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Tools of Practice: *Heritage or Baggage?*

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Over the years, occupational therapists have adopted or adapted numerous media and methods. The list is so long it staggers the imagination. Yet explanations for the changing practice scene are rare. Few therapists seem to know *why* media come and go or even *when* or *how* various media or methods became part of the occupational therapy tool kit. Why do occupational therapists drop some media or methods like so much excess baggage? Is occupational therapy losing its heritage or keeping up with the times?

The question of heritage first occurred to me during Mary Fiorentino's Slagle Lecture (Fiorentino, 1975). She said she used no arts and crafts in her clinic, implying that such media were no longer useful in the treatment tool kit of occupational therapists. Many people applauded her pronouncement as if occupational therapy finally had shed its 19th century image and joined the 20th century. Her denunciation of arts and crafts set me thinking. Why did arts and crafts become a medium of occupational therapy in the first place? What about other media and methods, such as sanding blocks or work-related programs? Discussions with colleagues produced few answers except that arts and crafts had always been taught since the days of the founders. Therefore, I decided to investigate the literature, historical documents, and old photographs to find some answers.

The objective of this article is to suggest reasons why certain media and methods have evolved as the treatment of choice in occupational therapy in a particular period of time. Likewise, a discussion of why certain media and methods fall into disfavor is relevant.

Definition of Media and Methods

A *medium* is an intervening mechanism through which a force acts or an effect is produced (Morris, 1981). In therapy the medium is the means by which the therapeutic effect is transmitted. A sanding block, a weaving loom, a vestibular board, and a large plastic ball are all media or means by which the therapeutic effect of occupational therapy is activated. Of

course, the same objects can be used for other purposes not related to the therapeutic effect of occupational therapy.

Methods are the manner of performing an act or operation: a procedure or technique (Dorland's, 1985). In therapy the methods constitute the steps, sequence, or approach used to activate the therapeutic effect of a medium. Examples include one-handed techniques, joint protection, work simplification, and activity configuration. Thus, media and methods are two sides of the same coin. Media provide the means, and methods provide the manner through which the therapeutic effect of occupational therapy is achieved.

Definitions describe but do not determine what will become a therapeutic medium or method. To discover how an object or approach becomes identified as having therapeutic potential, one must look outside a dictionary. Analysis of media and methods over several years has suggested to me that there are eight primary factors that account for which media and methods are selected or discarded from the occupational therapy tool kit. These factors are cultural, social, economic, political, technological, theoretical, historical, and research (Christiansen, 1981; Cynkin, 1979; Di Sante, 1978; English, 1975; Jantzen, 1964; Johnson, 1983; Kielhofner, 1985; Kielhofner & Burke, 1983).

Factors in Selecting and Discarding Media and Methods

Culture is the most pervasive but hidden factor in the selection of media and methods in occupational therapy practice (Cynkin, 1979; Kielhofner, 1985). Occupational therapy was organized around the concept of improving people's abilities to deal with their daily lives. Therefore, it is logical that activities, occupations, or daily living tasks would be selected and used as media and methods. The activities, occupations, and daily living tasks are determined by the culture in which a person lives. A simple example is eating utensils. In Western culture the knife, fork, and spoon are used, but in Eastern culture chopsticks are used to get food from the serving vessel to the mouth. Thus, an occupational therapy clinic in America likely will contain eating utensils that resemble knives, forks, and spoons, but an occupational therapy clinic in Japan likely will contain chopsticks or adaptations of chopsticks.

The social factor is more conspicuous than the cultural (Cynkin, 1979; Kielhofner, 1985). Media and methods are subject to social acceptance or nonacceptance, which often is influenced by marketing and advertising strategies and changing values. The marketing strategies and changing values in turn create fads or trends that influence purchasing decisions. An example is the ongoing issue of whether handmade or machine-made products are superior in quality and value. Is there a difference in the warmth provided by a sweater made of the same yarn when one is handmade and the other made by machine? Probably not. Why then would a person pay more for one than the other? Because social factors, such as perceived value, enter the picture.

The economic factor affects the selection or discarding of media because some media cost more to use and may or may not be reimbursable by third-party insurance. Building a 16-foot boat could be a very therapeutic occupational activity, but the cost is a little high for many therapists' budgets and probably not reimbursable through most health insurance plans.

The impact of political factors on media and methods has been well documented. Diversional methods of occupational therapy have been ruled out of reimbursable services for many years. More recently there have been disputes over the use of occupational therapy for people with hip replacements or sensory integrative dysfunction.

Technological factors can have a dramatic impact on the media and methods of occupational therapy. Perhaps the best example is the change that has occurred in splinting with the advent of plastics. Originally splints were made from plaster reinforced with wire. The process was tedious, and the product subject to frequent breakdown. Then came plastics, but they had to be heated at high temperatures and tended to become brittle with age. The advent of low-temperature plastics allowed a splint to be made in a few minutes in a small frying pan. Splints from this material last for many months without noticeable change in molecular structure.

Some media and methods develop directly from a given theoretical model. An example is the use of vestibular boards, which is a direct application of the sensory integration model. When a medium or method is associated only with one theoretical model, it is easy to determine the origin. However, some media and methods can be used within a variety of theoretical models, and thus identification becomes more difficult. Cooking, for example, can be viewed as essential to nutrition, a pleasurable reward, a social activity, a paid vocation, a leisure skill, or an educational task. How many theoretical models encompass cooking as a medium and method?

The historical factor influences media and methods because some media and methods have been associated with occupational therapy from the earliest records and their origin is now obscure. For example, the use of the bicycle jigsaw can be traced back to occupational therapy clinics in 1918, but the trail is difficult to follow beyond that point. Who built the first bicycle jigsaw, and what was the original therapeutic objective?

Finally, research influences the selection and discarding of media and methods. For example, the research on building muscle strength led to the concept of progressive resistive exercise, which in turn led to the development or adaptation of media that can be modified to provide increased resistance. Many floor looms were modified in the 1950s and 1960s to provide increased resistance to shoulder, arm, hand, and leg muscles.

These factors can be explained further in a set of assumptions about their effect on the selection and discarding of media and methods in occupational therapy. The 14 assumptions can be stated as follows:

1. Media and methods become tools of occupational therapy through one or more of the eight factors.
2. Media and methods disappear from the tool kit of occupational therapy because of one or more of the eight factors.
3. The factors may operate to change the selection or discarding of media and methods singly or, more often, in combination.
4. Occupational therapists should understand the effects of the eight factors on the media and methods used in occupational therapy practice. (See Table 34.1 for a list of subfactors under the factors.)

Table 34.1. Factors in the Selection and Use of Media and Methods

<p>1. Cultural factor Dominant culture Subdominant culture</p> <p>2. Social factor Upper, middle, or lowerclass custom Fad or tradition</p> <p>3. Political factor Family or extended family politics Local community politics State or national politics</p> <p>4. Economic factor Budget of department or hospital Reimbursement policies</p>	<p>5. Technological factor New invention Modification of known invention</p> <p>6. Theoretical factor Organismic philosophy Mechanistic philosophy</p> <p>7. Historical factor Significant Incidental</p> <p>8. Research factor Supports statements Refutes statements</p>
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5. Media and methods are selected from the dominant existing culture.
6. The sociocultural meaning of a medium and its methods may change over time and be used for a different reason or be discarded.
7. When the sociocultural rationale for a medium or method is lost or changed, the medium may be used in therapy in ways that make little sense to patients or other health professionals.
8. Economic considerations affect the selection and discarding of media and methods and thus restrict their use if the price is too high or if the cost is not reimbursable.
9. Changes in political issues may restrict or facilitate both the selection and use of various media and methods in occupational therapy based on decisions to cover them under or to exclude them from health care programs.
10. Technology introduces new possibilities or modifies existing ones, allowing new media or methods to emerge.
11. Media and methods may be selected because they operationalize an existing theoretical model recognized by the profession.
12. A medium or method may be used in more than one model. Therefore, the therapist must know why a medium or method is being used and change the explanation when a new model is adopted.
13. Historical precedent is the least desirable justification for the existence and continued use of a medium or method but the easiest to explain.
14. Selection and use of media and methods based on research and study is the most professionally responsible approach to justifying the use of a medium or method but the most difficult to obtain.

To illustrate how the eight factors and 14 assumptions operate, I have selected three media and their methods from among the many possible choices. The three are arts and crafts, sanding blocks, and work-related programs. Arts and crafts will illustrate the cultural, social, technological, and historical factors; the sanding blocks will illustrate the theoretical and research factors; and work-related programs will illustrate the political and economic factors.

Arts and Crafts

The use of arts and crafts as media and methods in occupational therapy is directly attributable to the arts and crafts movement that was in full swing during the formative years of occupational therapy early in this century (Levine, in press-a, in press-b). The movement was designed as a cure for the social ills of a society struggling to deal with the impact of the Industrial Revolution. During the 1800s, Western civilization changed from an agrarian to a manufacturing economy; from a cottage industry to a mass production society; from a consumer-driven marketplace to a producer-driven marketplace; from a patronage system to an industrial wealth system; from pride in workmanship to concern for profit; and from an ordered society of similar cultural backgrounds to a disordered society of many cultures and customs. These factors all played a role in the demise of moral treatment. The arts and crafts movement provided a means of revitalizing the ideas of moral treatment in a new rationale, which the founders and early leaders of occupational therapy were quick to understand. Thus, the arts and crafts movement is the missing link between moral treatment, which dominated the practice of medicine in the 1800s, and the treatment models to follow.

The arts and crafts movement began in England. The original philosophy was based on the “conviction that industrialization had brought with it the total destruction of ‘purpose, sense and life’ ” (Naylor, 1971). Mechanical progress had been gained at the expense of human misery and the destruction of fundamental human values. Thus, the arts and crafts movement “was inspired by a crisis of conscience” (Naylor, 1971). Its motivations were social and moral, and its aesthetic values derived from the conviction that a society produces the art and architecture it deserves (Naylor, 1971). To that idea could be added the thought that society produces the life-style it deserves.

Many people contributed ideas and thoughts to the arts and crafts movement, and not all agreed as to their importance. Therefore, a summary of concepts must be general. The arts and crafts movement did the following:

- Advocated the simplification of life and ordering of daily activity as opposed to the overcomplicated or idle life (Borris, 1986; Kornwolf, 1972; Lears, 1981; Shi, 1985; Wagner, 1904);
- Valued the “craftsman” ideal, in which occupation was pursued at its own pace and not on a production schedule (Borris, 1986; Kornwolf, 1972; Lears, 1981);
- Valued the standard of craftsmanship that gave an honest day’s work for an honest day’s pay, rather than exploitation of the worker or cheating by the employee (Borris, 1986; Kornwolf, 1972; Naylor, 1971);
- Favored returning to the land and the home as a means of escaping the crowded, unhealthy, unnatural conditions of the city and factory (Lears, 1981; Shi, 1985);
- Ennobled the power of handwork as useful, important, a joy, and a pleasure, as opposed to mindless, repetitive activity on an assembly line, which was viewed as drudgery (Borris, 1986; Lears, 1981);
- Promoted an appreciation of performing the process and the inherent satisfaction or pride in doing or making a product, as opposed to concern only for sale and profit (Naylor, 1971);

- Encouraged respect for the inherent properties of materials and opposed any deception designed to make a material look like something it was not (Kornwolf, 1972);
- Considered functionalism and fitness of purpose the best guide to decoration, as opposed to ornamentation that served no purpose (Borris, 1986; Kornwolf, 1972);
- Believed that manual training of children would increase knowledge of moral aesthetics and improve work skills, as opposed to intellectual learning only (Borris, 1986; Lears, 1981);
- Valued the creative spirit in the artist and abhorred the mindless copying of designs (Borris, 1986);
- Attempted to improve the standards of taste and aesthetics, as opposed to allowing moral decay (Borris, 1986; Shi, 1985); and
- Viewed people as more than mere machines; human beings as having morals, values, and a sense of purpose (Kornwolf, 1972; Shi, 1985).

One early influence of the arts and crafts movement on occupational therapy came from Jane Addams. In 1900 she started the Hull House Labor Museum, because she wanted young people to see that the complicated machinery of the factory had evolved from the simple tools that their parents had used in the old country before immigrating to America. She wanted to interest young people in the older forms of industry so they would see “a dramatic representation of the inherited resources of their daily occupation” (Addams, 1945). The Labor Museum not only showed how spinning, weaving, pottery, and many other crafts were done, but also provided classes to teach people how to do the crafts. Addams admonished educators, saying that “educators have failed to adjust themselves to the fact that cities have become great centers of production and manufacture, and manual labor has been left without historic interpretation or imaginative uplift” (Addams, 1900, p. 236). Thus, when the training courses for attendants were started in 1907, in conjunction with the Chicago School of Civics and Philanthropy, there was a stress on the idea that occupation should be used as a means of education and that education was to substitute for custodial care of the mentally ill (*20th Biennial Report*, 1909).

In 1914, Eleanor Clarke Slagle started the Community Workshop under the auspices of the Illinois Society of Mental Hygiene. Its purpose was to serve as a clearinghouse for cases of doubtful insanity whom the courts considered as showing promise of a return to usefulness if given a proper environment and trade (Favill, 1917). The environment was the Hull House Labor Museum. In 1917 the Community Workshop became the Henry B. Favill School of Occupations. The following year, the first course in curative occupations and recreation was offered (*Special Courses*, 1917). Again the Labor Museum at Hull House served as the laboratory until the school was moved to the headquarters of the Illinois Society of Mental Hygiene in late 1919.

Another person to incorporate the ideas of the arts and crafts movement into treatment was Herbert J. Hall. In 1904 Hall began his studies of alternate treatments to the “rest cure” for neurasthenia. He was assisted by Jessie Luther, OTR, the first curator of the Hull House Labor Museum (Luther, 1902). Hall states that the “modern Arts and Crafts idea appealed very strongly, because of the growing interest in the movement and because of the clean,

wholesome atmosphere which surrounds such work, and because of the many-sided appeal which such a work as the making of pottery, for instance, has to most educated minds" (Hall, 1905). Hall believed that faulty living was the cause of neurasthenia and that what was needed was a change in occupation and habits. Manual work based on the life of the artisan (craftsman ideal) was recommended itself because it was simple. The "simple life," he felt, was best for neurasthenics because it offered the least food for the nourishment of neurasthenia and provided a structure of normality. Today the person with neurasthenia would be classified as suffering from stress or burnout. The "simple life" would be called stress reduction, and the "craftsman ideal" would be called time management.

In 1906 Hall received a grant from the Procter Fund of Harvard University for \$1,000 to "assist in the study of the treatment of neurasthenia by progressive and graded manual occupation." His study at Marblehead, Massachusetts, probably was the first grant-funded research project on the use of occupation as a means of treating patients. He reported that 59 of 100 patients improved, 27 were much improved, and 14 received no relief (Hall, 1910).

The arts and crafts philosophy was summarized in the "Philosophy of Occupation Therapy" by Adolf Meyer (1922). He said, "Our industrialism has created the false idea of success in *production* to the point of overproduction, bringing with it a kind of nausea to the worker and a delirium of the trader . . ."—in other words, loss of the craftsman ideal. Meyer said, "The man of today has lost the capacity and pride of workmanship and has substituted for it a measure in terms of money." In other words, there was a loss of respect for hand work. And he said that there is "a real pleasure in the use and activity of one's hands and muscles." In other words, one can find pride and satisfaction in performing and doing. Furthermore, "Our body is not merely so many pounds of flesh and bone figuring as a machine."

A final example of the influence of the arts and crafts movement on occupational therapy is the regional location of the arts and crafts societies that developed to organize the work of the arts and crafts movement. The three major areas of the country that responded to the arts and crafts movement were New England, Chicago and the Midwest, and the Pacific area (Clark, 1972). There is a strong correspondence between these three areas and the areas where there are large numbers of occupational therapists today.

The specific location of the societies also influenced occupational therapy. Thirteen states had at least one known arts and crafts society in 1904 (West, 1904). Of the 13, nine (69%) developed early programs in occupational therapy before 1920. All 13 states have occupational therapy programs today (West, 1904).

Considering its influence, what happened to the arts and crafts movement? It was overtaken by World War I. The rules of the game changed for many people. The war effort provided its own sense of purpose. Some industries did hire craftsmen to improve designs, and machine-made products did improve in quality. City life improved as sanitation efforts made inroads against the piles of garbage. The expanding population meant that machine manufacture was the only means of providing products for everyone. Hand production was just too slow and too expensive.

How did the changes influence occupational therapy? What factors were changing the role of the arts and crafts in practice? The cultural scene had shifted: Society was no longer

struggling to adapt to city life, and the factory system had been integrated in the fabric of American life. The number of people living on the land would continue to decrease over the coming years. People had become used to the technological changes the factory had produced. Machine-made goods were acceptable and could be made in quantities unknown under the handmade system. Young therapists did not remember the arts and crafts movement and did not know what it represented. They only knew that arts and crafts always had been a part of occupational therapy's tool kit. Finally, a new philosophy was overtaking the profession. The humanistic ideas of the founding years were being challenged as unscientific and unmeasurable. The profession was being reformulated in such a manner that the arts and crafts philosophy made little sense. Not until the 1960s would the founding ideas resurface. Figure 34.1 illustrates the changing theory and philosophy of the arts and crafts ideology.

Sanding Blocks

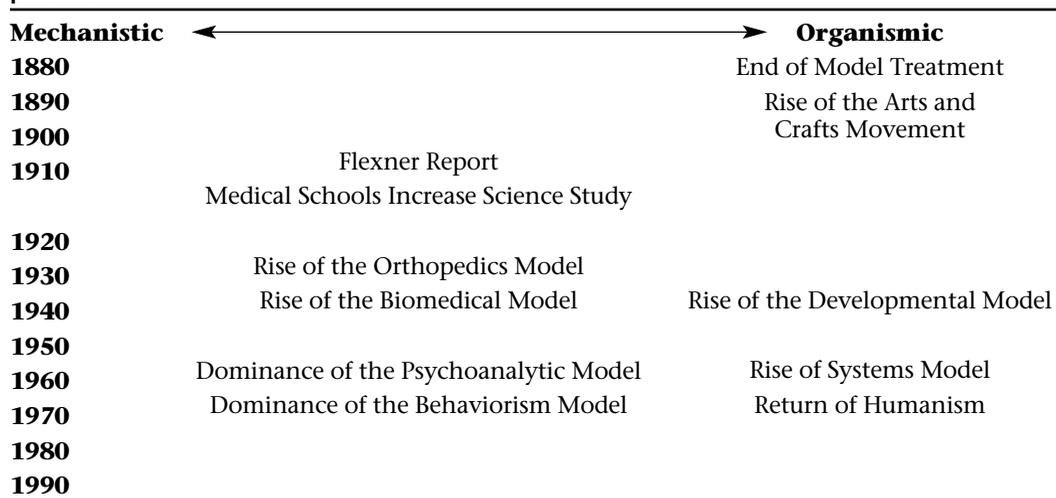
Sanding blocks, or sandblocks, are a common sight in many occupational therapy clinics. Nearly all occupational therapists become acquainted with them during their education, and many have made sanding blocks. Yet, few can describe the origin and original purpose of the sanding block or trace the changes in thinking about their use over the years.

Woodworking and sanding can be traced to the beginning of occupational therapy history. The initial use of sanding blocks, however, is unclear. The first mention of them appears in 1934 in an article by Henrietta McNary. In the same article, the first description of an adapted sanding block also appears. Its purpose was to improve opposition. The last article in our literature on a sanding block, a reciprocal sanding device, appears in 1965 (Mathews, 1965). In all, 14 different types of sanding blocks are presented. These are listed in Table 34.2.

The dates of the articles on sanding blocks coincide with the rise and fall of the orthopedic and kinesthetic treatment models of occupational therapy. The orthopedic model followed the arts and crafts model. It was concerned with muscle strengthening and range of motion. Stretching contractures, exercise, and physical tolerance also were included. These concepts form the basis of the objectives for which the sanding block was used. A summary of these purposes or objectives is found in Table 34.3.

The use of sanding blocks has not disappeared, but the theories underpinning their development and use have been superseded by the sensorimotor and sensory integration models. As a result some unusual uses of sanding blocks have surfaced. For example, one therapist was observed giving a patient a sanding block with no sandpaper and an incline plane made of formica. Because the patient did not want to make anything, the therapist explained that the purpose of the activity was bilateral exercise. In this example, the fundamental concepts of occupational therapy, performance through doing and the use of occupation toward some purpose, were overlooked or separated from the application. The medium of sanding blocks and the methods of setting up the activity to obtain selected objectives had been separated from the original concepts so the meaning and purpose of the activity were lost. The *motion* of sanding is a necessary but not sufficient part

Figure 34.1. Relative influence of organismic and mechanistic models on occupational therapy practice.



of the *activity* of sanding. The media, the methods, and the objective of an occupation must be consistent with each other. Three out of three—medium, method, and objective—must be the rule, not the exception.

Sanding blocks illustrate the factors of theory and research. The many adaptations of the sanding block are based on the theoretical concepts of the orthopedic and kinesthetic treatment models, which stress positioning the body part in the desired pattern of motion and then encouraging that motion to stretch, strengthen, or increase the motion of a particular body part or parts. Research supported the concept that increased amounts of resistance applied to a given muscle group would strengthen the muscle group involved. This concept became known as progressive resistive exercise.

Table 34.2. Types of Sanding Blocks

1. Proximal sanding blocks (Abbott, 1957; *Photographs*, 1947)
2. Proximal interphalangeal sanding block (Abbott, 1957; *Photographs*, 1947)
3. Metacarpal phalangeal sanding blocks (Abbott, 1957; *Photographs*, 1947)
4. Distal sanding block (Abbott, 1957)
5. Opponens sanding block (Abbott, 1957)
6. Shoulder abduction sanding block (“Adapted,” 1957; Bennett & Driver, 1957)
7. Spring squeeze sanding block (Gurney, 1959)
8. Grip sanding block (Hightower et al., 1963)
9. Reciprocal sanding device (Mathews, 1965)
10. Weighted sander or progressive resistive exercise sander (Svensson & Brennan, 1954)
11. Bilateral sander, horizontal or vertical handles (*Photographs*, 1947)
12. Wrist exercise sander (Blodgett, 1947)
13. Hemiplegia sander (Forbes, 1951)
14. Graduated sanding blocks—graduated straight handles or graduated round knob handles (*Photographs*, 1947)

Table 34.3. Purposes or Objectives of Sanding Blocks

Sanding blocks were adapted to provide the following:

1. Different hand grip position for active or passive stretching:
 - a. Handles were added and enlarged.
 - b. Holes or grooves were drilled or carved for finger and thumb placement.
 - c. Straps were added to hold the hand in place.
 - d. Gloves were used to position the hand.
 - e. Construction was altered to provide a different grip than that normally used.
 2. Dynamic exercise of wrist, elbow, or shoulder—usually range of motion
 3. Increased grip strength of hand and fingers
 4. Bilateral activity of the upper extremities
 5. Reciprocal activity of the upper extremities
 6. Improved trunk stability
 7. Standing and physical tolerance
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Work-Related Programs

Work-related programs were a part of the early ideology of occupational therapy. The term *work-related programs* is used to represent all efforts to enable people to engage in productive occupations through occupational therapy, whether the effort is aimed at vocational education, vocational guidance, prevocational evaluation and training, vocational training or retraining, vocational readiness, work hardening, work adjustment, or career education.

Hall was very interested in helping patients find an alternate occupation that would be less stressful and more suitable to the person's needs. The "work cure" was based on the assumption that by substituting or bringing about "by a gradual process the conditions of a normal life, a life of pleasant and progressive occupations, as different as possible from the previous life, a person could overcome the mental and nervous problems in his life" (Hall, 1905).

George E. Barton said he was going to "try to prove that the hours of idleness in convalescence could be filled with pastimes which would be useful not only to pass the time, but to prepare the person for remunerative labor later on to get a job, a better job, or to do a job better than it was before" (Barton, 1914). Consolation House was created to serve the needs of people who were learning to put their lives back together and who needed assistance to find an occupation suitable to their abilities but not limited by their disabilities.

Slagle had experience in assessing people's fitness for a job at the Community Workshop at Hull House. At the founding conference of occupational therapy in Clifton Springs, New York, she spoke of a family of five who had been supported by charities for many years. After one year at the Community Workshop, the family was self-sufficient (Dunton, 1917).

Thomas B. Kidner, Vocational Secretary to the Military Hospitals Commission in Ottawa, Canada, was well acquainted with the vocational side of occupational therapy. In June 1918, he was loaned by the Canadian government to the United States as a special adviser on rehabilitation to the Federal Board for Vocational Education (FBVE). The FBVE

had been created the previous year to establish a federal-state program in vocational education. In 1918 it had been given the authority and responsibility for the vocational rehabilitation of veterans ("Editorial," 1922). Elizabeth G. Upham (later Davis), who had been instrumental in starting the occupational therapy course at Milwaukee Downer College, also joined the FBVE in 1918. She wrote two documents illustrating the role of occupational therapy with the disabled veteran (Upham, 1918a, 1918b) and recommended that the FBVE be given control of military patients as soon as possible in order to prepare them for adjustment to normal life (Davis, no date). Had her recommendation been accepted, occupational therapy's role in vocational preparation would have been larger than it has been. Both Kidner and Upham left the FBVE in 1919.

The medical department of the army also had a plan for the rehabilitation of disabled soldiers. It had created a system of orthopedic reconstruction hospitals that included vocational workshops and employment bureaus (Gritzer & Arluke, 1985). The dispute over who would do what came to the floor of the U.S. Senate in July 1918. The medical department of the Army was granted the exclusive right to all aspects of functional restoration and medical control over curative work. This action bound occupational therapy to medicine's domain. The FBVE on the other hand was given responsibility for vocational rehabilitation. The separation became more divided in 1920 when the Industrial Rehabilitation Act was passed without any coverage for medical services. Bulletin #57 of the FBVE makes it quite clear than any occupational work not related to the vocation for which the injured person is being trained is evidently given for its therapeutic value. Therapeutic use of work was viewed as part of the injured person's physical rehabilitation rather than vocational rehabilitation and therefore was not covered under the act ("Industrial Rehabilitation," 1920). Thus, occupational therapy was cut off from many of its work-related programs by a political compromise over which it ultimately had little control. Work-related programs were not reestablished until 1943 when the Vocational Rehabilitation Act was changed to include coverage for medical services (Lassiter, 1972). In 1954, the Vocational Rehabilitation Act was further modified to include coverage for the training of rehabilitation personnel, including occupational therapists. In addition there were monies for research and demonstration projects (Lassiter, 1972). Among the demonstration projects were prevocational evaluation and training centers in which occupational therapists played a significant role. However, by the 1960s these projects became too expensive to continue, and the role of occupational therapy in work-related programs again went into a period of decline. Finally in the 1980s the interest returned. A position paper was written and a grant was funded to increase occupational therapists' awareness of the role of occupational therapy in work-related programs. Some of the current interests are assessment of work potential and aptitude skills, physical capacities assessment and work hardening, job evaluation, work experience, career exploration and job seeking skills, independent living, and industrial consultation.

The level of occupational therapists' interest and opportunities in work-related programs has waxed and waned over the past 80 years. The fluctuations can be traced to politics and economics. When both were favorable or neutral, occupational therapists

provided many examples of programs designed to help a person to gain or regain productive skills. However, when the politics and economics made it difficult for occupational therapists to provide such skill assessment and skill training, their activity in work-related programs decreased. The challenge will be to shape the political and economic factors in favor of occupational therapy if therapists want to maintain their role in helping people attain or regain productive skills.

Occupational Analysis

As illustrated thus far, the selection and discarding of media and methods in occupational therapy have not been accidental. Factors converge and diverge to increase or decrease the likelihood that a particular medium and its methods will be selected or discarded in the practice of occupational therapy. Culture sets the major parameters, but changes in society frequently alter the cultural set. Political and economic factors often work in combination. Political factors can be influenced by occupational therapists, but some events may occur over which therapists have little control. The results may be felt most keenly economically when reimbursement patterns result in changes in coverage of occupational therapy services. Technology may lead to dramatic changes in media or methods. Theoretical factors often introduce new media and methods into the treatment setting. Sometimes the new theory or model brings new media and methods with it; at other times just the explanation and the use of an existing medium or method changes. History often is used to explain the existence of media or methods when the origin has been lost through time. Research offers a better explanation for the use of media and methods but is more difficult to obtain.

All of these factors need to be considered when examining why certain media and methods appear in a clinic or practice setting. Can practicing occupational therapists explain why each medium or method is used in their practice setting? Is the explanation the best one, or is the explanation of history used by default? Perhaps a more systematic use of occupational or activity analysis should be promoted which includes the selection and discarding of factors as well as considerations such as range of motion, sensory stimulation, or amount of social interaction obtained.

Central to each of the factors are the concepts of interests and values. A culture, individuals, and professionals have interests and values. An interest is defined as a set that guides behavior in a certain direction or toward certain goals (Chaplin, 1975). A value is a social end or goal that is considered desirable to achieve (Chaplin, 1975).

In occupational therapy there seem to be three major areas to consider in interest and values. These are culture and society, the individual, and the profession. The eight factors that affect selection and discarding of media and methods can be organized under the cultural and social interest and values and professional interests and values. Under the *cultural and social* area are the cultural, social, economic, political, and technological factors. Under the *professional* are the theoretical, historical, and research factors. Under the *individual* are factors that must be determined by assessment of each individual. These are the roles per-

formed by the individual and the functional abilities, skills, and capacities of the individual. When the three areas of cultural–social, individual, and professional interests and values are considered, there should be less chance of using media and methods that are out-of-date in society, not meaningful to the individual, and of questionable use to the profession.

Summary

This article presents and illustrates the major factors that influence the selection and discarding of media and methods in occupational therapy. The eight factors are the cultural, social, economic, political, technological, theoretical, historical, and research factors. The factors may operate in various combinations or alone to influence the use of a specific medium or method in practice. Therapists are encouraged to know these eight factors and in particular to be familiar with (a) what media and methods occupational therapists use, (b) why occupational therapists use those media and methods, (c) from where the media and methods come, (d) with whom the media and methods should be used in treatment, (e) how the media and methods are used, (f) when the media and methods are used, and (g) how much of the medium or method should be used. Educators, in particular, need to teach why a medium or method is used as well as how. Researchers need to provide more information as to why certain media and methods became part of our tool kit. Practitioners would be wise to follow the statement, If you know how, be sure you know why and be sure the why is consistent with the philosophy of occupational therapy.

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