Occupational Therapy: A Focus for Roles in Practice

(human occupation, occupational therapy practice, professional development)

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Occupational therapists have a long-standing familiarity with and commitment to the concept of change. Our professional practice has always had a primary focus on assisting individuals as they adapt to change due to disability and disease. The recent literature on adaptation, stress, and coping presents a picture of how important our professional expertise is in helping people interact effectively in their environments. Now, as we enter a decade of unprecedented technological advances and associated social and economic response, we are finding that we must make significant changes if we are to survive as a profession.

As part of the General Sessions series at the 1983 AOTA Annual Conference, this paper addresses the issues confronting the changing individual in the '80s by exploring the new and expanding roles for occupational therapists in the near future. Outside influences, including consumer-based health trends, medical and scientific developments, and new patient and client needs, are discussed and analyzed according to their impact on internal professional factors such as leadership, management, and business skills.

Change. Some people dread it, others crave it, people prepare for it, spend time being counseled about dealing with it, resist it, or just accept it. Change seems to be a word that we all know about. But change is more mysterious than initially expected. It comes packaged in different sizes and shapes depending on one’s unique perspective. It is anticipated, managed, and reflected on in ways that mirror the biological; psychological, and emotional orientation of distinct cultural and social groups. “May you live in a time of change,” a Chinese curse that reflects the view that change signifies a turbulent period, fraught with difficulties and challenges to be feared.

Strategies for handling such changes are found in folklore that warns the individual, in order to move forward into change three steps, one must move backwards into the past three steps.

My intention today is to stimulate your thinking about what we can expect to see and experience in the years to come and how we as occupational therapists can prepare to meet those changes. My hope is to suggest potential strategies to support our future success as a profession. As an occupational therapist I am strongly committed to our professional orientation to purposeful activity. Like those and, like many others, I too believe our future is dependent upon our abilities to unite and define our practice. Our view of human behavior began with and has continued to be framed in the perspective of occupation. The original endowment that our founders gave to us was built on a foundation of purposeful activity. If we are to remain intact as we pass into the future, we must bring with us the richness of our legacy.

Occupational therapists are used to change. It is very much a part of our everyday practice when we work with people who are experiencing disruption and dysfunction in their lives. By finding out who a person is, what they want and need in their daily life, and how we can help them realize it, we are involved in the change process. Developing new skills, restructuring old habits; defining new roles; crystallizing interests, values, and goals; developing a sense of self—these are the areas of change that occupational therapists address.

This presentation will focus on an anthropological view of change in the individual in the '80s—change that will effect the environments we practice in, the people we work with, and the skills we will need to survive and grow.

The Concept of Change

The work on change in anthropo-
Adaptation. Adaptive behavior is about the environment. Adjustment occurs more frequently if individuals can maintain satisfactory internal conditions both for action and for processing information and maintaining autonomy." (2, p. 55). Change is also part of the developing literature on stress and coping. This material addresses the impact of change on individuals and includes how a person meets a threat to his or her stability and comes away from it functioning effectively (3). Researchers look at this material in order to develop profiles for identifying what I call “capers” (those persons who will be able to adjust to new situations) and “noncapers” (those who are at significant risk for not meeting new demands). Studies that look at coping strategies to identify such profiles are concerned with individuals under a great deal of stress. These are people in hazardous jobs such as nurses in intensive care units, people undergoing physical changes such as burn patients, surgical patients, and chronically disabled persons, and people being challenged intellectually such as college students preparing for exams (4-8).

In all of these groups we will find similar types of coping traits, styles, and dispositions that help to ensure the healthy survival of the individual. Again and again research has shown that success or failure in coping is, to some extent at least, a property of stable persons. Poor adjustment occurs more frequently in people who have had difficulty coping with life before their recent problems. Good adjustment occurs in those who have a strong history of making it through distressing experiences (7-10).

The literature on adaptation, stress, and coping is rich with ideas that are familiar to occupational therapy; in many cases, these are the very principles that have directed our treatment since occupational therapy was founded. I believe that as we confront the clinical puzzles of the future we will continue to be guided by notions that include: mastery of the environment, competence, learning through activity, organizing behaviors, seeking cues from the environment, and practicing for real life situations (11).

All of us use these basic tenets in our practice of occupational therapy. They are the fundamental underpinnings that have guided the development of our expertise in occupation. Every time an occupational therapist works with a patient and helps him or her select an activity that will help develop a skill while also matching the person’s interests and values to that activity, the occupational therapist is addressing occupation. Our value as experts in the development of skills to support human occupation is priceless for the highly stressful times of this decade.

Identifying Health Trends
The ‘80s will be marked as a decade of unprecedented diversity. According to John Naisbitt, we are members of a unified mass society that has fractionalized into many diverse groups of people with a wide array of differing tastes and values. This is what advertisers call a market-segmented, market decentralized society (12).

But commonalities do exist among the inhabitants of this society. These are what make up the clearly discernible trends that Wilma West has outlined (13). They represent dramatic philosophical shifts in how we manage our lives. Most significant among those trends is the movement of individuals away from dependence on institutions (12).

Reclaiming peoples’ traditional sense of self-reliance and self-help is evident by the changing habits of health and medical care in recent years. A few examples tell the story:

At least 100 million Americans, almost one half of the population, are now involved in exercising in some way. This represents a 100 percent increase since 1960 when only about one quarter of the population was involved in regular exercise programs (12).

Smoking, long blamed for poor health, is down substantially since 1965—13 percent among adult women, 28 percent among adult men (12).

Business organizations are becoming increasingly sensitive to the effect of stress on employee health and productivity (3).

More than 500 companies across the country have fitness programs, many of them with components such as disease prevention and early detection. Employers are becoming more aware of the need to offer employees incentives to maintain their health. At the Mendocino County Office of Education in California. 500 dollars per employee per year is set aside for medical expenses. As medical costs are accrued during the year, they are deducted from the 500 dollars. At the year’s end, the employee receives the balance in their account (12).

Escalating hospital costs, a boom in the for-profit hospital management industry, and the upsurge in the movement toward self-care are resulting in increased demands for home health services. More people are leaving hospitals sooner and are opting for treatment in their homes (14, 15).
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Each of these examples represents new arenas for occupational therapy practice. The opportunities for us to develop new and innovative services are just beginning to be discovered. Our response to these new frontiers depends on our own abilities to change.

The word change stirs up a wide range of emotions and interpretations in each of us. The definitions vary depending on our perspective, depending on our “cognitive lenses.” These lenses allow us to conceptualize, categorize, and act on information in our environments. For example, as an organizational psychologist you would view change as either unplanned or planned. Through these glasses, unplanned change evolves without guidance. Planned change is a conscious effort to alter the status quo. An action is planned after the “climate” for change is assessed (16). Individuals within an organization experience incentives or motives to change. They are rewarded for integrating and stabilizing change in their performance. The process is systematic, a result of an imbalance in “driving” and “restraining” forces. It is identified as synergistic change (1, 16).

The cognitive lenses that occupational therapists use to view change are tinted with hues from anthropology, social psychology, sociology, and biology (17). We wear these glasses and see the physical, emotional, and psychological effects of change on the individual. These are the changes that are the obligatory by-products of disease, disability, and dysfunction in individuals. To ensure that a person will be able to cope and adapt to changes, they require support, guidance, and facilitation by others. The ability to orchestrate biological, psychological, and social coping is unique to occupational therapy. Unlike organizational psychologists, we see change as adaptation, a dynamic process. We define it as “neither total triumph over the environment or total surrender, rather it is a striving toward acceptable compromise.” (2, p. 52).

Adaptation is full of subtle strategic adjustments that we constantly make in our behavior. Robert White, who has taught us much about the process of human competence, offers a comprehensive view of the phenomenon of adaptation. Consider if you will his explanation of the process:

...adaptation is anticipatory as well as reactive, people tend to approach their environment with plans, to calculate and recalculate their risks and opportunities, to take on tasks they feel they can handle, to seek actively for information and feedback, to prepare for probable difficulties, to provide multiple buffers against defeat, to keep some options open, to distribute commitments, to set the stage for new efforts by practice and rehearsal and to try a variety of hypothesis in resolving an important problem. (10, p. 412)

By the end of this decade occupational therapists will find themselves in places they could never before have imagined, using newly acquired skills and interacting in much different roles. Let us look at a future vision of the occupational therapy practice environment, the patients and clients to be served, and a profile of the occupational therapist in the ’80s.

The Impact of Technology
In the very near future, occupational therapy clinics will begin to reflect the technological advances that are being made throughout this society. By the end of this decade we will find ourselves surrounded by and using more high technological equipment (18). You may already be experiencing the greatest promise of technology, the computer. Computers for documenting patient progress, billing for occupational therapy services, designing modifications for homes and workplaces, and for training patients (19). Computers and satellites will allow us to consult, present papers, teach skills, and observe model programs while remaining at home, on opposite sides of the country and the world.

Although the impact of this technology will effect us greatly, our base for problem-solving treatment issues will remain strongly embedded in occupation. Consider, for example, the situation of Rob Marine—you may have read about him in the December 1982 issue of Time Magazine. Five years ago at age 17, he had a car accident. When he woke up in a hospital 2 days later, he was paralyzed, requiring permanent use of a respirator. Now at age 23, while still confined to a bed, his active participation with his environment is supported by his ability to be “one of the most sophisticated computer control and communication systems in the U.S.” Equipment adaptations that support such behavior include the use of a voice-activated input device that allows Rob to “work” his equipment. The device takes a numerical snapshot of the sound pat-
tern of Rob's voice and compares that picture with patterns Rob has previously recorded. When the machine finds a matching formation, it sends the computer the corresponding command. With these commands, Rob can search through the necklace of satellites that rings the earth and pick up any one of 150 television channels (20).

Or, consider if you will, the thousands of individuals who are paraplegic and quadriplegic who will one day be candidates for microprocessor pacemakerlike implants that will permit them to be ambulatory again (20, 21).

Both of these examples dramatically illustrate the types of technological advances the occupational therapists will find themselves involved with in the near future. Because of our expertise in activity analysis and adaptation, we will be part of the bioengineering teams that will provide service to individuals like those I just described (22).

How we define our roles on these teams is strongly dependent upon our definition of the clinical and human problems we confront. I see occupational therapists applying themselves to two urgent clinical needs. First are the problems and effects of dehumanization (23). By this I mean the helplessness and increased emotional distance that the patient feels when surrounded by newly developed machines. This is especially true when the concern is for what the machine can do. Then the care is for what can be done rather than who is doing it (23).

This takes us directly to the second need. When you look at what a person can do, you must account for the value they place on the activity, their interest in it, how it effects their self-esteem, the skill, roles, and habits that will support performance of the activity, and the individual's position in the life cycle (17, 24). These are the components of occupation that, when tapped, bring individual meaning to an activity.

An Expanded Definition of Chronicity
We will be expanding occupational therapy services in the '80s to new populations of individuals who are experiencing major and permanent changes in their behavior. One significant category of problems involves a group of individuals who suffer from what I call "no life purpose." These are people who may be chronically unemployed, they may be homeless, they may be battered, they are isolated and lonely.

A second category of clinical puzzles will include individuals who suffer with problems we have never seen before. People with new types of stress-induced illnesses. Carolyn Baum speaks to this group, saying, "As we experience increasing stressors in our environment, occupational therapists will treat more emotional and psychological role dysfunction." (25) Witness the ever-increasing population of youth with anorexia nervosa, a dysfunction that, until recently, was seen mainly in the female population and is now appearing among young males as well.

New Client Needs
Occupational therapists will also serve two new groups of clients in the future. These are individuals who are not part of the habilitation or rehabilitation community but who are interested in upgrading their skills and understanding of human occupation.

The first group are those therapists who are returning to practice after having withdrawn from the field, the population of individuals who have been identified as re-entering the profession and reactivating their roles (26).

We will meet these professionals' needs by opening our clinics as well as our minds to them. We will be developing special workshops and seminars as well as tutorial experiences and mini-affiliations for returning therapists. We can no longer leave continuing education to physicians, psychologists, and other professionals who focus solely on new advances in medical and surgical techniques. We need to be educating these returning therapists in the area of occupational therapists' expertise, that of occupation.

The second group of new clients will involve us as collaborators in the self-help movement. These are individuals who are seeking more information that will ensure their continued good health and well-being (27). They will lead us to more involvement with community groups, giving presentations and workshops where people can increase their understanding of the relationships between values, self-esteem, competence, and skills. Radio and cable television all over this country carry programs about time management, value congruence, and leisure activities: the principles of human occupation (27). It is time that we let people know that this is the occupational therapist's area of expertise. We need to publicly and professionally lay claim to our legacy.

Professional Leadership Changes
If our intent as a profession is to continue to provide patients with a sense of unity of self in doing, feeling, and becoming, then we must develop new skills to support these roles. First, we must be pro-active.
This means that we will be at the forefront of redesigning departmental consolidations and sorting out our professional roles and responsibilities. Our futures depend on our abilities to be in decision-making positions. Likewise, we need to be leaders in planning and developing new programs for patients and clients rather than as participants in programs spearheaded by other professionals.

Second, we need to be adaptive, setting the pace for changes in the environments we are in and with the ideas we generate. We need to cope and adapt to the theoretical and conceptual adjustments that are being researched and written about in our field. We need to cope and adapt to the increased focus on short-term acute care, improving our skills in evaluating patients quickly and succinctly (28).

Third, we need to develop skills in business and management to support our roles as managers. To be effective and grow in the climate of increased technological advances and escalating costs we need to combine knowledge of the health environment and knowledge of our field. We need to learn about strategies for interacting effectively in business environments. For example, changing patterns of employment in the '80s promise to extend opportunities for flexible, weekend work, and job sharing, all of which will strengthen our ability to find and keep jobs but will weaken our position as decisionmakers within a health care organization.

In the future, occupational therapists will continue to provide individuals with laboratories for rehearsing real life situations in the safety and security of a playful, accepting, and supportive environment (5,9). Now, more than ever, it is important for each of us to come forward and participate in the business of health care.

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