A Reaffirmed Philosophy and Practice of Occupational Therapy for the 1980s
(treatment modalities, purposeful activity, occupation)

Wilma L. West

This paper culled from the occupational therapy literature of the 1978-1983 period statements in support of our philosophical base, in opposition to our treatment modalities, and in examination of the cause and course of our internal professional debate. The futurist literature projecting external trends in economic and sociocultural areas, including medicine and health, was also sampled for evidence that might either sustain or further challenge traditional theory and practice. The conclusion drawn was that our heritage of belief in and use of occupation as both the central organizing theme and mode of professional practice is better suited to future intervention strategies than are borrowed, nontraditional treatment media. Four recommendations for actualizing a more unified theory and practice are proposed.

The current debate over a common philosophical base and appropriate treatment modalities suggested to 1983 Conference planners that these issues reflect differing respect for, or knowledge of, the philosophy and intervention strategies that early therapists employed. The program committee therefore proposed that an historical review of our heritage might enhance appreciation of the richness of our base and lend perspective to the practice and philosophy we now choose.

Something less than conviction that such a charge could be fulfilled rested in recall from our recent literature of the number and quality of articles dialoguing the very issues this paper was invited to address. Starting in the late 1970s and continuing into the current year, several colleagues have written perceptively and wistfully about an apparent loss of faith in the most fundamental beliefs of our profession. Nearly all recent commentators not only referred to tradition remembered but also subjected that tradition to re-examination, added individual perspectives that argued for its continuing verity, and defended re-commitment to our heritage of belief in occupation as both theory and mode of practice.

Others, however, have written with gathering force for change, questioning the efficacy and credibility of “purposeful activity” and promoting “pure exercise” and the use of physical agents as more effective means of treating patients with physical dysfunction. And so the debate began and still continues, alternatingly reflecting traditional and newer views. Major tasks were identified as selecting the broadest and best statements of concept in support of our philosophical base, while also reflecting as fairly as possible the substance and rationale of challenges to our treatment modalities so evident in the same literature.

Part 1 of this paper reviews both issues under the heading, “The Internal Professional Debate.” Part 2 draws on literature beyond our own about “External Societal Changes” that have an impact upon our professional as well as our personal lives. Part 3 presents conclusions and recommendations based on my concept of how traditional theory and practice, currently being reaffirmed, might also be re-interpreted to gain new force for internal consensus and extraprofessional credibility.

Part 1. The Internal Professional Debate

In Support of Our Philosophical Base. The following excerpts from selected papers present only a sample of the many statements in support of our philosophical base. Of more than casual interest is the notation that these references include the writings of COTAs and students, as well as OTRs, and of allied professionals such as nursing home administrators. In chronological order, here are those found most cogent:

- Activity is the essence of living (1) and is significantly interrelated with high morale (1, quoting Havighurst and Albrecht).
- Activities provide a special opportunity for creativity, variety, and refreshment (1, p 379).

Wilma L. West, M.A., OTR, FAOTA, is President Emeritus, American Occupational Therapy Foundation, 1393 Piccard Drive, Rockville, Maryland 20850.
• To some degree, life itself is seen as purposeful occupation—that is to say, as activity, as task, as challenge. . . . We continue to be true to our identity as occupational therapists if we act consistently with our conception of life as occupation (2).

• It is the purposefulness of behavior and activity that gives human life order (3).

• Occupational therapy’s body of knowledge lies in human behavior and activity as well as in the effect of pathology on behavior and the effect of activity on pathology (3, quoting Gillette).

• By developing skills in the use of one’s hands and raw materials, a person can revive a sense of competency and be re-connected with the natural environment, thus finding new purpose and meaning in self-initiated activity (4).

• The basic philosophy of occupational therapy speaks to Man as an active being and to the use of purposeful activity (as) Man’s interaction with and manipulation of his environment (5).

• The Activity Theory of Aging postulates that activity involvement promotes life satisfaction and is therefore compatible with occupational therapy theory that implies that “doing” experiences promote competence and independence (6).

• The required use of purposeful activities limits practice in the area of physical dysfunction, does not acknowledge the level of specialization achieved by experienced clinicians, and jeopardizes reimbursement (11).

These writings contain a treasure of re-statement of the most fundamental principles supporting the use of activities as the aspect that makes our therapy unique in both philosophy and practice. They are commended to our further thought and study, as is a more recent publication, Health Through Occupa-

Originaly, “our media . . . included not only the creative and manual skills . . . but also the skills found in play, education, recreation, self-care, and work.”

In Opposition to the Mode of Our Intervention Strategies. The second part of this topic is the negative side of the debate about treatment modalities. In the same literature that has expressed support for our philosophical base, numerous Letters to the Editor of this journal have protested the adoption of resolutions about Purposeful Activity and Occupation and defended the use of nontraditional media. Why is there such dissent in thought, practice, and writing among professional colleagues? How could such differing views be surfacing and serving to pit practitioners against philosophers, pragmatists against idealists? Why the denial of traditional media, and their replacement with modalities more closely identified with the knowledge base of other disciplines and the practice of their professions?

A search for answers to these questions revealed arguments against the effectiveness of “purposeful activities” expressed in the following statements, which are composites of multiple, individual, and departmental views.

• In many acute care settings, length of stay is insufficient to show progress through activities (7).

• There is pressure from physicians, administrators, and third-party payers for cost-effective and objectively measurable improvement (8).

• Crafts can be a frustrating and negative reinforcer of lost skills, particularly for patients with severe disabilities (9).

• JCAH and CARF requirements for quality assurance and cost containment dictate a sharp reduction in use of crafts and substitution of activities lending themselves to reliable standardization (10).

• Many patients referred to occupational therapy are at too low a level of motor activity to participate in complex tasks of self-directed activity (11).

• The required use of purposeful activities limits practice in the area of physical dysfunction, does not acknowledge the level of specialization achieved by experienced clinicians, and jeopardizes reimbursement (12).

Another aspect of the debate about appropriate treatment media, although not explicit in the foregoing statements, has been addressed by several occupational therapists writing in defense of tradition. This is the observation that today’s practitioners evidence a lack of faith in the efficacy of what they are doing by using modalities that are neither occupational therapy nor effective treatment (13). Such practice has served to diminish occupational therapy’s unique perspective and focus on assets, abilities, competen-
cies, and satisfying performance in all areas of human existence. Although “society does not yet value the commonplace . . . activities of play, leisure and self-maintenance,” it has been urged that we continue to “articulate and perpetuate the valuing of everyday activities . . . for what we value is what existence is about, finding meaning in all that we do.” (3, quoting Yerxa, p 521). And, as was so clearly expressed 21 years ago, “The wide and gaping chasm which exists between the complexity of illness and the commonplaceness of our treatment tools is, and always will be, both the pride and the anguish of our profession” (14). Possibly the most important reason why is has become more anguish than pride in today’s practice has been our collective failure to implement another of that philosopher’s farsighted observations that “For us, in occupational therapy, the most fundamental area of research is, and probably always will be, the nature and meaning of activity.” (15)

**Loss of Scope of Our Intervention Strategies.** What is the origin and course of the debate over treatment modalities and why has the debate become so narrowed?

Perhaps our currently differing views rest in the loss, long ago, of the concept of our earliest definition of occupational therapy as employing the use of “any activity, mental or physical . . . .” To more adequately define that global circumference of our media, one needs to remember that activities in those earliest days included not only the creative and manual skills, now unfortunately abbreviuated to include only crafts, but also the skills found in play, education, recreation, self-care, and work. Taking each of these in turn, the following scenarios surrounding loss of scope of our intervention strategies are suggested.

Occupational therapy’s early concern for play and playful modalities eroded as therapists became embarrassed about treatment that did not seem serious and technical. (Yet) Play prepares the immature individual for adult competency and participation in social life . . . . (It) also maintains the balance, morale and commitment essential to serious adult life . . . . Play (thereby) exercises innovating, organizing, and integrating functions on behavior . . . . (And) People seek in play the difficulties and demands, both intellectually and physically, they no longer find in work (4, quoting Lasch, p 531).

A focus on educational activities may have been lost with the disappearance from occupational therapy case loads of tuberculous, general medical/surgical, and medical pediatric patients. With such patients, the use of educational (in the sense of nonphysical) activities flourished, for those were days of long periods of enforced bed rest, limitation to sedentary, nonstressful occupations, and the judicious application of activities carefully graded to physiological tolerance. Then, with scientific advances in medicine came the conquest of tuberculosis; with new theories of early ambulation permitting shorter hospitalization, general medical and surgical patients were discharged without referral to our services; and finally, with our failure to interpret occupational therapy’s programs for hospitalized adults and children as “stress-reduction therapy,” we not only lost large and natural patient groups but we also “abandoned a whole area of human needs.” (17, p 436)

The broad range of activities of self-expression originally considered to be within the realm of occupational therapy was given away at the Allenberry Conference (18) when a consensus was reached and expressed in the principle that users of activities for patients should employ those media for which they were best qualified by education and practice. This era, circa 1956-1960, thus countenanced the settlement on various emerging activity therapies of media formerly in the accepted domain of occupational therapy; they included recreation, dance, music, and art. Although seen at that time as recognition of the development of new therapies whose practitioners were more skilled in various specialized media, one recent theorist has ascribed this rise of quasi-professional groups around modality-based specialties to the lack of unifying theory in occupational therapy (17, p 430).

Only in self-care/activity of daily living skills may it be said that occupational therapy has retained representation in practice, although, even here, the profession has lost some of its treatment techniques to rehabilitation nursing, physical therapy, and home economics (19). It also seems possible that we may forsake even more of these intervention strategies as we move farther away from our traditional focus on chronicity in favor of new emphases on the promotion of health and prevention of disability.

Finally, there was the once-bright and promising use of prevocational activities for evaluation and testing of work interests and abilities, in which many occupational therapists developed sophisticated methods of assessment. Somewhere around the mid-to-late 1950s, this too was lost as our former roles were assumed by vocational evaluators (19). Recently, however, some ef-
In the information society, stress and mental disorders will displace physical disabilities as the main threat to health, and the human need for nonwork-related activity will be compelling.

... in the information society, stress and mental disorders will displace physical disabilities as the main threat to health, and the human need for nonwork-related activity will be compelling.

In light of all these deductions from our initial broader-than-crafts definition, have we lost identifi
cation with modalities that should have been retained and more resourcefully used? Were they given away for lack of conviction in their efficacy, as seems to be the case in the current move now to relinquish crafts also? Or were they in fact adopted by groups with more specific skills for their use and greater appreciation for their broad appeal and applicability for patients with a wide range of presenting problems? Although educational programs probably cannot be said to be responsible for earlier losses of activities, they may be more implicated today as suggested in a recent observation that “Students don’t see supervisors using activities.” (22)

Narrow Interpretation of Professional Policies. A second inference drawn from the current debate over treatment media may be found in narrow interpretation of professional policies set in two 1979 resolutions. In the first of these, “The Philosophical Base of Occupational Therapy” (23), perhaps because the term purposeful activity is so prominent, therapists have overlooked broader concepts of the statement that define the role of activity in human development, adaptation, and self-actualization. Thus, in several of the critical comments about practice limitations imposed by the Purposeful Activity Resolution, we find extensions of the statement to imply that activity must be craft-based and product-oriented, as well as additional restrictions on practice related to the reputed failure of this resolution to distinguish purposeful from nonpurposeful activity. In such literal and limiting views, we seem to have forgotten larger concepts of purposeful activity.

With reference to the second of these resolutions (24) passed in tandem with the first at the 1979 meeting of the Representative Assembly, why has there been so little reference in the literature and reflection in practice of the liberalizing implications it contains? In “Occupation as the Common Core of Occupational Therapy” there is expressed official grace for the use of nontraditional forms of activity, including the use of “facilitating procedures . . . to prepare the patient/client for better performance and prevention of disability through self-participation in activity . . . .” Yet, in the dialogue about the issue of preparatory and facilitating procedures, there is more evidence of differing opinions than of agreement about specific techniques. Also, there are questions about the need to follow such procedures with engagement of the patient in self-initiated, purposeful, goal-directed activities designed to integrate function. Perhaps the profession should more specifically agree that such orthotic activities as bracing and splinting are as acceptable media of occupational therapy as work simplification, job modification, and adaptive equipment have always been.

At the other extreme, however, is the use of techniques such as hot packs, massage, ultrasound, paraffin, passive range of motion, joint manipulation, and exercise programs neither including nor followed by participation in purposeful activity (25). Here, ultimate decisions might be guided by the Principles of Occupational Therapy Ethics (26), which stipulate that “services provided should be planned in concert with clients’ involvement in goal-directed activities . . . .” and that occupational therapists “should not provide services or instruction (outside) their licensure laws and their implications for our practice (27, 20, p 179).

In summary, to this point, citations from the literature have been used to support our philosophical base, to examine opposition to traditional media, and to review some of the reasons for our current differences. It seems apparent, however, that neither policy-setting resolutions nor published statements on both sides of these questions have thus far brought us closer to resolving our internal professional debate.
Also, up to this point, we have looked only inwardly—that is, at our own profession—but there are extrinsic as well as intrinsic influences on us as individuals and those influences have an impact on our profession and on the patients it should be structured to serve. Similarly, there are emerging forces in our society and world that may be more significant for our future than those that preoccupied our past, and these cannot be ignored.

Part 2.
The External Societal Change

Introduction

The major catalyst for the following views was the book, Megatrends (28). In this book, Naisbitt introduces a range of developing directions that will transform our ways of viewing society and prepare us to accommodate to those changes. He then proceeds to define the content analysis method used to identify the trends and directions discussed. Basically, the system compiled and drew inferences from more than two million local articles about local events in local communities of America over a 12-year period (p 3). Findings from tracking 6,000 local newspapers each month are published quarterly in a national "Trend Report" (29), and these constitute a major base for projections of our future.

A Review of Selected Trends

Although an in-depth review of this highly readable and sobering book is neither feasible nor intended, subsequent conclusions and inferences will be more credible if viewed in the context of its major thrust. This is well defined in the first chapter, "From an Industrial Society to an Information Society" (28, Ch 1). The beginning of the information society and the corresponding end of the industrial era are timed in the 1956-1957 years when white collar workers—that is, those dealing with information, first outnumbered blue collar workers involved with the production of goods and services. Today that gap between the two classes has widened to a 60/40 percent ratio, with the larger number representing the size of the work force already in information-related jobs.

In commenting on these developments, Naisbitt points to two huge problems that will characterize the high technology era. First, computers will have an impact on the information age in ways similar to but even more seriously than the effect of mechanization in bringing about the industrial revolution; this time, the threat to workers will be from robots and microprocessors, rather than from machines. Second, a serious educational mismatch is seen in the results of lowered educational standards over the past two decades as today's high school graduates constitute the first generation in American history who are less prepared to cope than their parents. The remedial training that 300 of this country's largest corporations have been forced to provide in the basics of secondary school education, as well as in skills, for those entering the new work force is only one of many implications for the future.

If this first glimpse of the character of the new information society touches us primarily with reference to future competencies of our students, Chapter 2 should have greater meaning for us as therapists and for the patients we serve. That is clearly revealed in the title "From Forced Technology to High Tech/High Touch," and content of this chapter will invite identification by colleagues who still adhere to the philosophical base of our heritage as well as to the use of traditional media. For example, Naisbitt speaks in terms of the need to use our hands and bodies more in leisure and recreational activities to balance the constant use of mental energy that will be required in the information age; and also of such high touch signs as may be seen in the hospice and home care movements and what he projects as an inevitably more humanistic practice of medicine.

Another chapter in Megatrends (Ch 4) deplores the short-term orientation of American managers and suggests replacing current emphasis on immediate results with greater concern for the long range. Thus he advises us to think long-term, to ponder what business we are really in or what business it would be useful to be in, thereby giving vision and clarity to overall direction. His projection for health care of the future is from a sickness to a wellness orientation, a trend we in occupational therapy foresaw and responded to more than a decade ago. We have not been as collectively responsive—in fact, we seem to be facing in an opposite direction—to his suggestion that long-range perspectives may require a return to generalist education. Although specialties may become obsolete, the generalist, committed to lifelong education, can change with the times.

In a chapter entitled "From Insti-
After decades of trusting in America’s traditional sense of self-reliance after decades of trusting institutional help. Responsibility for our health and well-being, he says, is ours, not that of the medical establishment. Self-help on the rise in our health and well-being, he says, is ours, not that of the medical establishment. Self-help on the rise is seen in social moves against crime, to strengthen neighborhoods, provide services for the elderly and rebuild homes; medically, it is evident in personal responsibility for health habits, environment, life style and the demand to be treated holistically. Thus wellness, preventive medicine, and wholistic care will triumph over the old model of illness, drugs, surgery, and the isolated treatment of symptoms rather than individuals. Dealing with stress will be among the major concerns of tomorrow.

Such trends have significant implications for occupational therapy.

Other Writings in the Same Vein

A first reading of Megatrends may be somewhat superficial because it is as fast-moving as the pace of change it describes. Even that cursory review, however, may provide a sense of deja vu and send one back to Toffler’s Future Shock (30) and The Third Wave (31). In these two books, published in 1970 and 1980, respectively, there is both foresight and analysis of many of the new directions identified in Megatrends. Other publications indicate consensus among the futurists about the shape and meaning of trends, not just to come but already here. These include such books as The Information Society as Post-Industrial Society (32), The Turning Point (33), The Aquarian Conspiracy (34), In Search of Excellence (35) and The Youngest Science (36).

Related periodicals such as The Futurist (37) and The Tarrytown Letter (38) should also be high on the reading list of any who would use Toffler’s reversal of the time-mirror to see images of the future for insights today (30, p 4). The following thoughts from two of those books are in the same vein as Megatrends and seem especially relevant to occupational therapy.

First, from Toffler’s broad projections on the future individual, family, and social scene (31): Paralleling the new technological, informational, and sociospheres (p 223), there will be a new psychosphere. The mental health industry is experiencing unprecedented growth, with one-fourth of US citizens under severe emotional stress from collapse of the individual’s need for community, structure, and meaning. We must re-establish the role of the family and the sense of belonging, rebuild frameworks for purpose and being. We must also re-fashion education from teaching the structure of government or the amoeba to the structure of everyday life, including allocation of time, personal uses of money, and available sources of help (Ch 25).

From hobbyism, we will see prosumption—that is, we will move from being passive consumers to become active prosumers or producers for ourselves (p 296). There will be new values on what people do, rather than on what they earn or own, new values on self-reliance, the ability to adapt and survive, to do with one’s hands, whether in building a fence, cooking a meal, making clothes, or restoring an antique chest. There will be brought together the complementary pleasures of handwork and hardwork, this after looking down on handwork for 300 years of the industrial age. The personality of the future will crave balance in life—between work and play, production and prosumption, handwork and handwork, the abstract and the concrete, objectivity and subjectivity (pp 403-407).

Second, from Capra’s views (33) on changing approaches to medicine and health: In the biomedical model, which is the conceptual foundation of modern scientific medicine, the human body is regarded as a machine capable of analysis in terms of its parts. Thus disease is interpreted as a malfunction of biological mechanisms and studied with reference to cellular and molecular biology; it is the physician’s role to intervene, physically or chemically, to correct malfunction of specific mechanisms. But, by concentrating on small fragments of the body, medicine loses the patient as a human being (p 123). Although associating a particular illness with a definite part of the body is... useful in many cases, modern scientific medicine has overemphasized the reductionist approach and developed its specialized disciplines to a point where doctors are often no longer able to view illness as a disturbance of the whole organism, nor to treat it as such. They tend to treat a particular organ or tissue, usually without taking the rest of the body into account, let alone considering the psychological and social aspects of the patient’s illness (p 157).

Replacing this mechanistic view of the human organism, which led to an engineering approach to health (p 148), is the systems view from general systems theory, which “looks at the world in terms of relationships and integration (and) emphasizes basic principles of organization rather than basic building blocks or substances.” In this view, “the nature of the whole is always different from the mere sum of its parts.” (pp 266-267)
The holistic approach to health is consistent with the systems view of living organisms and in harmony with both traditional views and modern scientific theories (p 305). In this view, health is seen as the experience of well-being resulting from a dynamic balance that involves the physical and psychological aspects of the organism as well as its interactions with its natural and social environment (p 323). Similarly, illness is viewed as the consequence of imbalance and disharmony and may often be seen as stemming from a lack of integration (p 324).

Health care of the future will consist of restoring and maintaining the dynamic balance of individuals, families, and social groups, and it will mean people taking care of their own health individually, as a society, and with the help of therapists (p 332). The systems view of health will perceive the human organism as a dynamic system involving interdependent physiological and psychological patterns, and as embedded in interacting larger systems of physical, social, and cultural dimensions (p 359). In the revival of psychosomatic medicine, there will be recognition of the role of stress in disease and of the interplay between mind and body in health and illness (p 414).

These brief views of changes most immediately affecting those concerned about health and disability in the future were selected to set the stage for the conclusions and recommendations that follow.

Part 3.
The Growing Reaffirmation

"The Growing Reaffirmation" refers to ways in which I view external societal changes reaching congruity with the philosophical base and treatment modalities that have been both challenged and defended by internal professional debate. Again, the words and thoughts of others are used to fashion linkage between the foresight of the futurists and the trust of the traditionalists, thereby suggesting that the challenge of history may indeed be best suited to meet the challenge of evolving frontiers.

Conclusions

The most significant reaffirmation of traditional philosophical and practice modes of occupational therapy as relevant today and tomorrow is derived from futurist visions of a more humanistic and holistic approach to disability and health. If we can believe in the early advent and viable force of these predicted directions, we may be entering an era when other medical and health professionals will view as clearly as we have always professed to: the whole person, not just the part, organ or system; the individual's mental and physical assets and abilities, not just those that have been impaired or lost; and the maximal integrated function the individual may be able to regain, retain, or attain (39), not just the isolated amount of increased joint range, muscle strength, physical endurance, or psychological adjustment that is achieved without reference to their enhancement of meaningful life skills.

In these goals for the people we serve lie the basic premises and promise of occupational therapy. Although they have been in place since our earliest beginnings, creatively practiced by many and articulately defended by a few, our means of achieving these goals are undergoing serious challenge from within. This challenge and the resulting internal debate reviewed earlier appear to have stemmed from efforts in occupational therapy to become as scientific as medicine attempted to be, starting at mid-century. For, "as scientific advances and overall medical progress brought changes that emphasized techniques rather than theory, treatment modalities that appeared more precise were substituted for craft activities in therapy." (40) It seems that intraprofessional differences reminiscent of those examined 5 years ago at our San Diego Conference in the form of specialization might again be confronting us with potentials for disunity (41).

If the futurists are on target, and there is undeniable consensus among them, it would appear that we will have a quite different patient or client group from whom our traditional tools of treatment may provide singularly appropriate forms of intervention. For the millions of displaced workers of the industrial society and for the even greater number in the projected new sedentary and separate mode of work in the information society, stress and mental disorders will displace physical disabilities as the main threat to health, and the human need for non work-related activity will be compelling. Response to that need through the individual's engagement in interest-motivating and self-initiated occupations will acquire deeper meaning and will energize personal responsibility and discipline. It could also re-energize our professional responsibility and discipline.
We need “renewed commitment to another of occupational therapy’s most basic tenets, that of the mind-body-environment interrelationships activated through occupation.”

as trends in medical and health practices re-discover the humanism and holism so implicit in the concepts of our founders, so needed always, so crucial for the future if we are to help others who must find new ways of adapting to future society.

Recommendations
These remarks are concluded by indicating ways in which hopes for re-rooting occupational therapy in our deepest philosophical traditions might best be realized. These ways are stated in four specific recommendations organized around a central theme and, again, all are taken from the professional literature.

First, let us consistently use and more imaginatively implement the concept as well as the term occupation as the common core of occupational therapy. It is infinitely more expressive and encompassing than “purposive activity” and will continue to be broadly descriptive of our particular mode of intervention. It also suggests that we consider rescinding the Purposeful Activity Resolution. The rationale for this has been well stated: “While the term activity has been used throughout our history, its meaning has become narrow and impoverished. . . . The current meaning of activity as primarily a descriptor of occupational therapy media bears little resemblance to its rich original connotations . . . . There is an important difference between advancing theories about therapeutic activities and the traditional hypotheses that human beings have an occupational nature, that normal occupation can be disrupted and threaten health, and that occupation can restore health.” (42)

The second reorientation we might be urged to adopt is to speak might be urged to adopt is to speak of our profession as serving the occupational need of Man (42a), rather than “treating the whole person.” The latter term was aboundantly used in our early literature to indicate our greater concern for the individual than for the specific disability, and it has also pervaded recent medical and futurist literature. While always remembering its spirit, perhaps we should now relinquish this once-cherished term to those who have newly found it and promote, instead, the concept that the use of occupation as therapy implies “an awareness of occupation as a human trait, a human need and a natural mode of influencing health” (42). With this framework, we might simultaneously avoid offending other health service providers who also profess to consider “the whole person” and speak specifically to that which most clearly differentiates our services from those of all others in like endeavors.

A third suggestion is that we define and organize occupational therapy around occupational performance dysfunction, rather than in terms of disabilities. This concept was probably first suggested in 1974 in the following statement: “If occupational therapy is to survive as a profession, the schisms within the profession related to diagnostic or disability entities need to be removed by focusing on the essence of OT rather than a disability or pathological orientation” (43). That concept has since been re-stated in terms of two proposed theories. First, “A generic theory of occupational performance is needed to view occupational performance capacity regardless of medical problems as well as in the absence of medical problems” (44). Second, it has been proposed that “the unique science supporting the practice of occupational therapy is the science of occupation.” (4, p 534)

The fourth and final recommendation appeals for renewed commitment to another of occupational therapy’s most basic tenets, that of the mind-body-environment interrelationships activated through occupation. “Historically, occupational therapy has been philosophically committed to a view of Man that is consistent with the . . . Concept of . . . wholism . . . that perspective where mind and body are perceived as inextricably connected, integrated as one entity. In contrast (is) the dualistic perspective (in which) mind and body are perceived as separate and hierarchically related entities (one entity superior to the other) . . . . Man has the capacity to explore, to manipulate and . . . to alter his environment with which he has a reciprocal relationship of interdependence and influence. Man demonstrates this capacity by engaging in activities involving objects and people that serve the purposes of (1) promoting his survival; (2) providing a sense of being and a quality of becoming; and (3) creating opportunities to contribute to the perpetuation and progress of a society to which he is culturally bound . . . .” (45).
Final Summary
Putting these recommendations together in the service of the science of occupation as supporting the practice of occupational therapy, it is believed that we can summon both unity and credibility in our profession. When these splendid concepts of our heritage are paired with challenging predictions for the future, there may be seen a complementary mix that, if not fully substantiated in the passing Industrial Era, will gather new strength in the Information Age of the future. Or so it is hoped that we might be persuaded. Otherwise, occupational therapy may be seen as a disabled profession, as vulnerable in practice as it seems to be insecure in philosophy. That is an intolerable view. Rather, we prefer Naisbitt's concluding observation that this is "a fantastic time to be alive" (28, p 252) and therefore urge that we unite around time to be alive" (28, p 252) and therefore urge that we unite around.

Acknowledgment

REFERENCES
29. Published by the Naisbitt Group, 1225 19th Street, NW, Washington, DC 20009
37. The Futurist (bi-monthly journal). World Future Society, 4916 St. Elmo Avenue, Bethesda, MD 20814
38. The Tarrytown Letter (monthly). Executive Conference Center, East Sunnyside Lane, Tarrytown, NY 10591
45. Shannon PD: Project to identify the philosophy of occupational therapy. Pre-publication copy, pp 21-22, quoted with permission of the author.