Occupational Therapy Values and Beliefs: PART III

A New View of Occupation and the Profession, 1950–1969

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"I personally have little trust that we can continue to exist as an arts and crafts group which services muscle dysfunction or as an activity group which services the emotionally disabled" (p. 4).[1]

Mary Reilly stated a major theme leading to significant change in occupational therapy that evolved during the progressive movement of the 1960s.[1] Inherent in her words is Reilly's futuristic view that occupational therapy was evolving as a science-based profession. At the same time, occupational therapy practitioners were increasingly concerned that arts and crafts, often viewed as diversional, did not fully explain the essence of occupation or occupational therapy. Arts and craft projects seemed to be overemphasized, whereas the therapeutic value of occupation was being underemphasized.[2,3] Of importance to the profession is whether the values and beliefs inherent in the arts and crafts movement were still held within the profession when the teaching of arts and crafts was being deemphasized within the curriculum. A related question is whether the values and beliefs supported by the arts and crafts movement was broad enough to encompass an expanding view of occupation as a science-based concept within the profession.

The arts and crafts movement had advanced a number of ideas and ideals including design unity, joy in labor (work), individualism, regionalism, social responsibility, consistency and order, simplicity, and home and hearth (family and fireplace).[4,5] Many of these ideas focused on setting a tone and tempo of life in society through the organization of habits of work, play, rest, and sleep.[6] American social values had changed from conservative in the 1950s to progressive in the 1960s; in addition, the practice of medicine had changed after World War II.[7] Physicians, with a focus on scientific methods, expanded their knowledge through working with former soldiers with physical and mental disabilities. For example, psychotropic medication introduced changes in mental health practice and hospitalization patterns, leading to community mental health and mental retardation legislation in 1963.[8] Given the changes in medical practice patterns and occupational therapy's predominant reliance on guidance from medicine, the ideas of the arts and crafts movement may have been a difficult fit. Medicine was developing a focus on short-term care, while the arts and crafts tradition fit better in a long-term-care approach.

Occupational therapy in physical medicine and mental health, or *neuropsychiatry* as it was referred to at the time, also had a new agenda. For example, Shields, Oelhafen, and Sheeham stated that the role of occupational therapy in physical medicine is to increase endurance, improve coordination and dexterity, improve muscle power and strength, improve joint range of motion, relieve tightness of fascial planes, and obtain the best functional results.[9] The new focus was on the biomedical aspects of the body, not on the social or temporal life of the individual, which had been more conducive to the values of the arts and crafts movement. Similar views of the role of occupational therapy in physical medicine were expressed by Cummings,[10] Grove,[11] Helming,[12] and Huddleston.[13] Psychiatry, on the other hand, was focused on psychoanalytic psychotherapy, including the provision of the opportunity to satisfy the basic emotional need for security (e.g., the need to be loved, to be accepted, and to belong). Other occupational therapy objectives were to establish an atmosphere conducive to recovery, assist patients to undertake appropriate economic and social responsibilities, provide data for evaluation and diagnosis, and assist the patient to bridge the gap between hospital and community living.[14] Again, the tone and tempo of the arts and crafts movement, which emphasized the practical, hands-on approach of crafts labor, were deemphasized.

CONTINUING THE DISCUSSION

This article is the third in a series and continues the process of identifying and organizing the beliefs, values, and ideas gleaned from the historical foundations of the profession. The first article, "Occupational Therapy Values and Beliefs: The Formative Years, 1904–1929," appeared in the April 17, 2006, issue of *OT Practice*.[15] The second article, entitled "Occupational Therapy Values and Beliefs, Part II: The Great Depression and War Years: 1930–1949," appeared in the October 9, 2006, issues of *OT Practice*.[16] The methods used and themes developed to guide the historical literature review project were discussed in the first two articles, and included economics, education, health and medicine, philosophy, politics and government, professions and professionals, psychology and psychological concepts, religion and spirituality, and social themes and movements. This article discusses some new categories that became evident in a literature search from 1950 to

Figure 1. *A Statement of Basic Philosophy, Principle and Policy* (p. 159)[19]

Occupational therapy is particularly concerned with man and his ability to meet the demands of his environment. The therapist administers treatment to the patient designed to (1) evaluate and increase his physical function in relation to activities of daily living, the needs of his family, and the requirements of his job, (2) improve his self-understanding and psychosocial function as a total human being. Treatment involves the scientific use of activity procedures and/or controlled social relationships to meet the specific needs of the individual patient.

Figure 2. *Statement of Policy* (p. 24)[20]

1. Maintain and control the voluntary registration of its practitioners.
2. Regulate, in conjunction with the Council on Medical Education and hospitals of the American Medical Association, the education of occupational therapists to prepare them for their treatment function.
3. Establish and maintain standards of clinical practice in occupational therapy which will improve patient treatment.
4. Foster continuing growth in the professional competence of occupational therapists.
5. Encourage and facilitate increase in the body of specific occupational therapy knowledge available to physicians.
6. Protect the standards of occupational therapy and the environment in which the occupational therapist functions.
7. Strongly oppose and protest any administrative policy or structure which ignores or weakens the treatment function of occupational therapy.

1969. These categories will not follow the previous theme format. Rather, the topics represent a sampling of concerns addressed either by the American Occupational Therapy Association (AOTA) Board of Management, or concerns external to the Association that shaped occupational therapy practice, education, or both.

THE GREATER PROFESSION

Defining Occupational Therapy

In 1969, for the first time, AOTA adopted the following formal definition of occupational therapy: "Occupational Therapy is the art and science of directing man's response to selected activity to promote and maintain health, to prevent disability, to evaluate behavior and to treat or train patients with physical or psychosocial dysfunction" (p. 185).[17] This official definition replaced the commonly used definition that Pattison had developed in 1922[18] and expanded the description conveyed in AOTA's 1963 *A Statement of Basic Philosophy, Principle and Policy*[19] (see Figure 1). This definition, along with AOTA's 1958 definitions of function[14] and 1961 *Statement of Policy*[20] (see Figure 2), outlined the thought and direction of the occupational therapy profession and AOTA during the 1960s.

Responses From the Association

In response to changes in the profession during this time, the Association provided more direction and published more books. Of special interest are the previously mentioned documents *Statement of Policy*,[20] and *A Statement of Basic Philosophy, Principle and Policy,*[19] along with two manuals: *The Objectives and Functions of Occupational Therapy*[14] and *Occupational Therapy Reference Manual for Physicians*.[21] The two statements provided a description of the role of the Association and of occupational therapy. The two manuals outlined and detailed the services provided. The manuals and statements have been used as references in the preparation of this article. Perhaps of greatest value to the profession was the role of the Association in providing publications that were written by occupational therapists instead of relying on external publishing sources and physicians to advance the knowledge base and profession of occupational therapy.

Eleanor Clarke Slagle Lectureship and Award of Merit

To recognize the value of professional contributions, the Association established the Eleanor Clarke Slagle lectureship in 1953.[22] The "honorary occupational therapy guest lectureship" was to be awarded "in recognition of meritorious service to the profession" (p. 24).[22] "It perpetuates the memory of Mrs. Eleanor Clarke Slagle, one of the outstanding pioneers in the field (profession) of occupational therapy. The award is bestowed upon practicing therapists who are members of the AOTA and who have made or are making a significant contribution to the profession" (p. 24).[21] Since its inception, the Slagle lectureship has been given to 44 individuals. The Award of Merit had already been established in 1950 to recognize distinguished service to the profession.[23]

CHANGES IN PRACTICE AREAS

Practice areas were also changing relative to advances in technology, medicine, and pharmacology. Occupational therapists had worked with clients who had tuberculosis from the start of the profession, but sanatoriums treating tuberculosis were closing as drug therapy permitted outpatient care. The literature reflects the diminished practice area of tuberculosis, with the last article on this topic appearing in the *American Journal of Occupational Therapy* (*AJOT*) in 1960.[24] Similarly, the polio vaccination decreased rapidly the number of new cases of poliomyelitis in children and adults, and the last article on polio in *AJOT* appeared in 1957.[25] Curiously, vocational rehabilitation grants were still funding postprofessional education for occupational therapists in the areas of tuberculosis and polio, which kept them in both practice areas despite fewer patients.[26] During this time, as occupational therapists became more sophisticated

in their education and their knowledge base grew, new areas of treatment appeared or were expanded on in the literature. For example, interest in neurology and perceptual motor dysfunction was increasing,[27,28] and articles on neurophysiology and facilitation techniques began to appear.[29,30]

Activities of Daily Living

A major new focus for occupational therapy was activities of daily living. The first form to assess activities of daily living appearing in the occupational therapy literature was the 1949 *Scale for Rating Functional Demands for Daily Living*.[31] However, the term *activities of daily living* did not become popular in the occupational therapy literature until the 1950s. According to Isaac,[32] physician Howard Rusk, working with returning soldiers, established rehabilitation after World War II. Rush defined activities of daily living as "all those little things a person does for himself, that make him miserable if he is unable to do them" (p. 58).[32] Clinically, the initial work to develop the principles of activities of daily living was done at the Institute for the Crippled and Disabled in New York City, but spread quickly across the country in all areas of occupational therapy practice.

The concepts of independence and independent living were closely associated with activities of daily living.[33] The independent living movement is closely aligned with the physical rehabilitation efforts of occupational therapy, but it is not as clearly defined in occupational therapy mental health history. Occupational therapists working in mental health were exposed to various ways of conceptualizing activities of daily living. For example, Maxwell Jones's 1953 *The Therapeutic Community*[34] focused on role equality, with patients and staff members taking equal responsibility for daily housecleaning chores on a hospital unit or ward. In the 1950s, the community-based clubhouse models like Fountain House in New York created real-life situations for former patients to gather and share responsibility for the daily running and maintenance of their centers, from light cooking to administrative work.[35]

Prescription Versus Referral

Although physicians continued to supervise occupational therapists, the nature of this relationship was changing. In 1958 Mazer and Goodrich suggested that the prescription for psychiatric occupational therapy services was an anachronistic procedure and should be discontinued.[36] The argument was that occupational therapists did not need to have the details for treating a patient spelled out in a prescribed form because as professionals they could determine the needs for themselves. They needed the physician's permission to see the patient but could supply the expertise regarding treatment and intervention without physician assistance. Fidler concurred,[37] and in 1964 the AOTA Board of Management recommended that the term *referral* be used in place of *prescription*.[38] In 1969 the first statement on occupational therapy referral was adopted by the Association.[39] Zamir expanded on the

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challenge to the relationship between medicine and occupational therapy by stating that history had shown that professional development almost always demands autonomy.[40] She further stated that it was doubtful that any field could truly call itself a profession if it was merely a tool of another profession, working only under its direction and at its behest. Bockoven suggested that occupational therapy separate from medicine and focus on its concern for occupation.[41]

Registration Versus Licensure

Although change was happening in some areas of occupational therapy, professional beliefs about the value of state licensure remained unchanged. In 1951 Wilma L. West, as executive director of AOTA, summarized the accepted view of state licensure as not necessary.[42] Licensure was seen as a potential barrier to recruiting students (more costs), expensive to obtain because of legal fees, and having the potential to hinder the movement of occupational therapists across the country because states might have different requirements in their licensure regulations. The negative view of licensure was reinforced in 1969 when a position paper was adopted by the AOTA Delegate Assembly, stating that licensure had "done little to protect either the providers or consumers of specific services" and represented "an external attempt at imposing qualifications for entrance into the profession and to engage in practice" (p. 529).[43] A more positive view of licensure would not occur for several years.

OCCUPATIONAL THERAPY EDUCATION

Occupational therapy curriculum design also began to change during this period. A new concern was expanded courses in medical conditions, activities analysis, and therapeutic application, and a move away from a predominant arts and crafts curriculum. Nedra Gillette illustrated these shifts in 1965 when she summarized the recommendations of the AOTA Curriculum Study project as follows:

> …it was recommended that the traditional arts and crafts be de-emphasized as treatment media with decreased time devoted to these in the curricula, decreased number of media taught, emphasis on *methods* of acquiring skills, and teaching of a core course in media. (p. 352)[44]

Not only was curriculum content revamped, but occupational therapy levels of education became a topic of discussion. Given the 1963 adoption of a baccalaureate degree required for professional-level education, there was discussion about graduate education to promote scholarship.

Graduate Education

With a need for more research and for better-prepared occupational therapists in specialty areas of practice, came a need for occupational therapists with postprofessional degrees. Academic leaders discussed two entrances to occupational therapy graduate education. The first was a master's degree in occupational therapy for baccalaureate-trained occupational therapists who were already practicing. The more controversial second option was a master's degree as the entry level to practice.[45] The document *A Guide for the Development of Graduate Education Leading to Higher Degrees in Occupational Therapy* was adopted in 1958.[46] In 1964 the first proposed master's-level entry program, at the University of Southern California, was submitted and discussed in the Council on Education.[47]

Certified Occupation Therapy Assistants

The lack of trained occupational therapists, particularly in large state hospitals, was also a focus of concern.[48,49] In 1957 the AOTA Board of Management voted to accept the title Certified Occupational Therapy Assistant (COTA) and to adopt the standards for organizing a training program for occupational therapy assistants.[50] Educational programs for the occupational therapy assistant developed quickly throughout the country. Occupational therapy personnel were now recognized at two levels: professional and technical.

SUMMARY

The years 1950 to 1969 witnessed change and growth of occupational therapy practice, education, and organization. Practice responded to the need for more organization of information into models to guide the development of theoretical knowledge and practice skills. Educational opportunities in occupational therapy expanded through the development of more schools at the professional level and the initiation of schools at the technical level. The professional organization recognized the need for assistants to provide more manpower in occupational therapy practice, changed the relationships with physicians from prescription to referral, and facilitated the publication of more manuals and textbooks on occupational therapy written by occupational therapists. ■

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