A Historical Review of Occupational Therapy's Role in Preventive Health and Wellness

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The public is becoming increasingly cognizant of the importance of proactive health behavior and is seeking assistance from health care professionals in their pursuit of wellness. As occupational therapy strives to meet this growing consumer demand, a historical review of the profession's involvement in proactive health activities can enhance its response. Since its inception, occupational therapy has recognized the importance of both preventive action and the promotion of wellness. In this paper, the significant historical events in this area are discussed to stimulate future research and clinical application in health promotion.

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To survive in the current competitive health care arena, occupational therapy must examine and expand its contribution to health promotion and wellness. It has been documented that both occupational therapy and other professions must heed trends when planning a strategy to ensure continued growth, solvency, and accountability (American Occupational Therapy Association [AOTA], 1979b; Bair, 1982). Stattel (1977) reminded us that "we cannot accurately and professionally comprehend the present or look at the future intelligently until we become acquainted with and study the past" (p. 650).

Occupational therapy was founded on the humanistic ideal of promoting well-being through occupation. According to Serrett (1985), the inception of occupational therapy occurred during a period of U.S. history known as the Progressive Era, an era that promoted "optimism and humanitarianism" (p. 11). Occupational therapy, the mental hygiene movement, and the arts-and-crafts movement were all conceived in this era. Pragmatism, the most influential school of philosophy during this time period (Breines, 1986), had a major impact on organizations and professions interested in promoting social change. Leaders in these movements drew from the work of Dewey and other pragmatists as well as from social activists such as Addams and Meyer (Breines, 1986). Hull House in Chicago was a mecca for both individuals and emerging professions committed to improving the conditions of persons who were mentally ill, poor, or recent immigrants (Breines, 1986). It is from this rich heritage that occupational therapy's humanistic commitment to promote independence and optimal quality of life for all persons developed.

In 1921, Meyer presented a paper at the annual meeting of the National Society for the Promotion of Occupational Therapy—now known as AOTA. In this paper, which was originally published in 1922 and was reprinted in the American Journal of Occupational Therapy (AJOT) in 1977, Meyer articulated the evolving philosophical beliefs of the profession. Many of these beliefs can be linked to current concepts and beliefs in health promotion and wellness. Four examples of these beliefs are (a) an active interaction with reality (i.e., the environment) maintains and balances the individual, (b) the mind and body work in unison and this link must be studied and appreciated, (c) natural rhythms have a positive effect on well-being and human performance, and (d) there is a need for balance in all spheres of occupation.

Fuller, in the introduction to Tracy's landmark book Studies in Invalid Occupation (1910), stated that "suitable occupation is a valuable agent in the treatment of the sick" (p. 1). Dunton (1915), in Occupational Therapy: A Manual for Nurses, broadened this idea to include prevention by proposing that "another purpose of occupation may be to give the patient a hobby which may serve..."
as a safety valve and render the recurrence of an attack less likely” (p. 25).

The profession of occupational therapy was not very active in promoting preventive health between the 1920s and 1960s. In fact, few details of occupational therapy’s role in prevention could be found in the literature covering this time period. An exception was an article by Carpenter (1947), the director of the Philadelphia Committee for the Prevention of Blindness. The article, “Considerations for Prevention of Blindness and Conservation of Vision,” emphasized that “the specific contributions of all are required if the individual who is actively or potentially sick and ill adjusted is to be stimulated to want and to seek maximum benefits from the healing arts of medicine and social science” (p. 349).

Carpenter (1947) also pointed out that the three prime causes of blindness, venereal disease, glaucoma, and accident, are nearly all preventable, if members of the health field cooperate and engineer a successful campaign. Carpenter recommended training students in occupational therapy, public health, and social work in the early detection of visual problems. Carpenter believed that occupational therapists, through their personal contacts with patients’ families, could be instrumental in this early detection of visual problems and would be responsible for screening the entire family. This was a remarkable article considering both the year of its publication and the fact that the author was not an occupational therapist but vigorously promoted the profession’s role in preventive health.

Unfortunately, in the 1950s, occupational therapy concentrated solely on curative approaches, abandoning the philosophy of preventive health. Later, leaders in the field (Finn, 1972; Walker, 1971; Wiemer & West, 1970) acknowledged this trend and encouraged the profession to renew its efforts in the area of preventive health. The opportunity to prevent injury and disability, thereby decreasing the need for costly (in terms of emotional, physical, and financial cost) restorative care, was seen by these leaders as a challenge for both the present and the future.

In the 1960s, occupational therapy’s role in preventive health emerged as an issue in the profession. At this point in occupational therapy’s development, Reilly (1962) reminded the profession of its philosophical foundation with the declaration, “That man, through the use of his hands, as they are energized by mind and will, can influence the state of his own health” (p. 1). This statement became a basic premise for occupational therapy’s role in preventive health. In the late 1960s, West (1967) and Brunyate (later to be Wiemer) (1967) employed Reilly’s premise to initiate discussion of occupational therapy’s role in preventive health. West announced in a paper at AOTA’s 46th Annual Conference that there was a new focus in both occupational therapy and other health-related professions, “of increasing concern for health maintenance and the prevention of those deficits, diseases and disabilities which in the light of our present knowledge and skill, are so unyielding to cure” (West, 1967, p. 312).

Brunyate (1967) emphasized that occupational therapy needed to play an increasing role in the areas of both medicine and civic life, declaring that occupational therapy had a “vital, distinct and elsewhere unattainable contribution to make to restorative, preventive and maintenance health” (p. 262). Brunyate continued by stating that occupational therapy was “committed to health protection and health maintenance as well as to health restoration and rehabilitation” (p. 264).

The ideology of West and Brunyate was incorporated into the official definition of occupational therapy when it was updated and adopted by the Delegate Assembly of AOTA. This new definition was published in the AOTA Newsletter in 1969:

Occupational Therapy is the art and science of directing man's response to selected activity to promote and maintain health, to prevent disability, to evaluate behavior and to treat or train patients with physical or psychosocial dysfunction. (Wiemer & West, 1970, p. 324)

In the 1970s, the issue of occupational therapy’s role in preventive health was increasingly discussed in the literature. Walker (1971) reported that occupational therapy was undergoing a change in emphasis and that the “emerging model of occupational therapy” was concerned “with the well community and the maintenance of health and prevention of deficits, diseases, and disabilities” (p. 345). The role of the occupational therapist was seen as that of a consultant in the development of programs for the well community. These programs included home health care, maternal and child health care, community guidance centers, school systems, and chronic disease care.

Wiemer (1972) stressed that occupational therapy had a “natural vested interest” in preventive health, but had not found its “appropriate place within it” (p. 1). Preventive medicine was defined by Wiemer as dealing “with the quality of life and the interdependence of people... [acting] to limit health problems and the stress arising from them” (p. 1). Wiemer voiced concern regarding those therapists who felt they were practicing preventive health when they merely spliced or completed perceptual-motor evaluations on children. Wiemer identified this as a lay or technical response rather than a professional response, which would be to take a more active role in community and preventive health.

The therapist was visualized as being able to join together with other health professionals and take on the roles of health advocate and counselor. Specifically, the therapist could alert the public “to the relationship between a man’s health and the tasks (occupation) with which he challenges the use of his hands and mind” (Wiemer, 1972, p. 6). In conclusion, Wiemer stated:
Strong conviction is held that occupational therapy has the option to elect involvement in prevention and has an obligation to make significant contributions to the promotion of society's health. Prevention in community health care (which is prevention in all health care), more than treatment and rehabilitation, can be the realization of the profession's unique and real value to mankind. (p. 9)

The 1971 Eleanor Clarke Slagle Lecture, presented by Finn (1972), emphasized the need for the profession of occupational therapy to keep pace with a rapidly changing society. She suggested that one way to accomplish this would be to remain aware of current trends in society, specifically those related to health care. Preventive health was identified as one of those current trends. Finn stressed that

... to expand our services beyond the clinic into health planning for the community requires changes in the interpretation of our current knowledge, the addition of new knowledge and skills, the abolition of learned behavior patterns, and the revision of our educational process. (p. 60)

Finn emphasized, however, that there were several issues to be considered when implementing prevention programs: (a) the need to be familiar with the primary care institutions and their goals and policies; (b) the knowledge of and ability to institute programs based on purposeful activities to promote health; (c) the need to reinterpret occupational therapy's knowledge to apply it to maintaining health rather than merely minimizing disabilities; (d) the need to use creative thinking in dealing with these issues; (e) the establishment of a model to facilitate the translation of ideas to action; (f) an understanding of the necessity of risk taking in this type of venture; (g) a thorough understanding of the communication process and the ability to apply it; (h) the ability to foster a climate of acceptance to ensure that these programs are implemented; and (i) the ability to supervise staff to ensure optimal performance and professional growth.

Six years later, in an update on her Slagle lecture, Finn (1977) stated that occupational therapy had since expanded its role in community preventive health within the secondary and tertiary levels of prevention. Occupational therapy, however, was still not involved at the primary level of preventive health. Primary prevention was defined as actions "directed toward an understanding of the relationship between the basic elements of society and health" (p. 659).

In 1978, AOTA's Representative Assembly adopted a position paper entitled "Role of the Occupational Therapist in the Promotion of Health and Prevention of Disabilities" (AOTA, 1979c). This position paper, which was prepared by an ad hoc committee of the Commission on Practice, drew upon Reilly's thesis, as had West and Wiemer, that an individual can influence the state of his or her health through activity. The paper also stated that AOTA adheres to the World Health Organization's (WHO's) definition of health, that "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 50).

The position paper further defined the concepts of primary, secondary, and tertiary levels of preventive care. It stated that primary prevention programs "attempt to reduce the incidence of disease and injury by countering the harmful influence responsible" (AOTA, 1979c, p. 50). Examples of occupational therapy intervention at this level were given, such as educational programs for teenage mothers and expectant parents, retirement planning, and industrial consultation.

Secondary prevention programs were described as efforts "that reduce the duration of disorders occurring in a population at risk" (AOTA, 1979c, p. 50). Educational programs for appropriate clients in joint protection, body mechanics, and energy conservation were examples given of possible occupational therapy secondary prevention intervention. Other programs included screening at-risk infants, life skills programs in mental health for acute populations, work activity programs for at-risk adolescents, instruction in compensatory skills to school-age children, and identification of architectural barriers.

Finally, tertiary prevention programs were described as "attempts to reduce the rate of dysfunctional performance among disabled individuals within the community as well as in health and educational settings" (AOTA, 1979c). Occupational therapy involvement in home health care, cardiac care, life skills programs for chronic populations, public schools, and community rehabilitation centers were considered tertiary prevention programs.

In 1979, AOTA's Representative Assembly approved "The Philosophical Base of Occupational Therapy" (AOTA, 1979a), which included the following statements: (a) "Human beings are able to influence their physical and mental health and their social and physical environment through purposeful activity" and (b) "Occupational therapy is based on the belief that purposeful activity (occupation) ... may be used to prevent and mediate dysfunction" (p. 785). This philosophical statement further confirmed occupational therapy's role in preventive health and wellness.

During the 1960s and 1970s, the leaders of the profession demonstrated an increased awareness of the necessity for occupational therapy to become more active in the areas of preventive health and wellness. Unfortunately, a corresponding increase in clinical application could not be seen from AOTA membership data. Statistics from AOTA's Membership Data Surveys showed that few therapists worked primarily with the well population. In 1973, 1977, and 1982, statistics showed that 1% or less of occupational therapists worked primarily with the well population (AOTA, 1982, 1991b; Jantzen, 1979). It should be noted that these statistics do not represent those therapists who may have worked with this population on a part-time basis or those who engaged in wellness and health promotion activities with the ill or disabled. The
lack of reimbursement for preventive services has affected the ability of occupational therapists to engage in prevention and health promotion activities. This issue will need to be addressed if occupational therapy’s true potential to impact the well-being of society is to be realized.

Gilfoyle (1984), in her Eleanor Clarke Slagle Lecture, again stressed the need for occupational therapy to be responsive to trends in health care and increase the profession’s involvement in “a model of healthfulness where patients influence their own state of health” (p. 575). Gilfoyle’s prediction asserted that both medicine’s and society’s dependencies on the biomedical model are declining, while interest in a holistic health model is increasing.

In the fall of 1986, AJOT devoted an entire issue to the topic of health promotion and wellness (AOTA, 1986b). The issue comprised six feature articles, a guest editorial, a Nationally Speaking column, and a Brief or New article. Of the six feature articles, one defined the role of occupational therapy in preventive health, one discussed health care costs and health promotion programs, one reviewed the need for education in this area, and the other three detailed examples of practice in health promotion. White (1986), the guest editor of the issue, discussed (a) the increasing interest in health and wellness; (b) the location of health promotion programs; (c) the development of health risk assessments or appraisals; (d) the definition of terms such as wellness, health promotion, and prevention; and (e) the challenge that faces occupational therapy to meet the needs of consumers in health and wellness.

The locations of health promotion programs were identified as including the workplace, college campuses, primary and secondary schools, community settings, health maintenance organizations, hospitals, and health clubs. Programs were described as varying from a “comprehensive holistic health program, in which the worker’s environment has been changed to promote health, to a series of classes on smoking cessation, weight reduction, exercise, and stress management” (White, 1986, p. 745). White concluded with a plea for occupational therapists “to fulfill the mandate of a health oriented society” (p. 747).

Jaffe (1986) continued with a review of occupational therapy’s historical involvement in preventive health, a description of perceived changes needed in occupational therapy education, and a discussion of the need for increased research into the effectiveness of occupational therapy’s health promotion activities. The recommendation for changes in occupational therapy education was based on the belief that occupational therapists were receiving advanced training in health and wellness through a variety of programs outside of occupational therapy but that few students or therapists were trained in the specific role of occupational therapy in this area. Jaffe stressed that as health professionals, occupational therapists must remember the philosophical orientation of the profession and use their many skills to develop techniques and programs that enhance health, prevent disease, and improve the social climate that fosters and promotes a healthy society (p. 752).

Johnson (1986), in another article in the special issue of AJOT, defined the terms wellness, health promotion, illness, disease, health, and well-being. Johnson also presented a historical review of the evolution of wellness, followed by a discussion of the similarities between wellness philosophy and the philosophy of occupational therapy. Assumptions and beliefs that are compatible to both and that serve as justification for occupational therapy’s role in the wellness movement were also discussed.

The beliefs that health and illness fluctuate and have an impact on the functional abilities of an individual are shared by the wellness movement and occupational therapy. Another common belief is that individuals are integrated organisms, with the mind, body, spirit, emotions, and environment having an interrelated impact on health. The concepts of “fluidity, dynamic change, rhythm, and fluctuation” (Johnson, 1986, p. 757) are discussed in wellness literature and in general system theory, a theory that has influenced occupational therapy. A commitment to prevention and early remediation is also held by both, as is an interest regarding wellness and its relationship to stress, coping, and facilitating change in health behaviors. The publication of the 1986 special issue of AJOT on health promotion and wellness demonstrated that there was increasing interest and intervention in these areas, but, more important, it emphasized the need for continued growth and research.

In 1986, AOTA’s Representative Assembly approved the position paper entitled “Occupational Therapy and Hospice” (AOTA, 1986a). This position paper discussed the importance of maximizing the quality of life for the terminally ill and how occupational therapy can assist in this process. The concept of enhancing quality of life is very similar to Dunn’s (1977) concept of high-level wellness. Even if a person has a terminal illness and may have limited capabilities, he or she can still maximize his or her self-potential in the performance of a task or pursuit of importance. This can both facilitate the person’s adapta-
tion to the dying process and enhance the quality of life.

More recent developments in the areas of preventive health and wellness include the revision of AOTA's position paper on health promotion and prevention (1989a) and the increasing amount of attention paid to these topics at both national (AOTA, 1991a; Canadian Association of Occupational Therapists, 1991) and international (World Federation of Occupational Therapists, 1990) occupational therapy meetings. These presentations and lectures help foster occupational therapy's continued growth in prevention and wellness.

Recently, AOTA has taken a proactive interest in health promotion and wellness. In 1988, the Association appointed a Health Promotion/Wellness Program Manager to its staff. In the following year, AOTA participated in a consortium to assist with the development of the nation's health objectives for the year 2000 (AOTA, 1989b). In 1990, the Executive Director, the Health Promotion/Wellness Program Manager, and other representatives of AOTA were present at the official release of the report Healthy People 2000 by Dr. Louis Sullivan, Secretary of Health and Human Services (U.S. Department of Health and Human Services, 1990). This report detailed the national health promotion and disease prevention objectives for the next decade. During the conference at which the report was released, concern was voiced that (a) many of the objectives set for the past decade had not yet been achieved; (b) the funding necessary to ensure the attainment of these objectives may not be available; (c) grass roots health care workers must be mobilized, educated, and supported; and (d) for different segments of U.S. society, there continues to be disparity in both health status and access to health care.

Many of the strategies suggested to make these objectives a reality involve preventive interventions. However, financial constraints limit not only occupational therapy but all health professions from engaging in preventive efforts. A second Progressive Era with a new group of social activists is needed to encourage U.S. society to place a higher value on prevention and make it a fiscal priority. Financial support from individuals, businesses, states, and the federal government must be obtained, and creative cost-effective programs must be developed that can be easily replicated in communities across the country.

Healthy People 2000 is a potential catalyst that may foster a preventive philosophy in American society and its health care system. Recent literature (Johnson & Jaffe, 1989) in occupational therapy provides concrete examples of preventive programs that can be used as a resource to those both inside and outside the profession to meet the challenge of the nation's health objectives for the year 2000.

Summary
From the above historical review of the literature on preventive health and occupational therapy, it is clear that occupational therapy's leadership has long recognized the philosophical need for a commitment to improve society through preventive health interventions. Occupational therapy literature can stimulate the development of new and creative interventions to promote the health and wellness of the society. By expanding occupational therapy's efforts in community preventive interventions, conducting research on the impact of such programs, and reporting the cost savings in both human and financial terms, the profession may once again be proactive and serve the pragmatic ideals of its founders. ▲

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References
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