

1966 Eleanor Clarke Slagle Lecture

Authentic Occupational Therapy

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In the spring of 1963 I attended the “Workshop on Graduate Education in Occupational Therapy” held in the Ozark Mountains of Missouri. The air was heavy with the fragrance of a million dogwood blossoms. I was just settling into a mood of peacefulness when my tranquility was abruptly shattered by Earnest Brandenburg, dean of the University College of Washington University. Dean Brandenburg said, “It is my candid judgment that the field of occupational therapy in 1963 is *not* regarded and probably should not be identified as one of the professions.”¹

What image do you see when you think of a professional? A person who always wears clean white shoes or someone who can spout off the origins and insertions of every muscle in the body or one who can discuss Freudian theory with a psychiatrist? No, professionalism is much more than appearance and intellectual accomplishments. It means being able to meet real needs. It means being unique. It means having and acting upon a philosophy. It also means being “authentic.”

Steps Toward Professionalism

In 1966, occupational therapy is moving with speed and accelerating self-confidence toward true professionalism. In the past we often dwelled upon our insecurity about who or what we were to the point that we were paralyzed into inaction. Remember how much time we used to spend in masochistic soul-searching? One of my favorite cartoons from the *Saturday Review* shows two bearded meditators sitting side by side on a mountain top. One says to the other, “There must be more to life than pursuing the meaning of life.” Our growth toward appropriate confidence as professionals indicates that we have discovered there is much more to occupational therapy than contemplating its meaning.

What are some of the significant steps we have taken toward professionalism? In discussing the characteristics of a profession, Dean Brandenburg emphasized that a body of

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knowledge is essential. This body of knowledge must be based upon accepted research. Occupational therapists are becoming increasingly involved in planning, conducting and publishing the results of their own research studies. Clinicians are developing unique tools of evaluation and specialized methods for recording data. Treatment programs have thus not only become based upon sounder thought but have been sufficiently organized and objectified to be studied.

A few years ago our conferences relied primarily on physicians and other professionals from outside our field to identify what was important to our practice. Now our annual conferences plus workshops, seminars and study courses are loaded with excellent papers conceived and presented by occupational therapists. We have learned to look within our field for provocative thought and inspiration. We have found it in abundance.

Perhaps most significant for the future development of our body of knowledge is the increased awareness that the scientific attitude is not incompatible with concern for the client as a human being but may be one of the best foundations for acting upon that concern. This awareness is demonstrated by our students of today who are much more critical of the thinking of their elders, much more objective in assessing their own performance and much more likely to be able to frame a question which can lead to research than the students of ten years ago. Yet, if anything, today's students have gained in their capacities to care about the client.

The development of a body of knowledge in a professional carries with it considerable personal responsibility for making both rational (scientific) judgments and intuitive (artistic) decisions according to Dean Brandenburg. Occupational therapists are accepting greater responsibility to contribute to the pool of knowledge about the client, to exercise judgment as to how our skills can best be used to fulfill his needs, to assess the client's responses and communicate our unique findings to other professionals who need them in order to fulfill their responsibilities. The written prescription is no longer seen by many of us as necessary, holy or healthy. Instead our relationship to the referring physician is becoming much more communicative and collaborative. The pseudo-security of the prescription required that we pay a high price. That price was the reduction of our potential to help clients because we often stagnated at the level of applying technical skills.

Dean Brandenburg suggested that in order for occupational therapy to merit recognition as a "true" profession we needed to carry out a continuous evaluation and revision of our educational curricula. Do you realize that the past three years have constituted an educational revolution in occupational therapy? Since 1962, when we published the findings of our own curriculum study, we have engaged in an overwhelming amount of educational revisions of our curricula. For example, we held a workshop on graduate education in occupational therapy, revised the Essentials of an Acceptable Curriculum in Occupational Therapy, completed a study on the implications of the curriculum study including the formulation, for the first time in history, of a thought-provoking set of proposed educational objectives for occupational therapy. Two of our curricula have started pilot programs by which students can become registered occupational therapists and earn their master's degrees simultaneously. For

a profession which frequently perceives itself as moving slower than a snail going uphill against the wind, this is astounding educational progress made in three years. If I were a faculty member I think I would be tempted to say to my students, as I stood before the class, "Don't worry about today's lesson, what you will learn in tomorrow's will make all of this obsolete."

The real significance of our educational progress lies on a deeper level than studies completed and changes initiated. Clinicians and educators have worked more closely together on this process of educational self-assessment than at any time in our past history. As a result, each has learned to respect the contribution of the other. It is as if theory and practice have finally touched hands and found that they respect and need each other. This unity will lead to basic education for our students which is a unified and continuous process.

Many of these changes have been hammered out through vigorous argument and the obstinate patience of occupational therapists who defended their educational philosophies in meetings lasting far into the night. I am certain at such times many of them longed, in their secret hearts, to rely upon some outside "authority." But they did not choose the easy way. As a result we can point with pride to the fact that *we* have taken the initiative and responsibility to evaluate and upgrade our total educational system using our unique resources. As Dr. Mary Reilly put it, "Like Rumpelstiltskin, we have taken the straw and woven it into gold."

A profession obtains wide recognition of the need for the services which it can perform. How widely is the need for occupational therapy recognized? Remember how we used to laugh, rather painfully, about the persons who would smile politely and say "oh isn't that nice" when we told them we were occupational therapists? For we knew they had no idea of what we did. To make matters worse we were not at all sure that we could tell them. We still experience similar responses but they occur less and less.

More significantly, the people and agencies who can recognize the need for our services and *do* something about it are well aware of how much they need us. The Medicare bill and corresponding state legislation recognize the need for occupational therapy in hospitals, home health services and extended care programs. These bills and regulations write our profession into the law as one criterion for an acceptable program. For the first time in history, these bills recognize our own registration process and graduation from an acceptable curriculum as the criteria for professional qualification.

Convalescent homes, out-patient facilities, rehabilitation centers and schools are clamoring for our services. One of our greatest problems of the future is not going to be how to bring about a greater awareness of the need for our services but rather to provide for the need which already exists with a level of service of which we can be proud.

An organization for a profession is also widely recognized, Dean Brandenburg stated. How widely recognized is the American Occupational Therapy Association? Our leaders have been sought for advice and counsel in writing the regulations for "Medicare." Many professions are most cognizant of the educational and organizational changes we have instituted, including our pilot programs on a master's level. A physician said to me recently, "You are

far ahead of many other health professions educationally. Your organization is progressive. It looks toward the future." At a recent workshop for faculty members from schools of social work I was astounded at the reaction of intense interest and admiration for our foresight in both developing and having in operation certified occupational therapy assistants training programs.

Since 1963, occupational therapy has made important progress toward true professionalism by further identifying and substantiating our body of knowledge, developing the research attitude and tools for research among practitioners and students, accepting the responsibility for using judgment and making scientific and intuitive decisions, obtaining increasing recognition of the need for our services, maintaining standards for admission to the profession and obtaining legislative recognition of our own registration process as the criterion of professional qualification and undertaking a continuing evaluation and revision of our educational curricula.

This substantial progress does not mean that we have made it. For professionalism, by its very nature, requires our continual efforts to progress in all of these areas, particularly in identifying our own body of knowledge. Through our faith in the efficacy of our practice we have resisted pressures that would regress us to the level of technicians, pressures to drop our dual educational emphasis upon the behavioral and biological sciences, pressures to disavow in practice what we were unable to prove at the moment. In resisting these pressures we have acted in the present while maintaining a vision of the future.

Purpose of Occupational Therapy

It is all fine and good to talk about our steps toward true professionalism but what is the purpose of occupational therapy? I believe that our broad purpose is to produce a reality-orienting influence upon the client's perception of his physical environment and his social and psychological self, to the end that he can function in his environment with self-actualization. This purpose is certainly not unique to occupational therapy. It is shared by many professional groups who are motivated to provide altruistic service to the client.

If this broad purpose is a shared one, then how are we unique? When it comes to identifying even a part of the uniqueness of occupational therapy we frequently behave as though we belonged to the school of Chinese philosophers called Taoists. Substitute the words occupational therapy for the word Tao in the following poem and you will see the parallel. "The thing that is called Tao, is elusive, evasive. Elusive, evasive, yet latent in it are forms. Elusive, evasive yet latent in it are objects. Dark and dim yet latent in it is the life force."² We are often afraid that by defining our own elusive, evasive qualities we shall make our profession too small in concept.

For the purpose of provoking your thought and in full awareness of the dangers of limiting us, may I propose a concept? Occupational therapy is unique because we use the choice of self-initiated purposeful activities to produce a reality-orienting influence upon the client's perception of himself and his environment so that he can function. Let us examine four key

phrases which help identify our uniqueness: choice; self-initiated, purposeful activity; reality-orienting; and perception.

Choice

First, the factor of "*choice*." Occupational therapy has been unique, historically, because of the client's participation in his own treatment. Choice has been so fundamental to our thinking that we have questioned whether procedures which are done *to* the person, over which he has no control, should be called occupational therapy. Choice has been encouraged in the client's selection of media, his unique interaction with our media and, most importantly, in setting the objectives for his treatment program.

Since self-initiated activity is our "stock in trade" and since it is impossible to force any human being to initiate without his choosing to do so, choice is one of the keys to our unique therapeutic process. It is also a necessity if we are to achieve the ultimate goal of occupational therapy, that is, the ability of the person to function in his environment with self-actualization. For no matter how well-conceived the therapeutic program, the resulting achievement of the client's function depends both upon his capacities and his *choice* to use them.

Our everyday vocabulary reveals our attitudes. We ask, "What would you like to accomplish with your arm brace?" or, "Would you prefer to plan your kitchen today or concentrate on bathing the baby?" We say we "work with the client." We do not "do" the client or "care for" the client or "manage" him.

Does the emphasis on choice mean that occupational therapists abdicate responsibility for the client's welfare, that our milieu is one of anarchy or that we are less knowledgeable than other professionals who "know" what is best for the client and treat him accordingly? Not on your life! Our client's choice is based upon exposure to our therapeutic process which encourages him to make a series of decisions leading to progressing degrees of independence.

Occupational therapists use their knowledge, skills and personalities to enable the client to experience his possibilities. He must be given the chance to choose on the basis of reality, not fantasy. He is not adequately informed to make choices until he can anticipate the results of his choices.

The occupational therapist identifies the small steps necessary to attain the client's larger goal, the purposes of the media and what the client might expect to accomplish or fail to accomplish, depending upon his choices. The occupational therapist's personal conviction may be an important means of eliciting the client's participation in an activity which he initially rejects because the experience of success, which the therapist knows he can attain, is not initially a fact to him. Many "motivation" problems occur because the client is afraid to fail and cannot anticipate the gratification of success.

This active role of the occupational therapist in helping the client delineate his choices takes more knowledge, skill and sensitivity plus more faith in the individual than an authoritarian role of "you must do this because it is good for you."

Rose Meyer, medical social worker, in her article "Dependency as an Asset in the Rehabilitation Process" said, "the rehabilitation process may be a long and dynamic struggle that influences and is influenced by the dependency-independency conflict."³ She felt that the patient's ability to *use* his initial physical and psychological dependency could move him increasingly toward independence, similar to the evolution of his earlier life. Miss Meyer gave the following case history of a forty-year-old engineer who had recently become paraplegic: At first the patient rejected the dependency created by his injury. He tried to master his situation by learning all about his condition, his prognosis and how he could immediately participate in his own care. His aggressive, though reasonable attitude was overbearing to the nursing staff, for the progress he desired was always a bit ahead of reality. His behavior deteriorated to stubbornness and disinterested compliance. By the time he started his occupational therapy program he was threatening to leave the hospital in order to carry out many of his own ideas for developing independence. He was frustrated by the lack of opportunity to participate actively in his own program. When given the opportunity by the occupational therapist to make a choice for his treatment from several modalities for an explained purpose, he found structure for his move toward independence, not only in his own treatment but in his investment in the program of other patients for whom he designed appliances and work projects. As Miss Meyer stated, "He could depend upon the occupational therapist's knowledge and skill to act as a catalyst for his own creative investment."

The occupational therapist thus serves as a catalyst by which the client moves toward increasing self-direction. The process begins with the client's acceptance of a reasonable degree of dependence upon the therapist's skill and knowledge, moves toward his understanding of the reality of his condition, his formulation of goals based upon that reality and his selection of media within a category of choices appropriate to the goals.

But what about the patient who is too incapacitated, physically and/or emotionally, to make *any* choice. Sister Madeline Clemence, in her moving essay, "Existentialism: A Philosophy of Commitment," dealt with this question in relation to nursing. "Whenever the nurse takes an initiative which should have been the patient's, she should understand that it is only a temporary measure and that it should be ratified by the patient."⁴ The same principle applies to the occupational therapist.

Self-Initiated, Purposeful Activity

The second key phrase in investigating our uniqueness is "*self-initiated, purposeful activity.*" Self-initiated refers not only to psychological choice but to sensory-motor participation. Dr. Karl Smith, professor of psychology at the University of Wisconsin has criticized behavior theory for its past emphasis on physiological drive states as the basis for human motivation. He states, "Yet much of ordinary human behavior—verbal and graphic skills, patterns of work, artistic and recreational pursuits—which we observe in ourselves and others seem to bear little relation to hunger, thirst, sexual drives and the like."⁵ Dr. Smith feels that perceptual motivation or activity motivation should be considered of primary importance in

behavior organization. "The nature of this motivating force can be described specifically in terms of the intrinsic make-up of the regulatory mechanisms of motion, for the neuro-geometrically organized motion systems drive the individual to action as relentlessly and more consistently than hunger or thirst."

Self-initiated activity, specifically verbal and graphic skills, patterns of work, artistic and recreational pursuits—activity of concern to occupational therapists—is of primary importance in human motivation, if we accept Dr. Smith's theory.

Motion is patterned according to the spatial and temporal demands of the environment as the individual reacts to differences in stimuli. In resolving these differences, the individual continually and by his own movements produces new differences to which he must react. Thus self-initiated activity is both a response to sensory stimulation and a source of additional stimulation by which the individual develops patterns of adaptive behavior. Passive movements apparently do not result in the same degree of adaptation.⁵ The individual must respond dynamically to changed stimulus relationships in order to adapt.

Dr. Jean Ayres called occupational therapy's emphasis on purposeful activity the factor which unites our profession in its practice for patients with emotional as well as physical conditions. She said, "If purposeful activity is one of the distinguishing functions of occupational therapy, it might well be asked if it is necessary for the treatment of motor disability." Then she answered, "In the life of the neurologically normal individual, activity is not random but purposeful, i.e. directed toward the accomplishment of a goal. It is generally this *goal* that is the basis for activity in the central nervous system and therein lies its value."⁶

A year ago I helped evaluate a brain damaged client's function. She was asked to open her hand. No response occurred, except that she was obviously trying. Next she was moved passively into finger extension while the occupational therapist demonstrated the desired movement. This time the client responded with increased finger flexion. In frustration she cried, "I know, I know." Finally she was offered a cup of water. As the cup was perceived, her fingers opened almost miraculously to grasp it. Only the factor of purpose could produce the desired response.

Purposeful activity is activity which has meaning to the client, not just to the occupational therapist. Our clients are individuals who have differing ideas of purpose. Some individuals are deeply imbued with our cultural admonition that "work is virtue." Such persons may respond with greater motivation to resistive exercise than to an elaborately adapted craft activity given for the same reason. For persons with lower motor neuron disease for whom the objective is increased muscle strength which will be translated into function, such exercise, providing that it constitutes purposefulness for the client, may be the most effective physiological and psychological method for producing the desired result.

Conversely and most particularly for patients with central nervous system impairment, straight exercise might not only be purposeless to the client but through its demand for attention upon the movement and not upon the goal, might produce an undesirable response. Craft activities or other creative, goal-directed pursuits may, in such instances, elicit a neuromuscular response which cannot be attained through other

means. These activities also have the advantage of distracting the patient's attention from pain thus reducing the muscular splinting or neuromuscular alienation that often accompanies pain.

Reality Orientation

Third, the factor of "*reality orientation*." In occupational therapy the patient experiences the reality of his physical environment and his capacity to function within it. Our clinics may be chambers of horror for some individuals as they confront their physical disability for the first time by trying to do something, perhaps as simple as self-feeding. Yet, if the individual is to function with self-actualization he must discover both his limitations and his possibilities. We meet our responsibilities to the client when we provide him with opportunities to readjust his value system through the development of both new capacities and the ability to substitute for some lost capacities. We are like mirrors which can reflect, without the distortion of wish-fulfillment or self-deprecation, a true image of the client's potential.

Perception

Fourth, "*perception*." Occupational therapy produces a reality-orienting influence upon the client's perception of his physical environment as well as his psychological and social self. In the area of physical perception our media produce sensory stimuli which are perceived and reacted to by the client. Our professional literature is presently concerned with identifying syndromes of perceptual-motor dysfunction, the development of evaluation tools for identifying specific problems of perceptual-motor function and the development of theories upon which to base treatment programs to improve these functions. Because our media require the use of postural movements, transport and fine manipulation and because they allow us to stimulate many sensory modalities, we are appropriately and deeply concerned with perceptual-motor function. Dr. Ayres and others from our profession have contributed significantly to the available literature in this area.

It has been found in experiments of displaced or delayed sensory feedback that many normal individuals react to their resulting perceptual-motor discoordination with considerable emotional disturbance.⁵ Similarly, persons with perceptual-motor dysfunction may exhibit severe behavior problems. Psychotic episodes have been associated with the use of such perception distorting drugs as LSD. These findings indicate the existence of a link between perceptual-motor function and emotional responses. This link, with further study, might serve to bridge another apparent gap between our practice with the physically disabled and that with the emotionally disabled person. We are one of the few professions whose education prepares us to visualize the perceptual-motor function of man as a psychobiological unity.

In addition to perception of a neurophysiological nature, the individual also perceives himself as a psychological entity and a social being. Occupational therapy provides an

everyday environment in which the individual can determine, through choice, his own particular identity.

The following is an example of the kind of self-perception we sometimes deal with:

Look at me, look at me
What do you see?
A thing made of plaster, metal and skin.
Look at me, look at me
How can this be?
They make me exist in the place that I'm in.
Look at me, look at me
Help me to flee
From this world of blindness to that of the seeing.
Look at me.

This young lady, who is severely paralyzed, is pleading for help to escape from her own self-concept into the world of the "seeing," that is, a world in which she would perceive herself as being recognized, not as a "thing" but as a feeling, thinking, valuable human being.

Exposure to our media means a confrontation with objects and an opportunity for the individual to discover what he can and cannot do with them. Exposure to our professional spirit means that the individual confronts both our knowledge of his capacities and our faith that he has the right to control what happens to him.

Being a "thing" leads to social relationships based upon dependency, hostility or pity. As James Colbert, a paraplegic, said in his essay *A Study Establishing the Disabled as a Minority Group*, "pity can be referred to as a sort of sequence mechanism: disease or accident—hospitalization—disability—I am very sorry." Jim observed, "This attitude may, in fact, be responsible for motivating the disabled to stay apart from their [previous] social group and to act and interact mainly with their own [disabled] group."⁷ Pity implies the socially-sanctioned classification of the disabled into a minority group and with that classification comes dismissal from the stream of "normal" society. Occupational therapy which leads to the client's ability to function in his environment can help alter other people's perception of him as the object of pity and reduce their need to classify him apart from themselves.

Occupational therapists, in my experience, are remarkably free of the sort of cynicism and expediency which might result in the client perceiving himself as a "thing." Our positive attitude has been characterized as "regulated optimism" by one occupational therapist. Another fine occupational therapist said, "Occupational therapy begins when everyone else has given up." She meant it humorously. But like most humor it had a strong core of truth. Both of these statements reflect our faith in the client.

Being able to help the client confront himself is perhaps the most sensitive, personally and professionally demanding task of the occupational therapist. For it requires courage on the part of the client, emotional support on the part of the occupational therapist and a continual mutual testing and communication of what reality is.

Just as our emphasis on "purposeful activity" unites our practice for patients with emotional as well as physical conditions, so does our emphasis upon helping the patient grasp the reality of his life situation in order to move toward increasing degrees of self-direction.

For even in such a seemingly physically oriented activity as teaching a patient to dress himself, our ultimate goal is a psycho-social one. That is, by increasing the client's capacity to be independent we help him perceive himself as possessing worth. He is not a "thing" to be manipulated helplessly by others but is a human being who can exercise some control over his environment, even in being able to put on whatever shirt he wants to put on when he wants to do it.

Occupational Therapy's View of Man

The psalmist phrased the question: "What is man that thou art mindful of him?"⁸ That question has been repeated over the centuries. Although fragment by fragment has been added to our knowledge of man's nature, through the sciences and historical experience, our understanding remains incomplete. For man is mysterious. He defies definition.

Yet, in spite of this mystery, our profession has chosen unique methods to help the client function with self-actualization. Both our methods and our goals imply that we have a point of view regarding man's nature. For if we are to be helpful to him, we must conceive of what is valuable to him. This takes us into philosophy.

Our particular view of man agrees considerably with that of some existential thinkers. Unfortunately, existentialism has been associated with anti-intellectualism, egocentricity, irresponsibility and anarchy. It therefore frequently conveys mental pictures of bearded beatniks who wallow in pools of self-pity, bemoaning the meaninglessness of the universe, while regularly collecting their unemployment insurance checks. These associations are superficial.

According to David E. Roberts,⁹ existentialism is not an organized philosophical system but rather it represents a protest against all views which tend to regard man as though he were a *thing*, that is, only an assortment of functions and reactions. It stands against philosophies or social theories in which the mass mentality stifles the spontaneity and uniqueness of the individual person. In occupational therapy's recognition of the client as one who ought to participate in his treatment and be given the opportunity to make choices, we are as Martin Buber would say, "taking a stand" in relation to him. We are viewing the client, not as an object or thing to be manipulated, controlled or made to conform but as a unique individual whose very humanness entitles him to choices in determining his own destiny. For if the client interprets himself as a thing (one thing among others in the world) he might sacrifice his selfhood and neither recognize nor realize his potentials.

Existentialists see man as involved in the process of becoming. What he becomes is shaped by himself, in response to his life experiences and relationships to others. Heidegger, the philosopher who contributed significantly to existential thinking, made a distinction between "authentic" and "inauthentic" existence. He felt that in the world of everyday experience man comes to terms with what he is only by coming to terms with his possibilities or potentialities. If he lives mainly in terms of "what one does" or what one "does not do" and is therefore merged in conventional mass reactions, he is emerged in inauthentic existence. Authenticity is achieved to the degree that the individual reaches true selfhood by rising out of mass reactions, taking the initiative in discovering the meaning of his own existence and

disposing of his own potentialities accordingly. In order to achieve authentic existence man must have resolve to become his true self.

For the client who is hospitalized the institution may inadvertently represent the “mass mentality” with its pressures of what “one does” or what “one doesn’t do.” Louis Worth, the sociologist, once remarked that the only good institution is a dead institution.¹⁰ His comment was provoked by the common tendency of institutions, implicitly or explicitly, to regard their own survival as a major goal thus losing sight of the client’s individuality in the process.

Bill was the “ideal” patient. He kept all of his appointments religiously and worked diligently on every aspect of his treatment. He accepted the wisdom of the physicians who directed his rehabilitation program. He carried out his therapeutic activities without question. He used every piece of self-care equipment which was ordered for him. He attained an amazing degree of physical independence prior to discharge to the point that he became an example to inspire other patients. Six months after his discharge he came back to hospital for a clinic visit. His facial expression was passive and lifeless. He had gained thirty pounds, had developed a pressure sore and had become dependent in all activities except for minimal self-feeding. Obviously Bill had conformed to the hospital’s value system temporarily but once out of the institutional environment had become primarily a dependent and passive being. In that sense he had lived an “inauthentic” existence while hospitalized. Instead of encouraging his adherence to the value system of the institution, how much better it would have been if his behavior had been recognized as conformity. The occupational therapist might then have provided him with opportunities to question, complain and become emotionally involved in his rehabilitation program. Often the clients who distress the hospital staff the most by not behaving as “patients” become the most self-directed after discharge.

Earlier I mentioned the client’s confrontation with the reality of his disability in occupational therapy. This confrontation with pain, suffering, loss of function and the high anxiety associated with it are realities about which he can begin to determine the meaning of his life’s experiences. In other words, the pain and deep stresses of such an experience may lead to resolve. For such traumatic experiences, which cannot be ignored, can transform the individual’s existence from that of a day to day contact with superficial, meaningless events to a “mind and heart” involvement in being. Instead of regarding himself as surrounded by circumstances and chance events, he can begin to see himself in a situation which is something to be mastered. Action on his part can become, instead of mainly a series of external, practical activities, a development of inner resources which can be stronger than mere happenings.

The particular reality of the occupational therapy clinic involves not only the client’s disability but his opportunity to make the kinds of choices by which he can discover, for himself, the meaning of his own existence and realize his potentials in accordance with that meaning. Our clinics are one of the few environments within institutions in which the client can make such choices.

Existentialism also makes a firm distinction between subjective and objective truth. It does not deny that through common sense, science and logic men are able to arrive at genuinely objective truth. But, it insists that in connection with ultimate matters it is impossible to lay aside the impassioned concerns of the *individual*. In the search for ultimate truth, the

whole man, not just his reason and intellect, are involved. His emotions and his will must be aroused and engaged so that he can live the truth he sees. As Heidegger put it, "The scientist pursues one legitimate way of studying what is, but he makes an extra-scientific assertion when he adds, 'That's all there is. There isn't anymore.'"

In occupational therapy we are providing a milieu in which the total man, not just his reason, is involved. Our purposeful media, our emphasis upon the discovery of the client's potential, the necessity for him to act in occupational therapy and his relationship to us deeply involve his will and emotions, providing that we can be authentic in relation to him.

Authentic Occupational Therapy

What then, is authentic occupational therapy? Authentic occupational therapy is based upon a *commitment* to the client's realization of his own particular meaning. The authentic occupational therapist recognizes that although initial dependency might require a temporary suspension of the patient's right to choice, the therapeutic experience is primarily an opportunity for self-actualization. Therefore, the occupational therapist does not force his value system upon the client. But rather, through using his skills and knowledge, exposes the client to a range of possibilities which constitute his external reality. The client is the one who makes the choice.

Authentic occupational therapy means *involvement* of both the client and the occupational therapist. Through the use of media the client is involved intellectually and emotionally in discovering what is purposeful to him. He is also involved in relation to objects, actions and persons. Through these relationships he is helped to come to grips with his particular reality including his disability, his emotional reactions, his will and his potential.

Professional authenticity in occupational therapy means that the occupational therapist in every professional *act* defines the profession. For example, he may believe that it is important to perform clinical research but that belief has no meaning until he *acts* upon it by initiating research activity.

As a professional, the authentic occupational therapist recognizes his responsibility to be a lifelong student and to contribute to the body of knowledge. He also recognizes that an important part of what he will learn and contribute will be subjective, that is, concerned with feelings and human motivation. He will not expect science to provide him with all the answers but he will respect what science has to contribute.

Personal authenticity as an occupational therapist means that the therapist allows himself to feel real emotion as he enters into *mutual* relation with the client. In a mutual relationship as Martin Buber said, "My thou affects me as I affect it. We are molded by our pupils and built up by our works."¹¹ The authentic occupational therapist is involved in the process of caring and to care means to be affected just as surely as it means to affect.

William Barrett in his superb book *Irrational Man* cites the example of the successful businessman who flies to the country for the weekend, is whisked off to golf, tennis, sailing; who entertains his guests successfully, all on a split-second schedule and at the end of the weekend flies back to the city without ever having the desire to lose himself by walking down a

country lane. Such a man, we say, is marvelously organized and really knows how to manage things; but the point is that he has mastery over beings but not Being. "He never has contact with Being. He goes to the country and returns without ever *really* being there."¹² We cannot really help clients unless *we are there*; that is we feel, we encounter, we take time, we listen and we *are* ourselves.

The authentic occupational therapist is open to the client's ideas and feelings and real in responding to them. He does not give in to the temptation to insulate himself against feeling because if he does so he will lose his capacity to be there. "Being there" also means being able to separate his feelings for the client as a human being from projections of how *he* would feel if he had experienced the client's disability. For the authentic occupational therapist knows that the client is the only one who can discover his own particular meaning. Stephen Becker in his essay *On Being a Patient* put it this way. "One man's hangnail is another man's broken neck."¹³ He went on to say that once the disabled person has decided to live he must stop asking "why me?" He must reject pity and singularity with equal and absolute indifference. Mr. Becker, as a result of his experience of being a patient, reaffirmed his philosophy that nature never rejoices and never mourns.

In the new dimension of 1966, occupational therapy is becoming a true profession. This is a time to be proud of what we have accomplished. Our service to the client is unique in its application of choice, self-initiated, purposeful activity and its emphasis upon the goal of function with self-actualization. Our media have been identified as those activities which are at the very source of human motivation. Philosophically we do not see man as a "thing" but as a being whose choices allow him to discover and determine his own Being. Our media, our emphasis upon the client's potentials, the necessity for him to act and the mutuality of our relationship with him provide a milieu in which his suffering can be translated into the resolve to become his true self.

This is also a time for each of us to determine our own authenticity as professionals. The degree to which we can maintain faith in our profession and still strive to improve it by our own acts, the degree to which we can maintain faith in our clients while becoming involved in the process of helping them will determine the future authenticity of our practice. We are ever becoming.

Rainer Maria Rilke wrote:

"Out of infinite yearnings rise
finite deeds like feeble fountains,
that early and trembling droop.
But those, else silent within us,
Our happy strengths—reveal themselves
in these dancing tears."¹⁴

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