The Concept of Work in Occupational Therapy: A Historical Review

(occupational therapy, theory, vocational rehabilitation, work)

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This historical review traces the concept of work throughout the development of occupational therapy. Paradigm shifting is used as a framework for describing the conceptual definitions and therapeutic uses of work in four developmental stages.

The concept of work is fundamental to our profession; the terms occupation and therapy connote the strong relationship between healing and work. Throughout our profession's struggle to establish its credibility in the health care field, the therapeutic use of work has remained a central tenet. It is derived from two basic assumptions—the human need for mastery and self-actualization, and the occupational nature of the individual. Although the meaning of work has changed as the profession has developed, work has always been acknowledged as one concept that distinguishes occupational therapy from other health disciplines. However, our profession has not always translated its conceptual and philosophical importance into clinical practice.

This paper is a historical review of the concept of work and its use as a therapeutic medium in occupational therapy. In his 1981 Eleanor Clarke Slagle lecture (a scholarly historical review of the profession), Bing (1) stated that the history of occupational therapy is the most neglected aspect of the profession. This paper, by reviewing the past, reveals the importance of work as a concept in daily practice and serves to remind therapists of their responsibility in addressing this area of human occupation.

The majority of information for this historical review is drawn from The American Journal of Occupational Therapy. Particularly with regard to the early years of the profession, I relied heavily on the works of acknowledged historians, such as Hopkins (2) and Bing (1), who have produced scholarly comments on the development of the profession. I chose these secondary sources because of their excellence and because of the practical difficulty in obtaining original sources.

The theory of paradigm shifting, as applied to occupational therapy by Shannon (3) and Kielhofner and Burke (4), is used as a framework for the historical review. The concept of paradigm developed by Kuhn (5) sought to clarify shifts in scientific thought. Its applicability to professions is a contentious issue, but as Kielhofner and Burke

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Paradigm Shifting or Change

The notion of paradigm shifting is borrowed from Kuhn’s (5) exploration of how knowledge changes in the physical sciences. His historical studies suggest that knowledge development is a revolutionary process to which we can apply meaning by using the concept of paradigm. A paradigm reflects the nature and scope of the profession. Included in a paradigm is a description of values and beliefs, current theoretical systems, research practices, educational practices, and boundaries of the profession. A paradigm explains what the profession does and how it does it. The purpose of Kuhn’s work was to develop a theory of change in the field of science. Briefly, he describes this change as a process of development, acceptance, crisis, and eventual rejection of a paradigm. Kielhofner and Burke (4) describe the four stages in this process as preparadigm, paradigm, crisis, and return to paradigm. The preparadigm stage occurs before a discipline is formally recognized. It reflects its roots and often invokes conflict between competing schools of thought. The paradigm of a field is acknowledged when one group predominates and a common definition is subscribed to. A crisis occurs when the paradigm no longer fully explains the discipline and the problems with which it deals (i.e., when data no longer support the accepted theory base or a new aspect of practice is not accounted for). An example of such a crisis in occupational therapy was the introduction of projective techniques based on psychodynamic principles. The existing understanding of activities did not include symbolic interpretation. Again, schools of thought develop in an attempt to deal with gaps in the old paradigm and to reconceptualize old phenomena. The return to paradigm occurs when one school of thought succeeds in solving the problem. This process of crisis, followed by resolution in the form of a new paradigm, continues as the discipline grows.

These four stages reflect the revolutionary nature of occupational therapy and its current crisis. Although paradigm change is used as an organizing framework, I do not suggest that the therapeutic use of work has undergone a change separate from the profession as a whole. It should be understood that the purpose of this historical review is to focus on the development of one aspect of the profession (i.e., the therapeutic use of work) so that we may better understand its place in occupational therapy.

Preparadigm Stage

The preparadigm stage, the roots of the profession before it was known as such, is the earliest history of occupational therapy. Historians agree that occupational therapy was founded during the moral treatment movement in the 18th and 19th centuries (1, 2, 6, 7). At that time, inmates in asylums began to be treated humanely as rational beings. Previous assumptions about illness implied that a person suffering from a mental disorder was less than human. Frequently, such people were treated as if they were animals or demonically possessed. With the moral approach, manual occupation, including domestic work, agricultural activities, and recreation, were seen as a means to improve morale and discipline. This work in and around the asylum was the first recorded application of work as a “medical prescription.”

Regularity and bodily action were seen as two of the most therapeutic characteristics of work. The purpose of work was to distract the patient from symptoms and reintroduce the patient to the habit of attention. Work was not defined in terms of eventual employment but as fulfillment of present needs. The strong puritan influence supported the use of work; industry was viewed as something intrinsically necessary and good. It is interesting to note, however, that the much lauded moral treatment movement did not include “paupers.” Garrett (8) states that the poor, orphaned, and aged insane were excluded from its benefits; and Woodside (7) suggests that the patients were often put to work to relieve employers.

Another therapeutic use of work in the preparadigm stage was the introduction of workshops for the blind. With the development of the Braille code in the late 1800s, workshops were opened that offered music, crafts, and work projects. By having patients produce baskets, clotheslines, and rugs, the
therapeutic uses of work were combined with a demand for the product. Although some remuneration was involved, the purpose of the workshops was to give structure and worth to the lives of the blind patients rather than to provide economic independence (8).

In summary, work, along with recreation and daily tasks, was seen as a means of affecting disorganized behavior in the preparadigm stage of the profession. It was not necessarily relevant to the needs of a particular patient, nor was it associated with employment outside of the institution or asylum. The therapeutic use of work in this stage of occupational therapy gave dignity to the mentally ill, fulfilled the work ethic, and provided a tenuous connection to the rest of society.

Treatment is closely related to social attitudes and beliefs. The humanistic philosophy on which moral treatment was based was replaced by a philosophy that emphasized individualism and personal accountability for action. Moreover, moral treatment was influenced by a shift in the medical view of mental illness (4). Although mental illness was once believed to have an emotional-moral basis, a new biological perspective was accepted that defined mental illness as a disease of the brain. This perspective sought a "causative agent" for mental illness and largely regarded the mentally ill as having a poor prognosis. The therapeutic use of work largely disappeared until the early 1900s, when it resurfaced as a major tenet in the occupational paradigm.

The Occupational Paradigm

The occupational paradigm represents the period in which occupational therapy was formalized by the efforts of leaders, such as Tracy, Slagle, Major, and Barton (roughly 1900-1940). These pioneers revitalized the moral treatment movement, with their actions centering on the concept of occupation. They believed in the occupational nature of humans and saw the health-restoring effect of occupation in the extensive use of crafts as work projects. This therapeutic definition of work was influenced by the types of diseases and treatment approaches that predominated in that period. Prolonged bed rest was a widely used treatment for polio, pneumonia, and chronic diseases (e.g., arthritis and heart problems). A broad definition of work was accepted, one that emphasized the patient's intrinsic sense of productivity rather than paid employment. For example, for the patient with tuberculosis, rug hooking was a major role and method of being productive. What most people would consider a leisure occupation was treated as work.

Barton (9) stated that the purpose of work was to divert the mind, to exercise some part of the anatomy, or to relieve the monotony and boredom of illness. He suggested work did not have to be of practical value beyond its immediate purpose. Bing (1) described the importance of the creative instinct and the aesthetic interest in work projects. Although salability of articles was considered, remuneration did not take precedence over treatment purposes.

Meyer (10) emphasized the balance of occupation, saying that a blend of productivity and pleasure was essential.

Kiellhofner and Burke (4) described the occupational paradigm as a period when therapists treated problems stemming from "interruptions in work" or lack of occupation. Idleness, poor habit formation, and lack of social skills were seen as demoralizing and as fostering a sick or invalid role. Work was introduced to break this cycle.

World War I provided occupational therapy with the major impetus to become organized. Reconstruction workers (as the first therapists were called) were trained for field hospital work to promote the "work cure." These women were chosen because of their knowledge and experience in crafts to provide bedside occupation for the soldiers. Although crafts were chosen for the purpose of therapy, they were also used to assess the patient's interests and abilities, and this information was used to select an appropriate type of vocational training for the patient. Vocational training was done in workshops in the military hospitals, which were staffed by men with expertise to teach the returned soldiers a vocation (11). Thus work was a means, not a goal, during the occupational paradigm. According to Barton (9), therapeutic work was preliminary to and dovetailed with real vocational education, which was beyond the scope of occupational therapy.

Throughout the occupational paradigm stage, the emphasis was on physical illness. The school of thought that pronounced mental illness as incurable was still dominant. In fact, the United States' Vocational Rehabilitation Act introduced in the 1920s did not apply to psychiatric patients (7).

Therapists continued to acknowledge a broad definition of work and used mainly craft activities as work projects. They used work to improve general productivity, normalize routines, and raise tolerance for sustained effort. Crafts in the prevocational sense were seen as legitimate work projects and were used to foster a sense of in-
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The trend to reduce phenomena to constituent parts was evident in the changing definition of work. Instead of using a broad definition related to intrinsic productivity, some therapists began to understand work as employment. The concept of productivity was reduced and the socially defined concept of employment for remuneration was offered by some as the definition of work. As Jensen (12) and West (13) argued the need for more vocationally oriented therapists. Gordon and Wellerson (14) identified a major shortcoming in the profession: the use of modalities unrelated to the patient's sense of values. These researchers, by illustrating the obvious discrepancies between types of work in occupational therapy and those in industry, contended that crafts did not relate to the vocational demands of the contemporary world.

As the influence of reductionism increased and pressure was placed on the profession to become a more "exact science," the occupational paradigm no longer adequately defined the rationale, theory base, or methods of occupational therapy. As Mosey (15) observed, therapists began to feel uncomfortable with the simple operating principle that it was good for disabled people to keep busy. This discomfort eventually led to the borrowing and adapting of knowledge from other disciplines and hence the rise of the inner mechanisms paradigm.

Paradigm Stage

The acceptance of the paradigm of inner mechanisms marked the resolution of the crisis (4). Briefly stated, this paradigm was based on studying and modifying internal functions of the mind and body. Holistic principles accepted during the occupational paradigm were sacrificed to narrower, more precise concepts, such as defense mechanisms and sensory integration. The paradigm included a number of ideas drawn from the neurologic, kinesiologic, and psychodynamic schools of thought. Most importantly, it gave the profession the scientific grounding it needed.

The new definition of work and work's therapeutic uses were developed in the crisis stage, which was dominated by the inner mechanisms paradigm. Definitions of work included the concepts of employment, specific job skills, and remuneration. Gainful employment became the focus of treatment. The principles of intrinsic productivity and balance of occupation, central to the occupational paradigm, were no longer crucial in the therapeutic use of work. The influence of reductionism was obvious as work began to be analyzed into component parts, such as motivation, cognitive skills, and cultural influences. This was reflected in a more specialized approach to work in the formalization of work evaluation and industrial therapy.

Evaluation in the occupational paradigm was mainly prevocational in nature and used crafts or daily living skills to assess readiness for work therapy. In the inner mechanisms paradigm, therapists began to establish work evaluation programs and to develop work samples that reflected specific jobs. In the 1957 Eleanor Clarke Slagle lecture, Wegg (16) called for a more scientific approach to work evaluation and diagnosis, and Cromwell (17) delineated the principles and the therapist's role in prevocational evaluation. Efforts to improve evaluation were seen in reliability tests on prevocational instruments, development of formalized reports, and attempts to match evaluated skills with job skills from the Dictionary of Occupational Titles (18–20). The increasingly scientific approach to work evaluation was emphasized by Cromwell (21) when she called for therapists to become evaluators rather than observers, thereby implying that the former take a more scientific, objective, and professional approach.

Kester (22) observes that the in-
Involvement of occupational therapists in work evaluation was promoted by the passing of legislation that mandated evaluation accompanying vocational rehabilitation efforts. Initially, the majority of evaluators were occupational therapists. However, with the changes in legislation and funding policies, work evaluation became an attractive and lucrative field for other professionals.

A second area of specialization for occupational therapists during the inner mechanism paradigm was industrial therapy. Based on the idea of temporary employment for hospital patients, industrial programs used existing institutional services to assess job readiness and to provide some skills training (23-25). Industrial therapy was seen as more than a way to offer chronic patients some activity; it was considered a process that allowed the patient to progress from individual treatment through work evaluation to work training. Fellows and McKillip’s (26) program description illustrates the industrial therapy process. To establish rapport and to complete a prevocational assessment, the therapist first saw the patient on an individual basis in the craft shop. The patient then progressed to a job within the institution, which was structured to allow a graduated effort, up to 40 hours per week. Job placement was then sought in the community. Although therapists were not often involved in placing patients in employment situations in the community, they acted as work evaluators, program coordinators, and business managers.

Despite the increasing emphasis on employment as the final objective, evaluation flourished in the absence of skill training or work adjustment programs. Llorens (27) illustrates this in her description of the therapeutic use of work in the Lafayette Clinic. She states that although a program was entitled “work therapy,” it differed from work evaluation only in the sense that the expectations were higher and more related to a “real” job.

As industrial therapy and work evaluation flourished, evidence of effectiveness was demanded. Research studies appeared that discussed the ability of the evaluator to predict successful vocations (28) and compared various aspects of a program to patient outcomes (29, 30). DiMichael (31) described as one of the unfortunate consequences of accountability the tendency of rehabilitation programs to absorb the employable and ignore the hard-to-employ. Because success was defined as returning the patient to work, patients with higher potential were served, whereas those who were unlikely to return to the work force were largely ignored.

In addition to studies supporting work evaluation, attention was focused on the theoretical basis of practice. Borrowing from other disciplines, therapists began to conceptualize work in an even narrower sense than employment-related activity. Particularly notable was the adoption of principles of behaviorism, as seen in articles discussing the effects of contingency management and reinforcement on work behavior (32, 33). Humanistic psychology, using Maslow’s needs—satisfaction principle, was also offered as a basis for work therapy programs (34). However, it was the psychologists, social workers, and rehabilitation counselors who were contributing theoretical material to the occupational therapy journals (35, 36). Therapists were the practitioners, while other professionals generated the knowledge.

In summary, work became narrowly defined during the inner mechanisms stage. Influenced by reductionism and legislative changes, work virtually became synonymous with employment. The therapeutic use of work was seen primarily as work evaluation, either through work samples or industrial therapy programs.

The Current Paradigm Crisis

The current paradigm crisis in occupational therapy reflects the changing nature of the health care system. Dissatisfaction with the strict medical model, coupled with emphasis on preventative health measures, and an increase in the numbers of patients with chronic lifelong disability are the new developments that contribute to this crisis.

In the current paradigm crisis, the narrow definition of work and the associated role specialization of the therapist is undergoing critical review. Some therapists support increased specialization and propose enlarging the vocational rehabilitation aspect of the profession (37). The American Occupational Therapy Association’s (AOTA) position paper (38), which describes the role of the occupational therapist in the vocational rehabilitation process, illustrates this stance. The paper describes eight services occupational therapy offers, beginning with screening and general evaluation and ending with vocational training and placement. This is in contrast to the occupational and inner mechanisms paradigms, which limited the therapists role to prevocational evaluation and work adjustment. Another indication of increased specialization is the effort, albeit unsuccessful so far, to incorporate a vocational rehabilitation special interest group within AOTA. In addition, editorials
identifying vocational rehabilitation as a rich area for expansion also have appeared in recent years (39, 40); the discussion of vocational evaluation and training for job skills are two examples (41).

Other occupational therapists are taking a generalist approach to vocational rehabilitation that is based on a more fundamental interpretation of work (42, 43). They feel that an expanded definition of work must be adopted, one that is based on human performance or occupation. The essential consideration in this new definition is an intrinsic sense of competence or mastery.

It is important to acknowledge Reilly's (42) occupational behavior model as a basis for much of the current generalist approach (44). Her model was developed in response to the narrowness of the inner mechanisms paradigm, and it emphasized returning to earlier tenets of the profession. The occupational behavior model provided the impetus to reexamine occupational therapy in relation to traditional principles and concepts, such as occupation and purposive activity. The model's current impact can be seen in the work of some of her students. For example, Kielhofner (42) defines work as all forms of productive activity regardless of reimbursement, activity that is recognized as a major life role.

Reed and Sanderson (43) distinguish between occupational therapy and vocational therapy, stating that therapists are interested in peoples' ability to engage in productive work. Productive skills, however, are not necessarily work-related. These researchers suggest that occupational therapists with a narrow and specialized role are work evaluators, market analysts, or business managers, not therapists.

The resolution of the current paradigm crisis and the implications for the therapeutic use of work are difficult to forecast. In the next section, we propose some future uses based on this historical review and on predicted trends in health care.

The Future

Futurists such as Toffler (45), Dubos and Escande (46), and Naisbitt (47) have attempted to predict the effects that an increasingly turbulent environment and a complex technological state will have on the individual and society. Ferguson (48) suggests that there will be a shift from objective, socially acknowledged values to values that reflect subjective experiences. Toffler (45) agrees that values will be more person centered and predicts that individuals will try to regain control over their immediate environments. In the new social order, the definition of health and duties of health care workers will be altered dramatically.

Johnson and Kielhofner (49) and Monfette (50), in considering the role of occupational therapy services in the future, emphasize human productivity as a focus for professional services. These researchers state that workers will be increasingly alienated from their work and will therefore be unable to achieve satisfaction in traditionally productive roles. In spite of being employed, individuals will have a minimized sense of competence and mastery. These researchers also suggest that one of the major influences in this alienation will be technological change, which will reduce creativity and craftsmanship in the workplace.

Cousins (51) echoes this warning to future workers by stating that the most costly disease in America is boredom. Moreover, Ferguson (48) and Naisbitt (47) address the problem of unemployment caused by microelectronics. They identify a shift away from the industrial society to an information society, one in which the "thinking business" is primary. In this society, the young, the old, and women workers will be the most affected. For these individuals, maintaining or replacing jobs may not be possible. Even now, the number of individuals identified as "discouraged workers," people who have simply given up seeking employment, is growing. Other occupational problems of the future may include the lack of craftsmanship in workers who never see a finished product or in those whose responsibilities are so diverse that they are unable to master any one area. Occupational therapists then will not be working only with the diseased but also with those who are disengaged from productive existence.

These predicted social changes have major implications for occupational therapy personnel. Therapists may stop focusing on work as a therapeutic medium and instead emphasize work habits and skills to address the client's definition of work. Future clients may be those who are no longer challenged by their traditional role as a
worker, those who are overqualified for their position, or those who work in a mechanistic, nonhuman environment. Therapists can help such clients learn to maximize creativity or to shift the emphasis of productivity away from work to other areas of human occupation. Productivity then will become a more subjective experience, particularly for the unemployed, early retired, and the bored.

Conclusion

This paper illustrates the importance of work throughout the growth of occupational therapy. Despite the changes in the definition and the therapeutic application of work, I suggest that work has been a central part of occupational therapy’s unique contribution to the health care field. Although our profession has undergone major philosophical changes, which have been reflected in clinical practice, the focus on work has remained a distinguishing feature. For occupational therapy to survive in the crowded health care arena, the concept of work must remain central to our profession and must continue to be redefined.

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