Occupational therapy is based on the belief that the active participation of a client is facilitated by the performance of purposeful activity (Hopkins, 1988a). Occupational therapists believe that purposeful activity enhances effort by (a) tapping cognitive, social, and emotional sources of motivation and (b) showing the patient the immediate application of treatment procedures to daily function. The emergence of exercise as an occupational therapy modality has created a controversy regarding our legitimate tools and our true role as part of the health care team (Bing, 1981; English, Kasch, Silverman, & Walker, 1982; Huss, 1981; Reed, 1986; West, 1984). Historically, occupational therapists have been called the “activity specialists” because they teach patients how to use their new mobility (Hopkins, 1988b). Physical therapists have been called the “exercise specialists” because they restore mobility to body structures. However, this simplistic view of role delineation ignores some basic facts about changes in the health care system.

Occupational therapists used to treat patients only after they were medically stable and ready for purposeful activity. Today, occupational therapists are treating some patients in acute stages, which imposes new role responsibilities (Affleck, Lieberman, Polon, & Rohrkemper, 1986). The occupational therapist in an acute care setting must put homeostatic (life-threatening) issues first and restoration of function second. Repeated medical tests and procedures take priority over functional goals such as self-feeding. The occupational therapist must initially restrict treatment to simple, isolated movements that can be completed in 5- to 10-min windows. Even certain activity materials may be prohibited in an acute care setting. Additionally, during acute stages, the patient’s cognition is often temporarily impaired by pain, fear, medication, fever, metabolic imbalances, the inability to communicate orally, and sensory deprivation (Affleck et al., 1986). Even patients who appear lucid during the acute stage can later exhibit large memory gaps and distortions about what actually happened.

The acutely ill patient with a spinal cord injury who must be ventilated because of compromised respiration illustrates the problems that can arise from the treatment of patients in acute care settings. The therapist may have to interrupt a treatment session to perform an assisted cough to clear the airway or to accommodate a respiratory therapy procedure. In doing so, the therapist must also use an activity that does not overstress the patient’s current vital capacity. If this patient experiences respiratory distress during an activity, the activity must be stopped. Although the occupational therapist can break a purposeful activity down into 5-min segments, the patient may feel frustrated. This frustration may be due to the delayed...
The completion of even a simple project, to a restricted selection of activities, to repeated interruptions for life-preserving procedures or medical tests, or to temporarily impaired cognition. Therefore, a few simple, short exercises might be more desirable in this temporary acute phase.

The rehabilitation phase of treatment is also changing. Occupational therapists could once concentrate on purposeful activity in this phase, but changes in the provision of health care services have forced therapists to reconsider their role. Although traditional inpatient programs permit a team approach, today's rehabilitation efforts are being diverted to more cost-effective outpatient programs and home health care (Levy, 1988). Independently functioning health care professionals in these new service provision systems cannot ensure a cohesive, logical sequence of treatment on the basis of traditionally defined roles (Taira, 1985). There is often little interaction between team members, which further fragments care. This fragmentation has forced each member of the long-term care team to reconsider how to ensure a smooth transition from preparation to application.

The literature defines purposeful activity in several ways. Nelson (1984) identified two types of purposeful activity. The first type is directly related to the facilitation of occupational performance. This includes the practice of specific skills used in work, leisure, and self-care. Some skills, like brushing one's teeth, are generic cultural expectations. Other skills, like the use of a baton by a symphony conductor, are role specific. Nelson called the second type of purposeful activity dual-purpose activity. Dual-purpose activities seek to remediate foundation skills such as strength or attention, which support occupational performance. A modality can be a direct or dual-purpose activity. A client may play wheelchair basketball to assess it as a future leisure interest. Wheelchair basketball can also be used as a dual-purpose activity to increase cardiovascular conditioning in a client who has no intention of continuing this activity after discharge.

Both types of purposeful activity differ from what Huss (1981) called pure exercise, which she defined as a person's ability to consciously control a body part without having to think about anything else. Even simple activities require at least some subcortical control of movement, which enables the patient to divide his or her attention. For example, a patient racing to put clothespins on a line must monitor his or her competitor's actions, deal with his or her own emotional response to performance, and control his or her pinch and release movements.

This paper explores how the biomechanical and sensorimotor frames of reference provide specific guidelines for movement along the continuum from exercise (preparation) to purposeful activity (application). These guidelines are not hard-and-fast rules. They describe when it is easier for the therapist to adapt an activity or an exercise to achieve a specific goal. Ease of a treatment plan, characterized by good time management, safe treatment, and better patient education, is directly related to how well the inherent characteristics of an activity or an exercise match the patient's current level of performance. The closer the match, the less time the therapist has to spend modifying the modality to make it appropriate and safe. A closer match also has better face validity, so it takes less time to explain the purpose of the treatment to the patient and family.

**Biomechanical Frame of Reference**

The biomechanical frame of reference provides six continua that suggest criteria for when to use both activity and exercise. The continua are (a) isolated versus coordinated movements, (b) rhythmical versus arrhythmic movements, (c) linear versus diagonal movements, (d) reciprocal versus asymmetrical movements, (e) movements to increase versus movements to maintain range of motion, and (f) movements against excessive resistance versus maximal repetitions.

**Isolated versus coordinated movements.** Isolated movements are easy to achieve with exercises. A good example of this is an isolated finger extension exercise for a flexor tendon injury (Van Strien, 1987). Active finger extension to the limit of the dressing is followed by passive finger flexion achieved with rubber bands that have been attached to each fingernail. These isolated finger movements, which can be prescribed as early as 1 week after surgery, prevent adhe-
sions from forming by making the flexor tendons glide inside the tendon sheath. Functional grasp, which requires active finger flexion and wrist extension, is prohibited at this early stage, to keep all tension off the sutured flexor tendons. The modification of a purposeful activity that meets these severe restrictions may be difficult, because the patient is still wearing a bulky, compressive dressing. In addition, the patient could become so engrossed in an activity that he or she might actively flex the fingers instead of letting the rubber bands passively perform this motion. This is an example of what the occupational therapist faces when ordered to immediately start isolated remobilization. It is therefore easier and safer to facilitate isolated movements with exercises during this temporary phase of acute care.

Normal movements, however, are rarely isolated. Most movements involve the coordinated action of several muscle groups (Bobath, 1970; Voss, Ionta, & Myers, 1985). Yet the transition from simple, isolated movements to complex, coordinated movements is not always automatic. This is especially true for patients with central nervous system deficits, but even patients with no brain damage may have abnormal sensory feedback. Distorted feedback can be created by peripheral conditions such as pain, edema, impaired circulation, changes in the skin, peripheral nerve injury, or stabilization devices. Patients with either abnormal sensory feedback or abnormal sensory throughput often have to relearn how to execute coordinated movements. Purposeful activities, which have this inherent characteristic, make such relearning easy. For example, writing requires the coordinated action of the long finger flexors and extensors, the interossei and lumbrical muscles, several thumb extrinsic and intrinsic muscles, and the wrist and forearm muscles. Although the occupational therapist could have a patient perform complex nonsense movements in an exercise format that uses all of these muscles, it would be easier to use a purposeful activity that shows the patient how to move.

Rhythmic versus arrhythmic movements. Rhythmic movements performed at constant speeds are easy to achieve with exercise. For example, by using free weights or exercise pulleys, the patient can concentrate on perfecting one smooth, slow motion executed through a full range of motion without having to respond to unexpected changes. The therapist could use a purposeful activity, such as a ceramics project, to practice rhythmic movements, but it may be difficult for a patient to remember to reach for the glue and move each tile at the same speed each time. It is easier to reinforce rhythmic movement performed at a constant speed with exercises that already have these inherent characteristics.

Many human movements are, however, arrhythmic and performed at irregular speeds. For example, to ambulate around the kitchen in order to prepare a meal, a person must make frequent small turning motions. The person must pivot to turn on the stove and then pivot and lean forward to turn on the water faucet and fill a pot. Such a task becomes even more variable when obstacles such as table legs, open cabinet doors, and other people are present. The therapist could use exercises to practice arrhythmic movements performed at irregular speeds, but these exercises require the patient to visualize complexly timed nonsense sequences. Arrhythmic movements are reinforced more easily with purposeful activities like cooking, which already have these inherent characteristics and which remind the patient of the unpredictability of an unprotected environment.

Linear versus diagonal movements. Linear movements performed in anatomical planes are easy to achieve with exercise. Skateboard exercises, for example, require only horizontal shoulder abduction and adduction and elbow flexion and extension. Anyone who has watched a patient struggle with just these two simple movements knows that linear movements are sometimes the only movements a patient can perform initially. Some activities can be adapted to require only linear movement, but the selection is limited and the activity must be simplistic. Some patients may not be any more motivated by a repetitive bilateral sanding activity than by a repetitive skateboard exercise. It is therefore easier to design a linear exercise for this brief period of early remobilization.

Normal human movement, however, is not linear. Joint structures produce diagonal movements performed in irregular parabolic curves (Voss et al., 1985). Diagonal movement is more easily facilitated with purposeful activities that are intrinsically diagonal. For example, the shoulder and elbow joints travel through one set of parabolic curves during self-feeding and travel through a different set of parabolic curves during hair combing. Although the therapist could have a patient trace a number of imaginary parabolic curves in the air, a purposeful activity such as pushing a toy truck would more easily show the patient where to move.

This particular continuum, which was first described by sensorimotor theorists (Voss et al., 1985), is discussed here to emphasize the fact that all human movement is diagonal. These theorists would counsel against the therapist beginning with linear movements during initial treatment sessions. They believe that assisted diagonal movements are easier, more natural, and less painful to perform than linear movements, even for acutely ill or debilitated patients.

Reciprocal versus asymmetrical movements. Reciprocal movements are easy to achieve with exercise. Exercise pulleys, free weights, exercise bicycles, and
ergometers facilitate reciprocal movements. Few purposeful activities require only reciprocal movements (e.g., walking). Reciprocal exercises are easy to design, so why not use them?

Although reciprocal exercises are an easy way for patients to achieve early remobilization, they are more readily generalized to gait training than to upper extremity function. Upper extremity movements are more typically asymmetrical. The nondominant hand stabilizes the object while the dominant hand manipulates the object. Although some patients can generalize from reciprocal to asymmetrical movements, the occupational therapist cannot always predict which patients can make this transition unaided. Because purposeful activities such as opening a bottle often have the inherent characteristic of asymmetry, it is easy to use purposeful activities to achieve this goal.

Increasing versus maintaining range of motion. Movements to increase joint motion beyond a patient's currently available range are easy to achieve with exercise. For example, manual or static stretching can reverse a shoulder flexion contracture. Although the occupational therapist can design many activities that require increasing amounts of shoulder flexion, it is difficult for the patient to actively move beyond his or her own currently available range. Even normal muscles become actively insufficient at the extreme end of range, which decreases their power. In addition, the frequent presence of pain, disuse atrophy, and loss of endurance makes it difficult for a patient to actively stretch beyond his or her current performance ceiling. Exercise techniques such as a manual or static stretch allows the therapist to prevent substitutions and to assist the patient to the maximal range long after the patient's current strength and endurance have been exhausted.

However, one cannot assume that once the therapist has increased the patient's passive range of motion with exercise, the patient will automatically use that range of motion daily. For example, a woman with a shoulder injury may diligently perform her shoulder exercises at home, but end up with a refrozen shoulder because she constantly holds the injured arm against her body. Even well-educated patients may believe that doing a few daily exercises will maintain their increased range of motion despite constant disuse. The therapist must prescribe purposeful activities that require full range of motion in order to generalize the gains achieved by exercise in the hospital to occupational roles at home and work.

Excessive strength versus endurance. Movements against excessive resistance to develop above-average strength are easy to achieve with exercise. For example, a patient with C6 quadriplegia needs excessive strength in the wrist extensors to achieve functional pinch strength through tenodesis. It is easy to use free-weight exercises to strengthen these wrist muscles. Technically, it is also possible to put a 10-lb weight on a patient's wrist during self-feeding, but that is not very practical. First, failure to lift, which is required to increase strength, permits few repetitions. This can frustrate a patient who is trying to eat an entire meal in an allotted amount of time. Second, excessive weight can significantly interfere with the smooth, coordinated movements required to get the food to the mouth. Although above-average strength can be achieved with activities, it is more easily achieved with exercise.

Above-average strength alone does not ensure role performance. Strength is not functional without endurance, which is the ability to sustain effort. Exercises that increase endurance require the use of maximal repetitions, but such exercises can be boring. Instead, a meaningful activity can facilitate the compliance that is needed to ensure these maximal repetitions. Some patients would be more motivated to increase upper extremity endurance by playing basketball than by doing wheelchair laps up and down the hospital corridors.

Summary. In the biomechanical frame of reference, there are at least six continua that provide guidelines for the use of both exercise and activity. When considering whether to use an exercise (preparation) or a purposeful activity (application) for treatment, the occupational therapist should consider the patient's current status (see Table 1). Exercise is easier to use if the patient is capable of only isolated, rhythmical, linear, or reciprocal movements. Purposeful activities are easier to use once the patient is ready to advance to more complex skills, such as coordinated, arrhythmical, diagonal, or asymmetrical movements. Exercise is also easier to use if the therapist's biomechanical goals are to increase range of motion beyond the currently available range and to develop above-normal strength. When the therapist's biomechanical goals eventually shift, it is easier to use purposeful activity to maintain the new gains in range of motion and to develop the endurance needed to make strength functional.

Table 1

<table>
<thead>
<tr>
<th>Exercise-Purposeful Activity Continuum for the Biomechanical Frame of Reference</th>
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<tbody>
<tr>
<td>Movements More Easily Achieved Through Exercise</td>
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<tr>
<td>Isolated movement</td>
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<tr>
<td>Rhythical movement</td>
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<tr>
<td>Linear movement</td>
</tr>
<tr>
<td>Reciprocal movement</td>
</tr>
<tr>
<td>Increase in range of motion</td>
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<td>Excessive resistance for strength</td>
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September 1989, Volume 43, Number 9
Sensorimotor Frames of Reference

The sensorimotor frames of reference provide five continua that suggest specific criteria for the use of both activity and exercise. These continua are (a) therapist-controlled versus patient-controlled muscle tone, (b) tracking versus initiating normal movement, (c) initial versus repetitive weight shifts, (d) conscious versus automatic monitoring, and (e) routine movements versus motor planning.

Control of tone. Spasticity must be controlled initially by the therapist, who gives the sensation of what normal tone feels like (Bobath, 1970). Therapists are taught to give this normal sensation by using handling techniques, which are a form of preparation (exercise). One handling technique for a patient who has tight scapular retractors is to slowly roll the patient onto the hemiplegic side with the hemiplegic shoulder flexed and the scapula protracted. An activity cannot always be used at this early stage of giving the sensation of elongated retractors because active effort of spastic muscles increases their tone. This would give the patient the wrong sensation.

Before going home, however, the patient must take responsibility for his or her own muscle tone. The therapist must risk active movement even though it will increase tone. For example, the therapist might teach a patient to inhibit scapular retractors while putting on a button-down shirt by leaning forward with the hemiplegic arm dangling between abducted thighs. Because the patient's use of the sound arm to manipulate the shirt will initially increase tone in the hemiplegic arm, the therapist must initially use his or her hands to keep the patient's scapula protracted and elbow extended. Gradually, the therapist must remove his or her hands or at least fade to more distal key points of control to make the patient more responsible for controlling the tone. The therapist could have the patient perform a number of nonsense movements with the sound arm while trying to inhibit tone in the hemiplegic arm, but a purposeful activity like dressing would more accurately replicate the ongoing problems that the patient will encounter with high tone after discharge.

Tracking versus initiating normal movement. Brain-damaged patients initially relearn normal movement patterns by "tracking" a therapist's normal movement (Becker et al., 1985). The patient imitates this normal movement by maintaining physical contact with the therapist's moving body part and by learning not to resist the therapist's movements. The therapist might want a patient with a tightly retracted scapula to learn to roll. In such a situation, the patient lies on his or her side and remains passive while the therapist slowly rolls the patient back and forth in tiny midranges. Gradually, the patient is asked to actively follow the therapist's movement (Becker et al., 1985; Bobath, 1970). At this early stage, a purposeful activity is too stressful because it divides the patient's attention between tracking the therapist's motions and watching and thinking about the activity.

Eventually, the patient must stop tracking the therapist's normal movement and start initiating his or her own movement. At this stage, it is easy to use activity to teach initiation of movement. For example, the patient described above could roll in bed to reach for the bedside telephone or the nurses' call button. As the patient learns to initiate movement with graded control, the therapist gradually withdraws his or her control of the patient's movement. Although the patient could instead perform repetitive rolling exercises, it is easier for the patient to understand the purpose for performing a movement in his or her daily life if the movement is already incorporated into a purposeful activity.

Initial versus repetitive weight shifts. When brain-damaged patients first get motor return, they may expend all of their effort maintaining themselves in a fixed position (Adams & Dieterich, 1982). The therapist must discourage fixing immediately by teaching the patient to move within a posture. For example, stroke patients often have excessive extensor tone in the lower extremity, which inhibits weight shifts. A common handling technique for this problem is to place the patient in a sitting position, which has strong flexor characteristics, and then to passively shift the patient's trunk forward and backward in tiny ranges. Although the therapist could introduce an activity at this point, patients with moderate to severe extensor spasticity often cannot tolerate activity at this early stage. Initially, this weight shift can be a very frightening experience. The patient is so used to fixing the trunk behind the vertical position while sitting that he or she experiences an exaggerated sense of falling forward during any weight shift.

The patient usually accepts weight shift quickly and becomes less dependent on fixing for stability. At this point, the patient is able to perform repeated weight shifts. An activity such as opening a refrigerator door without falling forward while leaning forward to reach for an object and then stepping back to close the door is an excellent way to achieve repetitive weight shifts. An exercise could be used instead, but movements such as leaning forward and stepping backward are inherently boring and often have poor face validity. Many patients and family members do not understand the purpose of moving between and within postures until they see it incorporated in a functional activity.

Conscious versus automatic monitoring. Once patients can initiate a few normal movements, they can begin to teach themselves other normal move-
ments by paying conscious attention to their own somatic sensation. This is called a feedback loop (Stockmeyer, 1978). For example, once a hemiplegic patient learns how to roll and how to put the hemiplegic arm on a tabletop without retracting the scapula, he or she can learn to consciously inhibit scapular retraction in other movement situations. It is easy to use handling techniques to reinforce this conscious monitoring. By lightly touching the patient's scapula, the therapist can remind the patient to generalize scapular protraction to new situations. An activity could be used at this point, but the patient might regress when asked to generalize a newly learned movement while also being cognitively challenged.

Eventually, however, the patient must stop consciously attending to somatic feedback. The cerebellum must assume the job of automatically monitoring somatic feedback and coordinating habitually performed movement so that the cortex can deal with cognitive challenges. This process of automatic monitoring by the cerebellum is called feed forward (Stockmeyer, 1978). For example, a normal college student does not walk up the steps to get to class by looking intently at his or her feet. Instead, the cerebellum monitors the walking while the student attends to cognitive challenges such as conversing with a friend as they walk up the steps together. If patients don't develop this kind of automatic monitoring of movement, they will regress to primitive movement patterns whenever they are cognitively challenged. Although a patient could practice automatic monitoring by reciting the names of the presidents of the United States while walking up and down the hallway, a purposeful activity such as walking through a cafeteria line while choosing from the menu inherently requires automatic monitoring of limb movements.

Routine movements versus motor planning. Some brain-damaged patients have dyspraxia in addition to spasticity. Dyspraxia is the inability to generalize familiar, routine movement schema to new, unfamiliar movement situations. An explanation or demonstration of the component parts of new movements is not always successful with the dyspraxic patient. Handling techniques, however, can be very useful, especially when the dyspraxic patient perseverates during familiar routine movements instead of trying new patterns.

Eventually, the patient must be able to move about in an environment that offers a variety of subtly changing demands. These subtle variations do not impede normal persons, but dyspraxic patients find them to be exasperating. It is therefore not sufficient for the dyspraxic ambulatory patient to repeatedly practice navigating an uncrowded, fire-regulation-width hospital corridor. This patient will not be able to shop in a crowded store if he or she cannot motor-plan while in a crowd. The therapist could have the patient practice a sequence of subtly changing nonsense movements, but it is more effective to use a purposeful activity such as walking around different obstacles. This helps the dyspraxic patient understand the functional value of quick changes in motor output.

Summary. When using the sensorimotor frames of reference, the occupational therapist should consider the patient's current status when choosing a handling technique or an activity (see Table 2). The therapist more easily ensures quality movement by using handling techniques alone when the patient is functioning at a primitive level. This includes when the patient is (a) unable to control his or her own muscle tone, (b) dependent on tracking normal movements, (c) resistant to initial attempts at weight shift, (d) dependent on conscious monitoring, and (e) capable of learning only a few routine movements.

When the patient progresses to a more advanced level, handling techniques can be faded gradually while purposeful activity is added. The advanced patient is ready to (a) learn to control his or her own muscle tone, (b) initiate his or her own normal movement, (c) perform repetitive weight shifts, (d) progress to automatic monitoring, and (e) practice motor planning.

Conclusion

Some occupational therapists feel strongly that our activity base must be maintained at all costs. I believe, however, that purposeful activities are not always practical or safe for every phase of a patient's treatment. I do not believe that occupational therapists are going to stop using splints, massage, Reflex Inhibiting Patterns, and many other "nonpurposeful" modali-

Table 2
Exercise–Purposeful Activity Continuum for the Sensorimotor Frames of Reference

<table>
<thead>
<tr>
<th>Conditions in Which Exercise is Desirable</th>
<th>Conditions in Which Purposeful Activity is Desirable</th>
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<tbody>
<tr>
<td>Patient unable to control tone</td>
<td>Patient ready to control tone</td>
</tr>
<tr>
<td>Patient dependent on tracking</td>
<td>Patient ready to initiate movement</td>
</tr>
<tr>
<td>Patient resists initial weight shift</td>
<td>Patient ready to perform repetitive weight shifts</td>
</tr>
<tr>
<td>Patient uses conscious monitoring</td>
<td>Patient ready to practice automatic monitoring</td>
</tr>
<tr>
<td>Patient must relearn routine movements</td>
<td>Patient ready to relearn motor planning</td>
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</table>
ties. These modalities are too closely matched to the primitive needs of acutely ill and seriously debilitated patients to be abandoned. Exercises and handling techniques are also advantageous because they have no clear end product. These techniques can be abruptly terminated without frustrating the patient by failing to complete a project. These modalities are especially helpful during the brief period of early remobilization.

Some occupational therapists believe that the only way that we can establish our efficacy in this age of accountability is to use exercise. I believe that the use of only exercise and handling techniques is not valid. Many patients cannot or will not make the transition from simple to complex movements independently. Many patients need to practice complex movements in a purposeful activity before they go home or return to work. Purposeful activity implicitly tells the patient which complex movements to make, makes the patient less dependent on the therapist’s physical contact, and embeds complex movements in a functional context. The more closely the activity in the hospital resembles the activity at home or work, the more likely the patient is to retain what was learned and apply it in daily life.

Although some patients find exercise more intrinsically motivating than craft activities, this misses the point. Movement occurs in an environment that does not permit undivided attention to what various parts of the body are doing. There is always an object, another person, or an internal cognitive or emotional process that demands attention. Exercise alone does not prepare a patient to reenter this jungle of competing stimuli. Ironically, because shortened stays have prompted third-party payers to reimburse for functional goals, some occupational therapists are eliminating functional activities from their treatment plans.

I advocate the use of both activity and exercise within a single treatment plan. This can be an emotional issue, but the following example illustrates how these two approaches blend together in a more neutral context. A football coach knows that players who scrimmage (application) without first warming up (preparation) are at a greater risk of injury. The coach also knows that running laps around the field (preparation) does not fully prepare a player for running downfield with 1,000 pounds of crazed linemen coming at him from three directions (application). The coach therefore combines preparation and application without questioning the validity of these legitimate tools.

Changes in the health care system have forced the allied health professions to look at how they use both preparation and application. Occupational therapists have had to look at how safely acutely ill or seriously debilitated patients are handled. Prepara-

The timing of the transition from preparation to application depends on clinical experience and observation. As a stimulus for dialogue, I would like to briefly describe my own experience with this transition. When I begin treatment, I use both preparation and application. Although the first few treatment sessions may focus on preparation, I usually bring a purposeful activity to these early sessions. I may ask the patient to try one or two purposeful movements, such as taking two bites of food, knowing that the patient may initially fail. This brief application experience helps the patient see the long-term benefits of his or her effort from the beginning of the therapeutic program.

I sometimes find it difficult to accurately predict when to make the transition from preparation to application without actually trying it. This is another reason to bring materials for both to treatment sessions from the beginning. The patient’s progress can surprise even the experienced therapist. Conversely, if the patient initially performs well on an activity, he or she might still regress in the middle of the activity. When I begin an activity very early and the patient gets into trouble, I implement a brief return to preparation and then try the activity again later in the session. I find that moving freely back and forth between preparation and application is effective and practical. I gradually spend less time on preparation and more time on application as the patient improves.

I believe clinicians are already using both preparation and application. However, this makes marketing our services difficult. Gilroy (1988) suggested that our inability to define our product impairs our ability to control our destiny in the marketplace. This article has attempted to explain why our product changes as the patient’s condition improves.

I hope this article has stimulated some constructive thought about the question. Are both exercise and activity part of an occupational therapist’s repertoire? If the reader finds merit in this continuum approach to the prolonged debate about our legitimate tools, perhaps additional frames of reference would be analyzed from this perspective. Whatever the profession of occupational therapy does to resolve this conflict about activity versus exercise, it will have to be a constructive and creative solution. To remain viable, the
profession must be able to respond to the changing needs of both the individual and the health care system.

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