This paper was originally prepared as a presentation for the Symposium on the Directions for the Future in San Diego, California, January 12–14, 1989. I was asked to use the years 1949 and 1989 as historical reference points with which to prepare a brief snapshot of occupational therapy education. Changes in occupational therapy education will be discussed in terms of changes in the number of programs, students, and faculty; the shifts in academic designations of the educational institutions that sponsor occupational therapy educational programs; alterations in the standards of educational programs; and some of the major educational concerns that were being debated in 1949 and in 1989.

The primary sources for this comparison were information published in the 1949 issues of the American Journal of Occupational Therapy; particularly the Nationally Speaking columns (viz., West, 1949a, 1949b); the 1990 Education Data Survey Final Report: Survey of 1989 Educational Programs (American Occupational Therapy Association [AOTA], 1990); the Proceedings of the Commission on Education, 1989 (AOTA, 1989b); and personal communication with Wilma West. I am indebted to Wilma West for her vivid recollections of education during her tenure as Executive Director of the American Occupational Therapy Association as well as her consistent dedication to the improvement of occupational therapy education throughout her lengthy and distinguished career.

Changes in the Number of Educational Programs

There has been a remarkable increase in the number of educational programs, the number of students enrolled, the number of students who graduate annually, and the number of faculty members engaged in occupational therapy education. In 1989, there were 68 accredited occupational therapy educational programs (AOTA, 1990). In 1949, AOTA listed 25 schools in the continental United States offering courses in occupational therapy (26 if one counts the university extension program at the University of Toronto) (AOTA, 1949). Almost all of these programs offered a baccalaureate degree, though many continued to offer certificate or diploma courses as well. In 1949, occupational therapy courses were not required to be at the baccalaureate level. Students not following a combined course, that is, the occupational therapy course combined with a baccalaureate course, were expected to furnish proof of having completed 1 year of college education or its equivalent (see AOTA, 1949).

In 1949, the total enrollment among the schools was approximately 1,800 students. Although AOTA had predicted that 500 occupational therapy students would graduate during the 1949 academic year (West, 1949a), the program directors of the 25 U.S. schools reported that only 375 students did graduate (Willard, 1949). As might be expected from this difference, unfilled classes in all but 4 of the schools and an attrition rate reportedly as high as 40% of enrolled students were of considerable concern. In 1949, as in 1989, there were too few graduates to fill employment needs. Comments in several reports suggest that students often left school following marriage (Kahmann, 1949). Then, as now, public information efforts designed to create interest that would increase the number of schools and the number of students enrolled in each school were seen as the most effective way for the Association to make headway in meeting the employers' needs for more occupational therapists. The employment concerns in 1949 were sufficiently severe for the Association to discuss reestablishing a training program similar to the intensive 1-year War Emergency Courses initiated in 1943, in which more than 500 therapists had been trained for service in the U.S. Army.

In contrast, by 1989, there were 68 accredited educational programs for the occupational therapist, with approximately 8,013 students enrolled and approximately 2,323 entry-level occupational therapy graduates expected for that year (AOTA, 1990).

In 1949, there were no programs for the occupational therapy assistant. A report of the Education Committee (Willard, 1949) noted that Guy Morrow
of the Cleveland State Hospital presented a proposal for a 1-year training course for assistants in psychiatric hospitals. Despite this early effort, standards for occupational therapy assistant educational programs were not established until 1960. In 1989, there were 67 educational programs for the occupational therapy assistant, with approximately 3,050 students enrolled and an expected 1,038 graduates for the 1989 academic year (AOTA, 1990).

According to West's recollection, the number of faculty among the 25 schools in 1949 was as follows: several schools had only one faculty member, these being Professor Frieda Behlen at New York University, New York, Professor Henrietta McNary at Milwaukee-Downer College, and Sister Mary Arthur at Mount Mary College, Milwaukee; most of the other schools had two or three faculty members; and the University of Illinois, under Professor Beatrice Wade, had seven or eight faculty members (W. L. West, personal communication, December 29, 1989). By 1989, there were approximately 679 faculty members in the occupational therapy programs and approximately 249 faculty members in the technical programs (AOTA, 1990).

What Is in a Name?
The gradual movement of U.S. universities since 1949 toward liberal arts and research-oriented missions had and continues to have effects on occupational therapy education. Of the 25 occupational therapy schools recognized in 1949, 4 have since closed: those at the University of Iowa in Iowa City, Mills College in Oakland, California, Milwaukee-Downer College, and the Philadelphi­a School of Occupational Therapy. The sponsoring institutions of 8 of the 25 educational programs in existence in 1949 have undergone name changes, reflecting a shift from normal schools and colleges toward university status. These name changes are as follows:

- From the Boston School of Occupational Therapy, affiliated with Tufts College—School of Education (AOTA, 1949), to Tufts University—Boston School of Occupational Therapy (AOTA, 1989a).
- From the Colorado Agricultural and Mechanical College, Division of Home Economics, Fort Collins (AOTA, 1949), to the Colorado State University (AOTA, 1989a).
- From the Kalamazoo School of Occupational Therapy of Western Michigan College of Education (AOTA, 1949), to the Western Michigan University (AOTA, 1989a).
- From the Michigan State Normal College, Ypsilanti (AOTA, 1949), to Eastern Michigan University (AOTA, 1989a).
- From the College of Puget Sound, Tacoma, Washington (AOTA, 1949), to the University of Puget Sound (AOTA, 1989a).
- From the San Jose State College, San Jose, California (AOTA, 1949), to the San Jose State University (AOTA, 1989a).
- From the Texas College for Women, Denton (AOTA, 1949), to the Texas Woman's University (AOTA, 1989a).
- From the College of William and Mary, Richmond Professional Institute (AOTA, 1949), to the Virginia Commonwealth University (AOTA, 1989a).

The 1949 and 1989 listings of the remaining 25 programs also reflect changes in the departmental location of the occupational therapy educational program. In 1949, occupational therapy educational programs were associated with colleges or schools of education, colleges of liberal arts, colleges of medicine, a department of art, and a department of home economics. By 1989, the allied health movement had swept nearly two thirds of the 68 occupational therapy programs into colleges or schools of allied health. (There are several variants of the term allied health, including health sciences and health-related professions.) Only 4 programs retained the name "School of Occupational Therapy" by 1989, and AOTA no longer uses the term schools, but instead refers to educational programs in occupational therapy.

Just as the upward shift of schools to colleges, colleges to 4-year universities, and universities to research universities influenced the nature and names of our educational programs, the undergraduate curriculum reform movement highly visible in 1989 is influencing programs today. U.S. universities have been criticized for allowing undergraduate programs to overemphasize narrow, specialized skills while underemphasizing such areas as critical analysis, writing, foreign language, the humanities, and international studies. In the foreword to Stark and Lowther's (1988) report, Frank H. T. Rhoades, president of Cornell University, Ithaca, New York, said:

Regardless of their specific field or professional area, all college graduates should be skilled communicators and critical thinkers. They should have an understanding of the social goals their profession promotes and the ethical standards it demands. They should appreciate the aesthetic elements of their profession and its practice. Although these outcomes are widely endorsed in principle . . . too many institutions have simply added more liberal arts courses to already burdensome programs of professional education. Rarely have they attempted to integrate liberal and professional education in ways that have meaning for all students; rarely have they been able to link high standards of scholarship and professional practice to critical thinking on the fundamental issues of life. (p. v)

In 1989, and for several years more, the undergraduate curriculum reform movement will precipitate serious reviews of undergraduate professional programs in many of our sponsoring universities. One of the criticisms of higher education voiced within the curriculum reform movement is that accreditation standards and other practice standards asserted by professional organizations may force undergraduate students into narrow, overspecialized programs, to the detriment of a meaningful general education.

Changes in Educational Standards
It is difficult to contrast the educational Essentials of 1949 (Council on Medical Education and Hospitals of the American Medical Association [CME], 1950) with those in effect in 1989 (AOTA, 1983), because we have dramatically changed the language of our educational standards. In 1949, our Essentials listed required semester hours of a given content as the unit of measurement for meeting the standards. The Essentials were revised in 1949, and although they
were still published by the American Medical Association and only reprinted by AOTA, the 1949 revision did list occupational therapy theory as a separate entity for the first time, though the medical designations persisted. For example, in 1949, the theory of occupational therapy was defined as a specified number of semester hours in (a) administration, (b) general medicine and surgery, (c) orthopedics, (d) pediatrics, (e) tuberculosis, and (f) psychiatry.

In the Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapist (AOTA, 1983) of today, we see occupational therapy theories, rather than the theory of occupational therapy (i.e., theories are referred to as plural, not singular), and the Essentials in use during 1989 defined our theory in occupational therapy rather than in medical terms. For example, the current Essentials speak of theoretical approaches to human performance, purposeful activity, adaptation, and activity processes.

By 1989, the Essentials show little evidence of the strong technical requirements of 1949, which included requirements for the following (CME, 1950, p. 127):

- Arts—Fine and applied, including design, leather, metal, plastics, textiles, and wood.
- Education—Special and adult, including home economics and library science.
- Recreation—Music, dramatics, social activities, gardening, and physical education.

In 1949, 9 months of clinical training were required and the training was divided into 12 weeks of psychiatry, 8 weeks of physical disabilities, 4 to 8 weeks of working with patients with tuberculosis, 4 to 8 weeks of pediatrics, and 4 to 8 weeks of general medicine and surgery. By 1989, the fieldwork requirements had been reduced to 6 months, and present programs are simply expected to provide "experience with a wide range of client ages and a variety of physical and mental health conditions" (AOTA, 1983, p. 3). A concern in 1949 was that so many graduates were taking positions in physical disabilities that there were not enough graduates to provide the services needed in psychiatric hospitals. Schools were urged to ensure that students got a fair orientation in good psychiatric training. By 1989, we replaced clinical training with fieldwork. We are still concerned about the interaction between the mental health fieldwork placement and subsequent choice of careers in mental health; we are not sure whether the current requirement of 6 months of fieldwork is sufficient practical experience, and we are currently debating about returning to a required pediatric experience.

**Major Educational Issues Then and Now**

In 1949, the Association was involved in a number of efforts to improve education. The initiatives launched during this period are impressive not only in the number of projects that were underway, but also in the imagination and far-sightedness with which the projects were conceptualized. The Association had obtained Kellogg Foundation funding that supported an Education Office and permitted an active research program directed toward unifying and standardizing the educational system. Some of the projects of the period were as follows.

**Clinical training report form, guides, and interpretation key.** This was developed to standardize the grading of students in clinical training. In addition, it was the intention of the Association to analyze the report form across the registration examination performance of the graduate in order to assess the effectiveness of both measurements (Gleave, 1949; Otto, 1949a).

**Performance report form.** This was designed to assess the correlation of a graduate’s performance during the first year of employment with the results of the registration examination (Otto, 1949a).

**Curriculum Guide.** This was developed to unify and standardize the educational programs (AOTA, 1950). There was particular concern in 1949 that programs were overemphasizing physical disabilities and underemphasizing mental health.

**Activity survey.** Clinical centers were asked to use this survey to report what activities they were using. The intent was to provide guidance to the educational programs about what activities graduates should know. The results of the survey revealed the most used activities to be leather work, cord knotting, woodworking, and weaving (Otto, 1949a).

**Annual reciprocal evaluation plan.** This was developed so that clinical centers and educational programs could exchange evaluations of the students, and, perhaps because of the high attrition rate from the educational programs, help training centers maintain their quota of students. In 1949 there were more clinical training slots than students and, perhaps because of the high attrition rate from the educational programs, training slots were going unfilled (Otto, 1949a, 1949b). Times certainly have changed. In 1989, the number of fieldwork sites is sufficient for the number of students requiring placement, but few centers indicated a shortage of students to train.

**New instruments.** Another project undertaken in 1949 was one to construct instruments to measure students’ suitability to enter occupational therapy education. This had been written by the Grant Foundation (Otto, 1949a; West, 1949a).

Under West’s guidance as Executive Director, there was an active and successful search for scholarships. The National Foundation for Infantile Paralysis provided funds for graduate study and for special short courses. West also pursued funding for occupational therapy graduate study scholarships from funds authorized by the National Mental Health Act (West, 1949a). Then, as now, the Association sought attention from the federal government and from private agencies to encourage funds for occupational therapy educational projects and graduate scholarships.

In 1949, a discussion of the relationship between occupational therapy educational programs and physical medicine occurred. This is ironic, because in 1989, a study was undertaken that examined which physical agent modalities should be included in our educational programs. In 1949, Willard, as Chairman of the Education Committee, noted that the Council on Medical Education of the American Medical Association (AMA) was considering a recommendation that physiatrists or physicians be in charge of occupational therapy schools and that occupational therapists be called "O.T. technicians" (Willard, 1949, p. 221). Although Willard mentioned that a letter of response to
How Different Are We 40 Years Later?

In some respects, our professional practice, our educational programs, and our literature are nearly unrecognizable as representative of the same professional group. Our language has changed. We speak today of theories of occupational therapy rather than of the theory of occupational therapy and practice. We have moved away from the language of medicine and define our intentions and scope in terms we are struggling to make our own—terms such as occupation, adaptation, human performance, and purposeful, goal-directed activity. We are working toward incorporating and establishing ownership of language of such disciplines as sociology, anthropology, the cognitive sciences, and neurophysiology. And besides refining and researching our traditional techniques, we are adopting the techniques of other disciplines, such as those of qualitative research, statistical analyses, and physical modalities.

The explosion of new understandings and the reconfigurations of old ones have stretched our educational programs beyond the semester-hour limits set in 1949. Perhaps to cope with this discrepancy, our Essentials and our faculty members speak more in terms of important concepts and important critical analysis skills that students should be able to perform rather than how many hours the curriculum provides in a specific content area. Our Association’s ties to the quantitative approach remain strong, however; witness our current concerns about the number of months of fieldwork and the recent recommendations that specific topics (e.g., the use of the medical term pediatrics) should be required in every educational program.

Our basic ideas about why activities are useful have not changed as much as have the activities themselves. The important activities that clinical centers of 1949 believed that every student should know are hardly recognizable in today’s fast-paced fieldwork centers. As activities such as cord knotting of 1949 eat from occupational therapy practice, they also exit from the techniques students are expected to acquire during schooling.

Two major patterns have not changed. First, as a professional association, we have continued to act in the belief that education and practice each must inform the other. Silva (1976), in her work with occupational therapy educators, termed this a “self-connecting, self-correcting link” (p. 570), a succinct description of the practice—education collaboration that has been a hallmark of the Association’s approach to professional education.

Second, in 1949, AOTA was struggling with finances, but because of the commitment of its staff and volunteers, an Office of Education with an educational field secretary was maintained. The pattern was determined then, and continues today, of a strong Division of Education in the National Office working in collaboration with Association members and external funding agencies to create new models of instruction, to refine existing ideas of education, and to test the effectiveness of educational programs and processes.

Wilma West, as Executive Director of the American Occupational Therapy Association in 1949, set in motion a model of educational research and development for our profession. Her thoughtful analyses of the relationships between undergraduate professional education, graduate professional education, and advanced graduate studies for occupational therapists provided a rich climate for the development of professional education in 1949. The issues of the American Journal of Occupational Therapy for that year reflect her clear-headed handling of the concerns of the present as well as her vigorous work toward ensuring the future of occupational therapy. West’s propositions about the need for graduate education, contained in her report as Executive Director (West, 1949b), set forth explicit directives for what we in 1989 have termed The Directions for the Future.

References


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