I making a credible and meaningful connection for clients between occupation and each therapeutic approach that I use?

Once again, although each practitioner will have to work out specific methods for occupation-centered practice within the parameters of client populations served, cultural contexts for services, and practice settings, among others, occupation-centered practice is a methodology that naturally expresses the field's core values, ontology, and epistemology.

Context in Practice: Clients-and-Environments-as-a-Whole

The emphasis in OT's central belief about reality as an essential unity existing between people and environments leads to a third important methodology for practice, referred to here as clients-and-environments-as-a-whole. Occupations that are meaningful to clients—where they occur and with whom, the habits with which occupations are carried out, and the routines that help organize them, and even the musculoskeletal patterns used to perform them—occur in an interconnection between the environment and the client. This is equally true for the environments in which clients live and the environments in which they receive OT services, for example, the hospital, rehabilitation center, outpatient clinic, skilled nursing facility, home, work, school, or community (Cutchin, 2004).

According to Hasselkus (2011), seeing clients as tightly knit together with their environments through memories of places, occupation, meanings, roles, routines, and intentions can positively influence therapy outcomes related to adoption and follow-through with environmental modifications. Conversely, when practitioners view clients as separate from environments, they may overly focus on clients' performance. For example, practitioners may make recommendations for environmental modifications from a template such as widen doorways, put in stair lifts, remove throw rugs, add medical equipment, rearrange furniture, and move items to within easy reach. But because these recommendations have been considered as separate from the clients-and-environments-as-a-whole, the family may refuse to implement them.

Like the other methodologies presented, this textbook has much to say about OT's use of the performance context as a methodology in practice. Our purpose here is to illustrate how clients-and-environments-as-a-whole constitute a natural right action stemming directly from and manifesting the field's views of reality and knowledge. Clients-and-environments-as-a-whole can, therefore, serve as a stimulus for reflecting on the congruence between philosophy and practice by asking the following:

- Does this assessment or intervention or my way of being with this client reflects the unity reflected in clients-and-environments-as-a-whole?

Although each practitioner will, again, have to work out specific methods associated with this methodology within the multiple parameters previously mentioned, clients-and-environments-as-a-whole is a methodology that naturally expresses the field's core values, ontology, and epistemology.

Core Values in Occupational Therapy's Axiology

Lastly, although perhaps most importantly, the methodologies briefly presented earlier uphold and manifest core values of the profession that have been prominent throughout its history (e.g., Bing, 1981; Meyer, 1922; Peloquin, 1995, 2005, 2007; Yerxa, 1983). More specifically, inherent in these methodologies is a distinct valuing of and respect for

- The essential humanity and dignity of all people;
- The perspectives and subjective experiences of clients and their significant others;
- Empathy, caring, and genuine engagement in the therapeutic encounter;
- The use of imagination and integrity in creating occupational opportunities; and
- The inherent potential of people to experience well-being.

Application to Practice: From a Philosophical Framework to a Philosophical Mode of Thinking

Application of the philosophy of OT to practice requires a philosophical mode of thinking. A philosophical mode of thinking is bidirectional. In other words, this mode of thinking requires that a practitioner reflect on OT's philosophical assumptions about reality, knowledge, values, and action and walk those assumptions forward into practices that intentionally manifest them; it also involves reflecting on one's practice and identifying the assumptions about reality, knowledge, values, and action that it seems to manifest. Practicing this mode of thinking will help a practitioner develop a philosophical mind, which may be the most indispensable element of practice.

To further illustrate, consider Paul's (1995) contrast between a philosophical and nonphilosophical mind. The nonphilosophical mind is largely unaware that it thinks within a framework of assumptions and beliefs. Without a clear sense of the foundations that direct it, the nonphilosophical mind cannot critique those foundations; it is, therefore, somewhat trapped or run by its own unconscious, inherited system of thinking. The nonphilosophical mind tends to conform to how things are done, preferring straightforward methods and procedures without realizing that those also stem from systems of thinking. There is little awareness of a broader framework in light of which methods and procedures need to be evaluated.

Conversely, the philosophical mind is aware that all thinking occurs within and from a set of assumptions, beliefs, and values. It is keen on probing those, seeking congruence among them, and realizing them in action. The philosophical mind probes the systems of thinking reflected in methods and procedures and seeks to continuously refine those in light of its chosen broader framework of thinking. Because the philosophical mind does not confuse its own thinking with reality, it continuously considers alternative and refined thinking frameworks.

The two scenarios in the "Practice Dilemma" box (and additional learning activities on the Web) provide opportunities to build a philosophical mode of thinking, hence, to become more philosophically minded. The two scenarios are real, and we have portrayed them as accurately as possible based on direct knowledge of typical practices in each setting. We selected the scenarios because of their contrasts related to application of the philosophy of OT.

PRACTICE DILEMMA

Setting A

In Setting A, OT practitioners meet each morning to determine how the client caseload will be distributed and, as opportunities permit, collaborate across the day on intervention ideas. Priorities for self-care are determined with clients and only prioritized activities of daily living (ADL) tasks are addressed. In response to the many priorities of clients beyond basic and instrumental ADL, new occupational spaces have been created in the rehab "gym"; these include an office area with computers and Internet access and a work area in which various mechanical, leisure, or work-related activities occur. The kitchen is in constant use for clients whose priorities involve aspects of home management. After morning ADL, the day is filled with individual sessions, which range from 30 minutes to 1 hour, in addition to one group session. This scheduling approach meets productivity requirements. The occupational therapists played a leadership role in designing the group in which clients commit to completing one realistic occupational project over 3 to 5 days such as, for instance, outdoor picnics for clients and their families, collecting clothing for a women's shelter, and visiting a local flea market. Steps and tasks within these projects are assigned based on clients' interests and the likelihood that they will be both challenged and successful. Although individual sessions may include exercises as a "warm-up," the focus is on either the client's occupational goals or aspects of the group's occupational project. Clients are also often given "occupational homework" for weekends. Significant others are encouraged to take part in both individual and group therapy sessions. When possible, home visits are undertaken to help identify what occupations take place in what spaces and to collaborate with clients and their significant others about acceptable modifications. Discharge planning involves setting up environments and tasks as closely as possible to clients' usual contexts and performance patterns.

Setting B

In Setting B, OT practitioners meet each morning to determine how the client caseload will be distributed and then go about their day largely independent of each other. All clients receive OT for basic ADL in the morning; practitioners emphasize ADL independence and typically complete the same ADL tasks with all clients. The rest of the day consists of consecutive 30-minute individual sessions followed by brief documentation breaks; this way of scheduling sessions is sufficient to meet the high productivity demand of the setting. Sessions emphasize physical components of function such as range of motion, strength, and endurance; prominently used modalities include theraband or putty, the range of motion arc, cones, wrist weights, the upper extremity ergometer, pulleys, dowel exercises, various physical agent modalities, and ball or balloon toss. Also addressed are visual-perceptual and cognitive components of function using modalities such as paper-and-pencil activities, puzzles, pegboards, and computer-based exercises. Intervention seldom varies from client to client, and some clients question why they need to see the occupational therapist because they already had their "therapy," that is, physical therapy that day. There is a kitchen that is used for splinting and staff meetings. Significant others are discouraged from attending therapy so that clients will not be distracted. When a client needs two people to complete a transfer or ambulate, an occupational therapist and a physical therapist may see the client together. Discharge planning may include a kitchen activity such as making a cup of tea to determine safety for returning home. Significant others receive training the last day of service before a client is discharged.

Specifically, the practices in Setting A suggest that practitioners are well grounded in the philosophy of OT and apply a philosophical mode of thinking to how they conceive and deliver services. The practices in Setting B suggest only weak links to the profession's philosophy and little evidence of a philosophical mode of thinking. Despite this divergence, both scenarios are from fast-paced, for-profit hospitals with subacute adult neurorehabilitation programs in which demands for productivity are equally high. Also in both settings, clients have various neurological conditions and many have suffered from strokes or other brain injuries. Occupational therapy is provided two or three times daily in both settings and length of stay typically ranges from 3 to 10 days.

As you read each of these practice dilemmas, consider how philosophy contributes to the different practice approaches in each setting. Specifically,

1. Identify both ontological and epistemological assumptions and beliefs that are manifested in how OT is understood and practiced in each scenario.
2. Identify core values that underlie the predominant practice methodologies and methods in each scenario.
3. Guided by Figure 3-1, identify areas of congruence and incongruence with the philosophy of OT in each scenario.
4. For Setting A, identify strategies that practitioners may have used to help them practice in a philosophically minded manner. Do you believe these same strategies might have been possible in Setting B? Why or why not?

Conclusion

As is true of all professions, belonging to and working in OT requires fidelity to its unique philosophy and practice approaches and, additionally, building congruence between

those and one's personal philosophies. Wilcock (1999) urged that if such an examination suggests strong *in*compatibility between professional and personal philosophies, then engagement with OT should likely cease for the good of the professional (or student), future clients, and the profession itself. Conversely, Wilcock related congruence between one's personal philosophical and one's professional philosophy with the possibility for meaningful, satisfying, sustaining, and impactful work. Thus are the stakes high for engaging in philosophical modes of thinking.

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