Published by The Research and Training Center on Independent Living (RTC/IL), The University of Kansas, Dole Human Development Center, 1000 Sunnyside Avenue Room 4089, Lawrence, KS 66045-7555, Voice: (785) 864-4095, TTY: (785) 864-0706, Fax: (785) 864-5063, email: RTCIL@ku.edu

Meshing IL With Occupational Therapy

Sara E. Kennedy

Independent Living Forum 7(1), Spring 1989

An understanding of independent living values is crucial to appreciating the far-reaching ramifications they hold for the health sciences. In contrast to the medical model, which defines obstacles to independence as caused by the disability itself, the IL view asserts that the dependence fostered by traditional service models and society at large is often the cause of problems. The solution lies in consumer control, self-help, advocacy, removal of barriers and disincentives, and peer counseling. While the desired outcomes of the medical model are adaptation and adjustment through professional intervention, the IL movement strives for self-direction, social and economic productivity, and the human dignity in risk that fosters growth and development.

The documented tenets of occupational therapy suggest that it is the profession uniquely suited between the medical model and a holistic view of health as something far more than absence of disease--the hallmark of independent living. Functional independence is not just a core concept of occupational therapy theory. It is the goal of the occupational process. There seems to be no question that occupational therapy acts in concert with the IL movement . . . or is there?

People in the movement say that professions such as occupational therapy reduce the concept of independence to the extent of independent functioning in various skill domains. For example, people with develop mental disabilities are typically limited to community survival skills training. With this in mind, the issue is clear: Does occupational therapy subscribe as a field to the IL movement? Is there a role for it within a consumer-based model?

The very philosophy of occupational therapy is one of its strongest defenses to such accusations. Occupational therapists in their practice see competency where others might not because of the medical model limitations and common sense orientation. The concept of health through occupation espoused by occupational therapy affirms the value of meaningful activity as a promoter of adaptation and health, as opposed to the theory that those in the sick role have but one goal given to them by health professionals: They are expected to recover.

Occupational therapy has long since recognized the irrelevance of the sick role in disability issues, as well as the stance that health is an absolute value or state. Once people achieve it, they are home free, cured, normal, and healthy as the medical model suggests. Indeed, there have been movements in the field advocating a future role for people with disabilities to replace the sick role. Concepts such as ‘Therapists must believe in the intrinsic value of individuals as sources of their own health, restoration and maintenance, and ‘Therapists must assume an advocate role in preventing

processes that rob patients and clients of respect, control and responsibility" certainly aid in destroying the foundations of the sick role, an anathema to independent living.

Methods used in occupation al therapy are, in general, congruent with IL tenets. Continual reference can be found to patient as co-manager in rehabilitation and the importance placed on his or her input in the treatment process. The profession is based on the science of adaptation, which includes such IL values as changing the environment to remove obstacles to independence and views the individual as a whole being and an open system.

A third aspect of occupational therapy that favors its role in the movement is its high degree of flexibility in its scope of practice. Occupational therapy lends itself to IL arenas such as home health care and community-based service. Occupational therapists are increasingly employed in day-care, day health, and outpatient programs, as part of architectural design teams for barrier-free living and as consultants to firms offering services or adaptative equipment. The wide and variable scope of practice gives occupational therapy many avenues to serve where the needs exist, and a foundation of experience outside the realm of institutional care cannot but broaden the profession's view of people as self-directed beings.

The philosophy, methods, and scope of practice have been shown to be, in principle, compatible with the IL model. However, evidence is found to suggest that the field has not gone far enough in implementing IL practices. More often than not, patients have a say in rehabilitation issues when their opinions are considered realistic by the therapist.

And why is there still a lingering aura of dependency surrounding persons with disabilities in the literature of occupational therapy? For example, a spinal cord injury manual written by and for therapists lists generic discharge plans that include obtaining information from the patient's family concerning the projected role of the patient in the home and also instructs the therapist to teach the family the patient's routine of care. The IL paradigm asserts that disabled people have the right to speak for themselves and are eminently capable of teaching attendant care routines. In many cases, people with disabilities have the closest possible knowledge of their own disability and are highly qualified to establish the level of care they need.

One of the trademarks of the sick role is the exemption from normal activities depending on the nature and severity of the illness. If normal activity in occupational therapy literature is used to measure the field's rejection of the sick role premise, mixed results occur. While the desired outcome of therapy is frequently a return to productivity, aspects such as sexuality and sexual activity are often slighted. If therapists believe that sexuality issues are not part of their sphere, then who will provide these informational services to disabled people? Or, should disabled people be left to decisions and conclusions that may be based on inaccurate information and myth?

Occupational therapists often use language that is quite destructive in terms of portrayals of people with disabilities. Even more disturbing are some of the definitions of independence set forth in the literature. Independence is defined in one book as "can per- form the activity without cueing, supervision, or assistance . . . ." This implies that independence is merely an ability to perform certain functions. Also, occupational therapy literature portrays people with disabilities as dependent, even though they may hire, train, supervise and fire employees to perform particular tasks. The whole issue of

attendant services, so central to the IL movement, is conspicuously absent in occupational therapy literature.

Proponents of the IL paradigm view independence as the degree of control individuals have over their own lives based on the choice of acceptable options that reduce dependence on others in making decisions and performing everyday activities. Occupational therapy is perhaps the most closely allied health field to IL, and, indeed, embraces many of its values. However, these ideals are not consistently put into practice, and, if they were, the impact on the profession would be immeasurable.