Looking Back

Occupational Therapy and Rehabilitation: An Awkward Alliance

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This article argues that although occupational therapy and rehabilitation are often considered synonymous, the latter is but one aspect of the former. Early influences on occupational therapy are briefly reviewed, and some philosophical ideas about activity are described. The rationale for the use of occupations as treatment in the early part of this century, both in Canada and in the United States, is examined and contrasted with the development of physical medicine and rehabilitation after World War II. This discussion demonstrates that the origins of occupational therapy and rehabilitation in North America had little in common. As occupational therapy became incorporated into rehabilitation, the profession’s core values eroded, and although current definitions of rehabilitation offer a more appropriate fit for occupational therapy, rehabilitation continues to see engagement in occupations as a separate and subsequent step. The article concludes by considering future directions and the tasks that lie ahead.

In the preface to his book Rehabilitation Medicine: A Textbook on Physical Medicine and Rehabilitation, Rusk (1958) noted the objectives of the newly founded field of rehabilitation medicine. The first was to eliminate the physical disability if that is possible; the second, to reduce or alleviate the disability to the greatest extent possible; and the third, to retain the person with a residual physical disability to live and work within the limits of the disability but to the hilt of his capabilities. (p. 7)

Rusk went on to say that although effective rehabilitation depended on the skills and services of members of many professions, “the physician, however, by the very nature of the problem [italics added], must be the leader of the team” (p. 7).

The phrase “by the very nature of the problem” provides the clue to the difficulty for occupational therapists in rehabilitation as well as the theme for this article. If the very nature of the problem is the disability itself, and efforts are directed at eliminating it, then occupational therapists are at a disadvantage, because for us, the very nature of the problem is not the disability but the occupational performance of the person with the disability. We must then consider the possibility that some of the difficulties we have with our roles and with the content of our curricula are a result of there being more in the paradigm of rehabilitation that conflicts with occupational therapy than complements it.

In this article, I argue that rehabilitation is only a part of occupational therapy; that it is an aspect but not the essence of occupational therapy, that embracing rehabilitation in the way that we have has contributed to our identity problems; and that although occupational therapy has enhanced the field of rehabilitation, rehabilitation has not helped the profession of occupational therapy to the same extent. I briefly review early influences on occupational therapy and reflect on some philosophical ideas about activity and occupation. I examine the role of occupational therapy as treatment both in Canada and in the United States during the first part of this century and then trace the incorporation of occupational therapy into rehabilitation. Finally, I reflect on the influence that rehabilitation has had on our core values and note recent changes that hold some promise for our future directions.

Early Influences in Occupational Therapy

Articles that describe the use of occupation to promote or restore health (e.g., Bing, 1981; Engelhardt, 1977; Haas, 1944; Kielhofner & Burke, 1977; Peloquin, 1991a, 1991b) often begin with ancient Egypt and work through biblical times to Greece and Rome, where the virtues of activities and pastimes (e.g., art, music, exercise, dance)
were extolled. These chronicles tend to skip several centuries to reach the Moral Treatment Era of the early 1800s, where a caring environment and the notion of work were added to activities as a means of promoting health (Bockhoven, 1972). With World War I (WWI), the Arts and Crafts movement became well established (Levine, 1987), as did curative workshops (Robinson, 1981), and occupational therapy as we know it began to unfold. No longer do we see the profession as embedded in other movements; rather, it has become a separate entity (Peloquin, 1991a, 1991b). In the late 1930s and early 1940s, the profession began to take a biomedical turn and pretty much stayed there for the next four decades, with periodic visits back to core concepts through contributions from, among others, Reilly (1962), Keilhoffer and Burke (1977), Fidler and Fidler (1978), Gilfoyle (1984), and West (1984). It is as though the core concept of occupation as a means of promoting health and well-being was somehow elusive and, in not being well enough articulated, became dissipated.

Philosophical Ideas About Activity and Occupation

For all the histories of the profession that have traced the idea of occupation, very few have grappled with what it is that is so therapeutic about occupation and why its value has persisted over the centuries. Philosophical ideas have contributed to the importance we attach to the concept of activity while also fostering its elusiveness. Plato came closest to noting what we consider the inherent need for activity when he suggested that “In every man and woman there is born the instinct to make and to do” (as cited in Bruce, 1933, p. 6). The implication for occupational therapy is that although injured or ill in some way, people still need to make and to do. This idea is probably the closest we come in philosophical terms to the essence of occupational therapy.

Plato also spoke about therapeutic arts, which could be considered to include rehabilitation, and noted their different components:

In the state of all [such] therapeutic arts, the corrective portion is more apparent but less important, while the regulative portion is largely hidden but far more essential. [Hence] there is grave danger lest “prevention” and “maintenance,” the real work of the art, be overlooked, and attention exclusively devoted to the correction of diseases already there, a mere by-product of the art. (Wild, 1946, p. 65)

Thus, in Plato’s terms, because occupational therapy’s role in rehabilitation does not cure disease or remove disability (i.e., the corrective portion of therapeutic arts) but, instead, works to develop or maintain occupational performance despite disease or disability (i.e., the regulative and essential portion of therapeutic arts), its importance is often overlooked.

Aristotle (trans. 1925) wrote about pursuing well-being. He saw well-being of the soul (eudaimonia) as the end result of desirable and satisfying activity or action (praxis). In The Nicomachean Ethics, he expounded on the notion that “of all things that come to us by nature, we first acquire the potentiality and later exhibit the activity.” He said that “the things we have to learn before we can do them, we learn by doing them,” and although his comment that “states of character arise out of like activities” (p. 28) refers to how man becomes virtuous, it also reflects the notion that only by doing can one become. Adler (1991) commented on Aristotle’s view that both practical thinking and productive thinking are required to carry out purposeful activity and noted that Aristotle believed that “until making and doing actually begins, productive thinking and practical thinking bear no fruit” (p. 71).

In distinguishing between basic needs and wants, Aristotle noted that everyone has the same basic needs. These “needs” (for food, for shelter, for love, etc.) were called the “external goods,” and like Maslow, Aristotle said that they must be met in order to approach the fulfillment of all our human capacities. The “wants” in life can also be met as long as they do not interfere with our abilities to satisfy our needs or fulfill our capacities. Occupational therapists facilitate their patients’ abilities to meet their needs and wants and recognize the necessity of enacting thinking to achieve those ends.

Aristotle also examined the meaning of happiness and the ways in which it could be achieved. For him, happiness was in and of itself an activity; more specifically, happiness existed when one was engaged in “virtuous” activity. It was Aristotelian, perhaps, who started the debate on the relationship between work and leisure when he stated that “happiness is thought to depend on leisure; for we are busy that we may have leisure.” His ideas about reaching a sense of self through activity that develops our capacity and makes us happy and fulfilled in the process are certainly echoed within occupational therapy (e.g., Reilly, 1962; Yerxa, 1993) and psychology (Csikszentmihalyi, 1991; White, 1971).

Voltaire, whose works appeared in the middle and late 1700s, also thought about the meaning of occupation. For Voltaire, activity was a means of bringing relief to much of the unhappiness that life brought: “Man is born for action...not to be occupied and not to exist amount to the same thing” (as cited in Waterman, 1942, p. 40). Thus, at the very least, to support existence, one
must be occupied so as to see evidence of existing. Occupational therapists who have worked with persons who are severely depressed know the glimmer of hope that comes to one who has been occupied and has seen that something qualitatively different can be experienced than is outside of despair. Indeed, labeling such engagement as positive is a cornerstone of cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979).

John Stuart Mill (1859/1947) wrote in On Liberty about the importance of encouraging and celebrating individuality in the activities that people undertake. Provided no harm was done to others, individuality could bring human beings nearer to the best thing they could be and could have a cumulative effect on the whole human race. Mill said, “In proportion to the development of his individuality, each person becomes more valuable to himself, and is therefore capable of being more valuable to others” (p. 63). Therapists who assume a client-centered approach to enabling occupation help their clients to develop their individuality and increase their opportunities for self-fulfillment.

Philosophical ideas about occupation seem to have centered on, at the very least, making life bearable (Voltaire); maintaining health (Plato); being responsible for happiness (Aristotle); and at the highest level, being self-actualized (Mill, 1859/1947). These ideas can readily be seen in the roots of our profession (Friedland, 1988; Peloquin, 1991a, 1991b) where it was believed that occupation could relieve despair (e.g., of persons who were mentally ill) and could contribute to overall well-being (e.g., of soldiers during WWI). It was also thought that lack of meaningful activity could make one more ill or dysfunctional (e.g., as with persons recovering from tuberculosis) and that the right type and level of activity could bring one to a state of mastery. Johnson (1996) noted the importance of these ideas remaining central to our profession: “The greater our understanding of occupations and how they maintain, enhance, and promote health and well-being, the greater will be our ability to link this knowledge with practice and education of future therapists” (p. 393).

Occupation as Treatment: The United States and Canada (1900–1940)

In the United States, an early rationale for occupation as treatment was simply that patients did better and were less restless if they were engaged in activity. Nurse Susan Tracy started using occupations as treatment in 1905 and is credited with providing the first course in occupations in 1906 (Reed & Sanderson, 1983). Other early courses in occupational therapy were prompted by similar reasoning; for example, the course at the Chicago School of Civics and Philanthropy in 1908 was instigated by two members of the State Board of Control in protest against the idleness they saw on the wards of the state hospitals (Dunton, 1918). Indeed the formation of the National Society for the Promotion of Occupational Therapy (NSPOT) was itself prompted by George Barton’s experience of being ill with tuberculosis and finding that manual activities hastened his recovery. It is interesting to note the professions of the founders of NSPOT and to consider their perspectives on occupations. For psychiatrist William Rush Dunton, architects Thomas Kidner and George Barton, social worker Eleanor Clarke Slagle, teacher Susan Johnston, secretary Isabel Newton, and nurse Susan Tracy, the key idea was that the right occupation could help persons in need (Peloquin, 1991b). Although they spoke of occupation as curative, it was not in relation to medical or psychiatric conditions but rather to the human condition, to harnessing occupation for what Hall called one of the “sources of human power” (as cited in Peloquin, 1991b, p. 739). Schwartz (1992) emphasized the similarities between Dewey’s ideas on the importance of occupations in education and occupational therapy’s use of occupations to facilitate healthy development in patients. Similarly, Schemm (1994) noted that the Arts and Crafts movement, which greatly influenced early practice in occupational therapy, saw activity as a means of improving society; it was a way “to socialize less accepted members of society such as disabled, mentally ill, impoverished, and underachieving persons in insane asylums and manual training programs” (p. 1083).

Although Adolph Meyer was not considered an official founder of occupational therapy, his influence in psychiatric circles of the day meant that his ideas on the importance of occupation carried considerable weight. Meyer (1922/1977) promoted the value of occupation, including work-like activities, and his words on the subject have become very familiar to occupational therapists: “The proper use of time in some helpful and gratifying activity appeared to me a fundamental issue in the treatment of any neuropsychiatric patient” (p. 639). Meyer stressed the need for “giving opportunities rather than prescriptions... opportunities to work, opportunities to do and to plan and create, and to learn to use material” (p. 641).

In Canada at the turn of the century, C. K. Clarke was prominent among those advocating occupation in the Ontario Hospitals for the Insane. Clarke, who was a noted psychiatrist, wrote of his experiences at the Rockwood Asylum in Kingston, Ontario, where he incorporated a wide range of activities (e.g., painting, carpentry, music, work, sports) into the daily regime. At that time, there was great concern over the need to restrain patients. Clarke noted that nonrestraint had become an established practice at Rockwood, and he (like Meyer) credited this fact to the use of occupation. Clarke (1922) stated:
No one comforted himself with the belief that occupation was a panacea for all the ills that the mind is heir to, but we did realize that intelligently supervised occupation was a tremendous factor not only in aiding cure in recent cases, but in making happy and improving the most unfortunate class in our community. (p. 13)

In 1918, the University of Toronto offered the first course in occupations in Canada (Robinson, 1981). These short courses were established in the faculty of applied science at the request of Herbert Haultain, a professor of engineering, and Norman Burnette, the head of a workshop at a military hospital. Both men saw the need for occupations for soldiers who, on returning from WWI, were confined to bed. Professor C. H. C. Wright of the department of architecture was in charge, and Winifred Brainerd, an American occupational therapist, was brought from New York to teach. Kidner, the Canadian architect who had also been a founder of NSPOT, was then vocational secretary of the Canadian Military Hospitals Commission, and he helped to organize the venture. Within the year, some 350 women had graduated from one of these short courses, and most of them went on to work with soldiers returning from the war (Robinson, 1981).

C. B. Farrar (1940b), a noted psychiatrist who was later to become the first superintendent of the Toronto Psychiatric Hospital, wrote about occupation as treatment for war neuroses and psychoses during WWI. He stated that “congenital and systemic occupation should be given foremost place in any scheme of treatment. Idleness... should be reduced to the uttermost minimum” (p. 16). He elaborated on this idea, noting that

there is the benefit of occupation as such, common to practically all cases; and there is the possible benefit of an awakened and sustained interest in an employment which is new, and which affords a pleasing relief from a former distasteful or humdrum occupation. Here we have occupation-therapy passing over into vocational re-training, with the latter perhaps completing the cure begun by the former. (Farrar, 1940a, p. 23)

At Government House in Ottawa in 1925, Farrar was among those who spoke at an open meeting of the newly formed Ontario Society of Occupational Therapists. A prominent newspaper of the time reported his comments as follows:

Next to proper housing and proper feeding, occupational therapy is the most important factor in the cure of nervous patients. The rest cure, so long ordered for these patients, has been supplanted by work, and occupational therapy provides this most necessary employment and effects the cure. (“Is Practical Christianity,” 1925)

This link between occupations and work had been important since the Moral Treatment Era and has continued throughout our history.

In summary, the main focus of occupational therapy in the early part of the century, both in the United States and in Canada, was on the person and on the activity. The approach did not address pathology, which at the time was primarily mental illness; rather, it focused on interests and abilities and worked around the pathology to engage the person in occupations. It was engagement in occupation that could have an effect on the person and could, over time, be transformative. Engagement in occupation was made possible by the therapist’s knowledge and understanding of the patient’s condition and came from within the therapeutic relationship that had been established. As the profession continued to develop, occupational therapists began to work with persons with physical disabilities, for example, those who were injured in industrial accidents. The goal of therapy was to return them to productive lives, economic independence, and social usefulness (Ambrosi & Schwartz, 1995a). By the early 1920s, curative workshops were established in both the United States (Baldwin, 1919) and Canada (LeVesconte, 1935) where work-like activities were designed to prepare patients for employment.

The largest population of persons with physical injuries had been the soldiers returning from WWI, and, with them, began a gradual shift in occupational therapy toward a focus on medical outcomes and away from earlier humanitarian and social benefits (Ambrosi & Schwartz, 1995b). During this early period, different philosophies of occupational therapy for persons with physical disabilities began to be seen. In the United States, Wilson H. Henderson was one of the first physicians to apply occupational therapy to physical disabilities. He thought that occupational therapy for men with war-time injuries should require technical rather than physical strength, more mental than physical activity, and enough general exercise to stimulate recovery (Reed & Sanderson, 1983). Referring to Canadian war-time experience, Goldwin Howland (1944/1986), physician and first president of the Canadian Association of Occupational Therapists, delineated five forms of occupational therapy: diversional, physical, recreational, psychological, and preventive. All but the second of these (physical) were directed at maintaining interest and morale.

Graded activity, which had been widely used with patients with tuberculosis in both countries to improve overall physical endurance and maintain morale, soon became more focused and was directed to improving range of motion and strengthening muscle groups (Creighton, 1993). The psychologist Baldwin tried to use both a holistic approach and the scientific method in designing activities for WWI veterans attending his occupational therapy department at Walter Reed Hospital (Wish-Baratz, 1989). He stated that the purpose of occupational therapy was to “help each patient find himself and function again as a complete man, physically, socially, educa-
tionally and economically" (Baldwin, 1919, p. 447). However, the means of achieving that purpose was through remedial exercises that required “a series of specific voluntary movements involved in the ordinary trades or occupations, physical training, play, or the daily routine activities of life” (p. 448). By the 1940s, Sidney Licht, a physician and editor of the journal *Occupational Therapy and Rehabilitation*, was promoting “kinetic” and “metric” occupational therapy (i.e., muscle strengthening, joint mobilization, coordination training) and increasing the amount of work completed in a unit of time or the number of times an activity was completed in a calendar unit (Reed & Sanderson, 1983).

**Occupational Therapy and Rehabilitation**

By 1937, occupational therapy practice patterns, as reported by the American Medical Association (AMA), which registered all American occupational therapists at that time, showed that 36 occupational therapists worked in orthopedics, 456 in general hospitals, and 1,809 in mental hospitals (Reed & Sanderson, 1983). These numbers reflect the state of health care at the time, that is, the high numbers of persons with mental illness who were institutionalized and the fact that people were not surviving the serious illnesses and injuries that were later to be seen with the development of modern medicine. However, the numbers also reflect the fact that the profession was still strongly focused on mental health.

It was not until after WWII that the shift in focus for occupational therapy from occupation as a means of developing or maintaining health to occupation as a means of enhancing medical outcomes became firmly established. The change came with the development of the new specialty of “physical therapy physicians” and the subsequent development of departments of physical medicine and rehabilitation. This medical specialty area, which had been developing since the turn of the century, had been based primarily on an interest in the use of “medical electricity,” later called electrotherapy (Gritzer & Arluk, 1985).

Rusk, who was a major figure in the development of this new medical specialty, recalled that he had created programs in air force hospitals for making good use of convalescent time. He said that “gradually, the concept of rehabilitation came to me as I found out how much really could be done for these men” (as cited in Gritzer & Arluk, 1985, p. 91). After several years of battling with the AMA, orthopedic surgeons, the Department of Veterans Affairs, and the Office of Vocational Rehabilitation, physical therapy physicians were finally allowed to call themselves physiatrists and to call their field physical medicine and rehabilitation. One of their early acts was to bring physical therapy and occupational therapy training programs, such as those at Columbia University and the University of Illinois, under their authority (Gritzer & Arluk, 1985). At the University of Toronto, a department of physical medicine and rehabilitation was created in 1950 that actually combined the educational programs for physical therapists and occupational therapists into one and brought the new program, for “P&OTs,” under the control of physiatry. During this same period, many hospitals in the United States and Canada developed departments of physical medicine and rehabilitation. As Brintnell, Cardwell, Robinson, and Madill (1986) pointed out, “The development of physical medicine was to influence the services provided by occupational therapy for years to come” (p. 27). (See also Colman [1992] for a description of occupational therapy’s struggle to maintain its roots and autonomy as physical therapists and physiatrists came to dominate the field.)

In his chapter on the role of occupational therapy in rehabilitation, Rusk (1958) had delineated three areas of therapy: supportive (psychologic), prevocational (vocational), and functional (physical). Supportive therapy was intended to maintain morale by helping the patient to realize his or her abilities and was to be closely coordinated with the psychiatrist and psychologist. Prevocational therapy was designed to assess and train the patient in preparation for a return to work and was to be a joint effort with the vocational counselor. The functional component of occupational therapy was directed to exercise in which the patient used his or her disabled part in the course of some constructive procedure, such as woodworking. Principles of therapeutic exercise were followed, starting with active-assistive exercises for those muscles that had a muscle-testing grade of poor plus or better and working toward active and active-resistive activities. For Rusk, the activity had become the means, and improving joint range, muscle strength, and motor skill the end. Brintnell et al. (1986) summed up the period during which these practices were followed in Canada, stating that “the fifties and sixties saw the emergence of the rehabilitation movement and with it, mixed blessings for occupational therapy. The physical aspects of treatment gained prominence over psychological concerns” (p. 33).

Gradually, the role of occupation as central to maintaining health and well-being began to erode. The pressure for occupational therapists to be a part of rehabilitation as it was conceived and practiced was too hard to resist. To modify the concept and practice of rehabilitation to better suit occupational therapy was too difficult, given the small size of the profession and its perceived lack of power and credibility (Froehlich, 1992). Equally important was the fact that rehabilitation was a glamorous
term. The medical model, complete with its uniforms and jargon, gave occupational therapists what was considered a loftier status. Rehabilitation was more respected and better understood than occupational therapy, and it caught the public eye. Persons with physical disabilities had the public’s sympathy (certainly more so than persons who were mentally ill), and if we were helping them in such obvious and concrete ways as getting stronger, moving faster, or gaining a fuller range of motion, well, then we must be good too.

Another pressure away from the meaning and value attributed to occupation came in work with children with cerebral palsy and persons with polio. During this period, occupational therapists became fixated on the value of independence (Froehlich, 1992) and worked with their patients to achieve it despite the time away from occupations that might have been more meaningful, such as being a student. The focus on dressing as an end in and of itself rather than as the means to an end continues to this day in many settings. Of course, there were exceptions, and many facilities still engaged their patients in occupations. One interesting example of where meaningful activity continued to be important was in the craft work that occupational therapists did with Native North American populations with tuberculosis (Staples & McConnell, 1993).

So for many years we have devoted a large part of our energies to fitting in with the medical model, where occupational therapists were never intended to be (West, 1984). As occupational therapists continued to compete in the reductionist environment of medicine, we found that our qualifications were generally not as good as others who could fix broken parts. And although no one else could do what we did, no one, including ourselves, seemed to value that. No one, including ourselves, seemed to notice that we had abdicated our role in developing and maintaining health and well-being through occupation in order to join the ranks of the reductionists. Meanwhile, physical therapists, who most of us would agree are the better “fixers,” grew in number and stature so that, today, in North America, there are twice as many physical therapists as occupational therapists. Some would support Yerxa (1992) in saying that in our efforts to align ourselves more closely with medical values and medical thinking, we have become more like physical therapy in the role we play in rehabilitation. It is ironic that we should be competing with physical therapists when, on the basis of the backgrounds of those who created our profession, one would have predicted that we would be competing with nurses, engineers, architects, social workers, or teachers.

**Newer Models of Rehabilitation**

Over the years since Rusk’s initial description of rehabilita-

tion, the concept of rehabilitation has broadened, and its definition is now somewhat more in tune with the foundations of occupational therapy. Instead of focusing only on restoring function, the field now recognizes other important outcomes. For example, the World Health Organization’s 1981 definition stated that rehabilitation includes all measures aimed at reducing the impact of disabling and handicapping conditions, and at enabling the disabled and handicapped to achieve social integration. Rehabilitation aims not only at training disabled and handicapped persons to adapt to their environment, but also intervening in the immediate environment and society as a whole in order to facilitate their social integration.

Such a definition recognized the end result of social integration, a broad category that could be considered to subsume occupations. It sharpened the focus of rehabilitation on reducing the impact of disability and handicap, thus opening the door to interventions in the environment.

More recently, the **Research Plan for the National Center for Medical Rehabilitation Research** (U.S. Department of Health and Human Services, 1993) has suggested that “the successful process of rehabilitation restores the individual to maximal functioning and provides a foundation for a fulfilling, productive life following rehabilitation (italics added)” (p. 29). Note that the definition is still tied to function, and rehabilitation needs only to provide the foundation for a fulfilling, productive life. It is as though somehow after rehabilitation these attributes of life will magically occur. However, the document further stated:

> Activities which enhance productivity and give a sense of purpose and enjoyment to life must be possible; these may include employment, education, recreation, family, and community involvement. This participation should provide meaning and dignity to life so that people with disability have a reason to live, not merely to exist. (p. 29)

So perhaps at last, we are beginning to see some of our occupational therapy values coming to the forefront in rehabilitation and that the field is richer for the role that we can play. Moreover, in this role, we can use our understanding of medical thinking without adopting the medical paradigm (Yerxa, 1992). And from a pragmatic point of view, if “social integration and fulfillment” become outcome measures in rehabilitation—as indeed they should—then our special skills and core values could become very important in this era of evidence-based practice. But how do we go from the if’s, shoulds, and coulds to the (re)enactment of our core values?

Friedson (1994) suggested that

> the competition between professions for jurisdiction over a particular area may be analyzed as conflicting definitions of the nature of the problem or activity (italics added) each is seeking to control, and claims about the way they can best be solved or carried out. (p. 70)

Rusk and the founders of rehabilitation thought that the
very nature of the problem was the disability itself, and in practice, they focused their efforts on restoring function to the person with the disability where our role was helpful, though limited. The founders of occupational therapy incorporated philosophical views about the importance of activity and determined that the very nature of the problem was a person's intrinsic need for occupation that was thwarted by illness or disability. Social integration, productivity, meaning, and dignity in life are outcomes of rehabilitation that are consonant with the core values of occupational therapy. Knowing how to enable persons with disabilities to achieve these outcomes is the special knowledge and skill that, in sociological terms, make occupational therapy a profession (Friedson, 1994).

Future Directions
Our profession has its own view of what the issue in rehabilitation is and how it is solvable; that is, we have our own paradigm within which to operate. Both in the United States and in Canada, there appears to be a growing consensus in occupational therapy that a return to our core values is needed (e.g., Kielhofner & Burke, 1977; Polatjoko, 1992; Townsend, 1997; West, 1984; Yerxa, 1992). As a profession, occupational therapy must now be prepared to champion that cause and to advance its aims.

However, there is a deep concern that as a profession we may not be up to the task. In 1966, Thelma Cardwell, the first occupational therapist to hold the position of president of the Canadian Association of Occupational Therapists (which since its inception in 1926 had a male physician as president) stated:

We are too diffident a group, both individually and collectively. We are much too timid in bringing our work to the attention of others. In short, we are ineffective in telling our profession. It is time we learned to be vocal, to be enthusiastic, to be competent, in representing the professional point of view of our discipline and in interpreting our aims and functions. These, with an added degree of confidence, can do an immeasurable amount in establishing the personal and professional reputation and respect that our profession warrants. (Cardwell, 1966, p. 139)

Others have made this plea before (Reilly, 1962) and since (Johnson, 1996). We know what to do; the question is will we do it? Will we undertake the research needed to study occupation and expand our understanding of the concept? Will we develop a core body of knowledge regarding occupation? Will we redesign our curricula to reflect our focus on the centrality of occupation? Will we demand the liberal arts background for entry to our programs that this focus requires? Will we instill confidence in our students about the value of our focus, and can we establish the competence to underpin that confidence? Finally, can we move on from the education of our students to the reeducation of practicing therapists who for too long have supported narrow views of our role in rehabilitation? Only then will we have a strong enough voice to undertake the social and political activity that is required. As Friedson (1994) noted:

The maintenance and improvement of the profession's position in the marketplace, and in the division of labour surrounding it, requires continuous political activity. The profession must become an interest group to act on its behalf and to protect itself from those with competing aims. (p. 68)

Conclusion
We are the only health profession that can focus on occupation; others can focus on function but not on occupation. As philosophers noted centuries ago, activity is what defines the lives of human beings. With illness or disability, this route to meaning is often threatened. It is the mission of occupational therapists, along with health professionals, to keep that route open. When we define ourselves exclusively as "rehab professionals"—even with the most modern of definitions—we limit our ability to make that unique contribution.

There is clearly a common denominator, a unifying theme, in all that we do, and as has been said in many different ways, occupation is it. Occupation is what explains the "jack of all trades" epithet that makes us so uncomfortable. It is why we can help persons with all kinds of disabilities and at all ages. In occupation, we have had, and do have, a unique and powerful tool not to cure, but to positively influence health and well-being. However, we must get on with it and not continue to be lured away. For to paraphrase that great contemporary philosopher Will Rogers, we may be on the right track, but if we just sit on it, we will be run over by the train. ▲

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