For almost two decades now the alarm has been sounded for the impending doom of psychosocial occupational therapy. The warnings have been heard both in the United States (Bonder, 1987; Scott, 1990) and in Canada (Brintnell, 1989; MacKinnon, 1985). Decreasing status and declining numbers in psychosocial occupational therapy are of great concern to everyone in the profession. Various reasons can be offered to explain this perilous state of affairs; for example, the rebirth of the medical model in psychiatry, deinstitutionalization, the attraction of the more concrete science within physical medicine areas, and the lack of reward to therapists who work with chronic populations. However, most of the literature on this topic has a not-so-subtle subtext of blame and the following piece of advice is generally offered: if psychosocial occupational therapy is to survive, it had better get its house in order.

Before such advice is acted upon and psychosocial occupational therapists go about making wholesale change to their practice, some questions must be asked. The answers to these questions may, in turn, alter our view of the problem and, more importantly, our ideas about solutions. We must examine more carefully how this state of affairs came to be. We also want to question whether the parameters of the crisis, as described, are appropriately defined. If, as we believe, a new definition of psychosocial occupational therapy is evolving, then a different view of the future may well be justified. And if this is the case, then perhaps the gloom and doom can be dispelled.

Background of the Current State of Affairs

To understand the current state of affairs, we need to consider issues specific to the profession and not only those that apply to practice in psychiatry. In particular, we need to review the development of the profession of occupational therapy and how it came to be dichotomized into the areas of physical medicine and psychiatry.

The work that occupational therapists did with soldiers injured during World War I or with persons with tuberculosis in the early 1920s was neither physical medicine occupational therapy nor psychosocial occupational therapy. The occupational therapist was not helping to cure the physical disorder, nor did the client have a psychiatric illness, but the treatment was clearly occupational therapy. Persons were helped to adjust and adapt to their illnesses, to keep as active and independent as possible, and to maintain their morale (Bockhoven, 1972; Friedland, 1988). However, with the growing predominance of the reductionist perspective in medicine in the decades that followed, occupational therapy also became more narrowly focused and we now find ourselves without the holism with which we began. Kielhofner (1983) has documented the crises and resultant paradigm shifts within the profession. However, we have not as yet fully acknowledged—and certainly not lamented—that in this evolutionary process, we lost sight of the whole person and began to label him or her diagnostically. Clients were segregated for treatment depending on whether they were physically ill or mentally ill, and therapists, once proud to be holistic, became specialized and segregated themselves accordingly. Naturally, the number of therapists working with clients with psychiatric diagnoses would not equal the number of the therapists who worked with clients having diagnoses of physical disorders. This is the case, of course, because there are many more categories of physical disorder (e.g., orthopedics and neurology) and subcategories (e.g., arthritis and fractures, cerebrovascular accident and cerebral palsy) and greater numbers of clients diagnosed with physical disorders.

The separation into two distinct areas of practice based on diagnoses soon became a cause of concern to the profession. In 1974, the American Occupational Therapy Association (AOTA) Task Force on Target Populations stated that if the profession of occupational therapy was to survive, "the schisms within the profession related to diagnostic or disability entities need to be removed" (p. 159). Not only has this advice gone unheeded, but the schism has widened. Although our educational institutions might have been expected to lead the way in bringing practice areas within the profession back together, instead they have tended to perpetuate the dichotomy through the organization of their curricula.
Curricular Issues

Curricula are often designed around a need to organize and categorize material. As many occupational therapy academic programs are currently structured, most content is taught in great detail within special areas (e.g., neurorehabilitation, psychosocial rehabilitation, musculoskeletal disabilities, etc.). Nelson, Cash, and Lauer (1990) provided an illustration of this detailed curricular content as it pertains to adult physical dysfunction. One reason for this reductionistic, narrowly focused attention to detail may be that course content, to a large extent, still emphasizes acute care where the medical model prevails and specialization is expected. In addition, many of the clinical placements and internships offered to students are classified as either psychosocial or physical medicine. When curricular focus is on acute care and fieldwork is so divided, the dichotomy is perpetuated. If, however, the focus were on long-term care or maintenance in the community and on prevention and health promotion (areas that have always been a part of occupational therapy practice), the emphasis would, of necessity, be on broader and more holistic content.

Given that new graduates are forced to choose within the existing dichotomy, it is not surprising that more of them prefer physical medicine. It has been suggested that, in some ways, it is easier to master the complex but typically more clear-cut material associated with physical medicine specialties. Ethridge (1986) stated that the relative lack of structure and the abstract nature of mental health practice may be reasons that many therapists do not choose to practice in mental health. Psychosocial interventions are not typically hands-on, that is, they are not executed by the provider. You do not do something to the client as you do in much of physical medicine occupational therapy (e.g., making a splint or prescribing a particular activity to strengthen a specific muscle group). Further, selection of psychosocial approaches is often more difficult because their appropriateness is more dependent on contextual and environmental factors. All of this may make students feel that it is easier to gain demonstrable competence in physical medicine and thus feel more confident about working in that area upon graduation.

Mental Health Practice

In contrast to the foregoing concerns, Garrett (1990) provided evidence to suggest that therapists working in psychosocial occupational therapy are confident of their abilities. Her study of 95 psychosocial occupational therapists showed that they had a high degree of perceived competence. In contrast to studies that suggest a lack of a clear role definition as problematic, her respondents were confident about being able to describe their role in mental health.

In addition to lacking structure and having an abstract nature, practice in mental health is often eclectic in its approach to intervention and, unfortunately, the word eclectic has negative connotations despite its actual meaning. Woolf (1977) defined eclectic as “selecting what appears to be the best in various doctrines, methods, or styles” (p. 359), a concept that is clearly positive and potentially creative. In fact, eclectic practice is quite common and widely accepted in other health professions. For instance, several recent Canadian and American studies of clinical psychologists’ theoretical orientations to their practice indicated that between 29% and 43% surveyed reported using an eclectic approach (see Warner, 1991, for a review).

This is not to suggest an absence of clear choices, effective solutions to many problems, and appropriate ways of doing things. But when the overall goal for many of our clients is to improve quality of life under trying conditions (see Boyle, 1990, for a discussion of today’s rehabilitation population), those ready-made solutions are not feasible. For our students (or graduates) to assume that such solutions should be the rule and not the exception is simplistic. As a profession that is based on creative problem solving, we should not be proud to be expounding concrete, linear thinking about solutions for complex, human problems.

Debate Over a Unified Approach

Within the profession itself, the attempt to simplify practice by choosing a unifying approach continues despite suggestions to the contrary (e.g., see Duncombe, Howe, & Schwartzberg, 1988, Llorens, 1989; Mosey, 1989). One such unifying approach is that of occupational performance. Although the conceptualization of this approach was broadly based, in practice the approach seems to emphasize occupations (i.e., self-care, productivity, and leisure and play) and to draw attention away from the larger context in which the occupations are embedded. It is critical, however, that the links among occupations, occupational behavior, and this larger context be enhanced. This larger context includes the physical, social, and cultural aspects of the environment and, most importantly, the dynamic interaction between the environment and the person. To resolve our identity crises, we have opted for delineating occupational therapy roles and responsibilities to such an extent that we are now meant to focus explicitly on occupations; meanwhile we have left behind other equally important aspects of our heritage, such as an emphasis on the quality of life and morale of our clients. In our haste to develop a unified frame of reference, we have still not captured the essence of occupational therapy, which is its holistic approach. Instead, we have developed highly specialized interventions and, in the process, have not only dichotomized the client but also fragment the holistic philosophy that underlies the profession.

Criticism of the current education of students for practice in psychosocial occupational therapy has been levied by Barris and Kielhofner (1986). They surveyed psychosocial occupational therapy educators (n = 34) on matters related to curriculum content as well as on their ideas about current and future roles for therapists. They found a prevailing theme of educational eclecticism in responses to their questionnaire. Some respondents (n = 8) saw the lack of a unified theory as a serious deficiency, and Barris and Kielhofner pointed out that this concern is incongruent with educational eclecticism. Although these educators responded to a forced-choice questionnaire by indicating that the view they most wanted to transmit to students was one that emphasized occupational behavior, this view is not synonymous with the notion that other approaches in mental health should be
disregarded. More importantly, it is not synonymous with disregard for the role of those other approaches in helping clients to achieve functional occupational behavior. Of interest is the finding that 97% of these educators agreed that "students should be prepared to be change agents, developing new roles in new settings based on a firm sense of theory and tradition" (Barris & Kielhofner, 1986, p. 539). However, it should be pointed out that such lofty goals may be constrained by too much reliance on a single, unified theory. As Warner has pointed out (1991), a multiplicity of theoretical approaches is normal for a health discipline and is thought to encourage healthy debate and the resulting synthesis of ideas.

**Psychosocial Occupational Therapists Are Their Own Worst Enemies**

Psychosocial occupational therapy, as compared with physical medicine occupational therapy, seems to invite more analytical thinking about itself as a professional group. Certainly its issues are written about frequently in the scholarly literature (e.g., Atwater & Davis, 1990; Bondler, 1987; Brinell, 1990; Cowell, 1990; Ezerly, Havanet, Scott, & Zettler, 1989; MacKinnon, 1985; Scott, 1990). Perhaps there is something about the practice of psychosocial occupational therapy itself that encourages self-reflection and emphasizes insight and understanding. If one tends to analyze individual behavior and experience (i.e., one's clients and one's own) in this way, then it is perhaps not surprising to find collective professional behavior and experience being similarly examined. Because this examination increases awareness of limitations, psychosocial occupational therapists may feel that theirs is the only segment of the profession with problems when, in fact, other occupational therapists are simply not engaging in this level of public introspection.

This mental set makes psychosocial occupational therapists vulnerable to accepting, uncritically, negative reports of the declining status of their specialty area. However, the studies reported may be flawed (e.g., in sampling procedures, sample sizes, and variables measured) or the interpretations of the results may be too simplistic. For example, the decline in numbers of psychosocial occupational therapists indicated in some studies may have less to do with the value of their roles and more to do with changes in health care policy. Silverglett (1987) pointed out that the 1985 AOTA Manpower Survey did not show a decline in occupational therapists in mental health as is often quoted. Furthermore, in his analysis of the 1986 AOTA Member Data Survey, he noted that, although the numbers of registered occupational therapists declined by 21.8% between 1977 and 1986, the number of occupational therapy assistants increased by 1244% during that same period. Thus, it may be that a change in provision of service, rather than an increase in consultative roles for registered occupational therapists, is so that this is surely a positive, evolutionary step for the profession and does not represent a decline in status.

**The Position of Psychosocial Occupational Therapists Is Not as Bad as It Seems**

To analyze reports of declining numbers and status in psychosocial occupational therapy more critically, we conducted a survey of occupational therapy managers in Toronto and its surrounding area (population approximately 5.2 million) (Renwick, Freeland, Semas, & Raybould, 1989). One of our research questions was aimed at the issue of the alleged unpopularity of practice in psychiatry. We reasoned that if psychosocial occupational therapy were so unpopular, there would be greater difficulty in recruiting occupational therapists in that area of practice than in physical medicine. We asked all occupational therapy managers (who were collectively responsible for supervising 516 occupational therapists) whether they experienced shortages and whether they perceived difficulty in finding and hiring occupational therapy staff. Sixty-three percent of all managers were experiencing shortages. However, with regard to problems in recruiting staff, there was an interesting discrepancy between reality and perception for both physical medicine managers and psychosocial managers. One hundred percent of the psychosocial occupational therapy managers perceived that they had a problem with recruitment, whereas only 79% of physical medicine managers thought they had a problem. In fact, psychosocial occupational therapy managers' difficulties in hiring (measured in terms of vacancy rates and periods) were not as serious as those of the physical medicine occupational therapy managers, who were experiencing higher vacancy rates and longer vacancy periods. A possible explanation for psychosocial occupational therapy managers' pessimistic view of their staffing problems is that they have a negative perception of psychosocial occupational therapy, and, consequently, they think that therapists will not want to work in their area of practice.

The perception that psychosocial occupational therapy is declining in status and is a second-rate area of practice is a potent force in determining its future, for it can lead to a self-fulfilling prophecy (Rosenthal, 1966). That is, such negative perceptions are thought to lead to congruent behavior patterns, which then fulfill the negative expectations. Specifically, our attitudes, concerns, and feelings are communicated unconsciously (or consciously) to the students we teach and supervise, to the new graduates for whom we are meant to be role models, to other health professional colleagues, and even to our clients.

**The Need for a Definition Focused on Type of Intervention**

When a holistic approach is taken in occupational therapy today, for instance, with a client who is suffering from chronic pain, the psychosocial interventions generally are seen as an adjunct to the work done by the physical medicine therapist, even though these issues are more rightly the purview of the psychosocial occupational therapist.

There is no need to quibble over occupational therapy territory unless, of course, we are forced to declare ourselves and be counted. Thus, it is interesting to note that when surveys (e.g., AOTA, 1990; Canadian Association of Occupational Therapists [CAOT], 1991) are conducted to see how many people are working in which areas, we see psychosocial occupational therapy numbers as very small and representing only the
work that is done with clients who have psychiatric diagnoses. For instance, Canadian survey results for 1990 (CAOT, 1991) indicated that 73.6% of therapists worked in physical dysfunction and 26.4% worked in mental dysfunction. Similarly, American survey results for the same year (AOTA, 1990) indicated that 83.4% and 16.6% practiced in physical disabilities and mental health, respectively. However, when diagnostically based categories are employed, physical disability numbers are inflated by all those therapists working more holistically, for example, in palliative care, in pediatrics, with persons who experience chronic pain, with persons who have developmental problems, in geriatrics, with burn patients, and so on.

In contrast to the surveys described above, the survey of occupational therapy managers in the Toronto area referred to earlier (Renwick et al., 1990) asked about the type of intervention therapists used rather than the diagnoses of their clients. The survey also included a category defined as a "combined approach" that referred to the equally important use of both psychosocial and physical rehabilitation interventions with clients. Results indicated that of 516 therapists, 44% used physical rehabilitation interventions, 30% used psychosocial interventions, and 26% used a combined approach. These figures contrast sharply with the CAOT and AOTA statistics, which are derived from surveys focusing on diagnoses rather than on the particular approach employed by the therapists sampled.

Atwater and Davis (1990) employed a similar strategy when they included a category of "combined" (with a slightly different definition and for a different purpose). They questioned newly graduated occupational therapists about the value of their psychosocial level II fieldwork experience in their day-to-day practice and found that 97.4% of all respondents dealt with psychosocial issues as part of their clinical practice.

Thus far, we have discussed how previous reportage of therapist numbers in psychosocial occupational therapy and physical medicine occupational therapy may be open to interpretation. We have noted that the way these surveys are conceptualized reflects (and perpetuates) the dichotomized view the profession has come to take of itself over the past few decades. We have also noted how this view is at odds with the profession's traditional philosophy of holism. We can now discuss how this compartmentalization of areas of practice is not serving us well when current perspectives on health (Boyle, 1990; Carswell-Opzoomer, 1990; Ellek, 1990; Rootman, Warren, Stephens, & Peers, 1988; World Health Organization, 1984) demand an expanded role in, and a holistic approach to, health service provision.

New Perspectives on Health
Demand an Expanded Holistic Role

As the aging population continues to increase, more persons with chronic illnesses and disabilities live longer, holistic interventions will be required in occupational therapy more than ever before. There will be an emphasis on enhancing quality of life (Taylor, 1991) and on meeting psychosocial needs for those in palliative care, long-term care, gerontology, and pediatrics, and for the ever-increasing number of persons with chronic illness and disability who will be living in the community. The well-being of these persons will not be enhanced by reductionist paradigms and a dichotomized approach to occupational therapy practice.

Furthermore, Boyle (1990) pointed out that we have not truly understood the nature of the rehabilitation populations that we serve—and that until we do, our interventions will lack effectiveness. We must address the social, economic, and political realities: the illiteracy, the poverty, the homelessness, and the general inability of many people to cope with everyday life. To address these issues we will need a whole new set of skills, not purely psychosocial and not purely physical medicine.

Devereaux (1991) noted that as society begins to examine the economics of unemployment and the need for services currently unavailable in many areas due to labor shortage, attention will shift to those with handicaps as an untapped human resource. Consequently, there will be an increased need for therapists to help people with disabilities make informed vocational choices and to prepare them to enter the workplace. Employment equity laws will ensure that people with disabilities have the opportunity to be employed, and occupational therapists, with their skills in vocational rehabilitation and environmental management (Law, 1991), should be in the forefront of this movement. But making jobs feasible for more people with disabilities will require a mix of occupational therapy skills that can help persons to adapt both physically and emotionally. And adapting work settings will require other skills, like advocacy, assertiveness, and creativity, to ensure that environments become both physically accessible and socially receptive.

Prevention and Health Promotion

As health care models shift their focus to prevention (at all levels, particularly at the primary level) there will be an increasing need to work with those who are well (Jaffe, 1986) to help them maintain and enhance their health status. For example, occupational therapists will be working to enable people to increase their own sense of control and to improve their health through developing the resources to cope. With the aging population, this approach gives us much to do that is holistic. We will work with those close to and planning for their retirement to facilitate the transition and to help them to create a new balance in the rhythm of their daily round of activities (Meyer, 1977); we will work with the well elderly to help them maintain or build new social networks and to educate them about the importance of social support in determining health outcomes; and we will work with caregivers to provide support and advice. We should be involved in developing appropriate environments for housing the homeless (Townsend, 1991); in facilitating adaptation in daily tasks for new immigrants (Khoo & Renwick, 1989); and in reducing stress and increasing well-being of persons in work (Allen, 1986; Mungai, 1985) and school (White, 1986) environments.

It has been predicted that health promotion efforts will soon be recognized as not only cost-effective but also better in the long run for meeting health and social justice goals. Ellek (1990) pointed out that, rather than using quality assurance schemes to cut
costs, society will be looking at the value of health care as it relates to the person’s ability to function in everyday life. Further, the role of consumers in promoting their own health and in shaping health service provision (Law, 1991; McPherson, 1990) will continue to be vital issues.

In summary, it is clear that increasing attention is already being paid to psychosocial issues but not in the traditional context (i.e., not in terms of psychiatric clients in an inpatient, acute care setting). Given current health policies, this trend will continue. One way to maximize the opportunity to shape health services is to stop dichotomizing the way we think about our areas of practice. At this time in the evolution of our profession, it is important to reclaim the territory that once was ours, to publicly declare our use of combined skills, and to apply our traditional holistic principles. These skills position us well to meet the health care needs of today. However, we must move quickly, because if we are not meeting current needs, how will we as health professionals be ready to meet tomorrow’s needs?

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References


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