Making sense of our daily experience is a significantly human pastime. We try to understand and structure our experiences so that we can come to grips with the messiness and confusion of everyday life and by so doing give meaning and direction to our actions.

Philosophy is one method that we use for explaining our experiences. A philosophy is a collection of beliefs. A belief is a conviction in the truth of something. Our beliefs are based on our values, experiences, and knowledge. Once we have organized our beliefs into a philosophy, that philosophy provides a powerful, generally nonconscious, guide for our actions. It is because of the nonconscious way in which a philosophy influences our actions that it is appropriate to reflect on the beliefs that comprise occupational therapy philosophy in regard to functional independence. Functional independence is not just a core concept of occupational therapy theory, it is the goal of the occupational therapy process. Once our beliefs about functional independence have been articulated, we can explore their implications for practice.

**Basic Beliefs**

What do we mean then when we say that a client is functionally independent? Independence connotes self-reliance, self-determination, self-directedness, and a perspective of personal control. In occupational therapy, we regard persons who can do things for themselves as independent. We believe that this doing is made possible by both personal and environmental characteristics. The personal requirements for independence are competence and autonomy. The environmental requirements include an array of physical, social, and temporal factors that facilitate independent behavior. Functional independence occurs as a result of the interaction between the person and environment. For us to appreciate our philosophy of functional independence requires a rethinking of our beliefs about humans, the environment, and the person-environment interaction. Each of these concepts will be discussed and related to the occupational therapy process.

**Personal Components of Independent Behavior**

*Humans as Competent.* Occupational therapists view independent behavior as a composite of competence, competencies, and perceived competence. Competence is a transactional concept that involves effectiveness in interacting with the environment (2). It arises from an urge to learn about the environment by testing our actions upon it. Competence implies adaptability in organizing skills into integrated courses of action to serve innumerable purposes. Competence is an overall strategy of adaptation consisting of thinking, deciding, doing, and evaluating. We think about what we want to do. We make a choice from available options and plan a course of action. We implement the plan in our day-to-day activities. We assess the outcomes. Repeated application of this sequence—of thinking, deciding, doing, and evaluating—leads to mastery. By mastering some things, we develop a sense of competence as well as technical skill. Perceived competence leads to an image of the self as a doer. It allows us to say with confidence, “I can do it. I can achieve.” Competence implies a wide range of abilities and skills. The competencies that lie within the parameters of occupational therapy relate to self-care, play, and work occupations and the biological, psychological, and social skills that support these endeavors. Self-care competencies are fundamental to independent survival. The ability to more to obtain food and fluids and to eliminate waste products is critical for biological existence. The ability to communicate with others is also intimately tied to survival. It is through (our) interactions with others, that we learn technical skills for working and playing and socially acceptable patterns of behavior.

*Humans as Autonomou s.* Pivotal to our philosophy of independent behavior is the belief that competence must be accompanied by autonomy. Autonomy is the quality of being self-governing (3). It is the freedom to make choices compatible with one's needs, capabilities, and desires. It includes a concept of the self as separate from the environment and is accompanied by a tendency to resist control by the external forces of the environment.
Autonomy results in the self-confidence to regulate one's daily life and to be productive.

To be autonomous one needs an accurate self-appraisal of one's competence to accomplish a task (4). Underestimating one's skills may lead to more dependency than is needed, while overestimating them may lead to involvement in tasks that are beyond one's capability to achieve. Self-appraisal influences both the selection of and persistence in daily living occupations. We choose occupations that we think we can succeed in and avoid those that we assess as having requirements that exceed our abilities. When engaged in activity, autonomous individuals can deploy their energies to accomplish the task. Obstacles are generally seen as challenges and effort is sustained until the task is completed. Individuals lacking self-assurance, on the other hand, frequently interpret obstacles as personal deficiencies and may readily give up when challenged. The effort necessary to acquire essential skills is not exerted and potential is not adequately tested.

Thus, autonomy is directly related to skill development, and to the formulation of a set of internal standards to monitor one's actions.

Norms for competence and autonomy vary with age, culture, and personal abilities and values, making functional independence age-graded, socially defined, and to a certain degree idiosyncratic. The underlying principle that occupational therapists subscribe to is that individuals are not competent or incompetent, autonomous or not autonomous, rather, they have various levels of competence and autonomy that result in various levels of functional independence.

Independence of the Disabled. To be functionally independent is to be both competent and autonomous. Having examined competence and autonomy, we can now consider these concepts in reference to the disabled. As occupational therapists, we adhere to the belief that the functional independence of disabled individuals is within the framework of normal development.

Human development from infancy through adulthood involves a learning process in which many dependency behaviors are gradually displaced by competence. The adult standard of autonomy entails a comfortable balance of dependent and independent behaviors. Control of the physical environment and fulfillment of psychosocial needs requires us to be dependent on others as well as independent of them.

The impact of disablement on an individual's life largely depends on the extent to which it interferes with competence and induces nonnormative dependence on others. The potential competence of disabled persons is molded by what is lost and what is left by disability. Adaptive competence is determined by the development of residual and latent abilities as well as functional losses. The functional abilities that remain essentially untouched by disability, or that can be nurtured, will serve to enhance normative developmental processes.

The occupational therapy process is geared toward what is left after disablement rather than what is lost. This leads us to encourage disabled persons to make the most of their remaining capabilities and to assume age-appropriate responsibilities. Exemptions from ordinary social responsibilities are directly related to the degree of disablement. We might sum up our view of functional independence by saying, "Because you can't do some things, doesn't mean that you can't do anything, and we believe that you should do as much as possible for as long as possible." In occupational therapy theory, "I can" is a symptom of health.

Our attitude toward doing is applied with a major qualification, however, and one that we all too easily neglect. The functional independence of disabled persons is not entirely determined by competence or potential competence, any more than is yours or mine. In our professional interactions with disabled persons, we must guard against thinking that because they can do something they should do it (5, 6). This is particularly true in regard to self-care skills. For example, because you can dress yourself, does not mean that you should. Taking an hour to get dressed may not result in the greatest functional independence. The bits and pieces of daily life must be placed within the spectrum of the whole life of the individual. When physical, mental, or emotional endurance is limited, energies must be channelled into high-priority pursuits. In a real sense, the more energy required to deal with the disability, the less is available for other things. By depleting time and energy on basic tasks, the possibility of realizing achievement in work or leisure may be eliminated.

If so much of the mother's or therapist's energy goes into getting a child to eat alone, dress alone, stand alone, and walk alone, the cost to the emotional security of the child, and to greater independence at a later time, may outweigh the skill achieved. In our efforts to build functional competence, we must be careful to respect the autonomy of the client.

The autonomy of disabled persons is determined by what they want to do rather than what we think is in their best interest. To
make realistic choices requires an accurate appraisal of one's assets and liabilities. For disabled persons, this appraisal includes a discernment of those limitations caused by disability and those caused by other factors. The implications of disability for one's life must be understood and accepted but not exaggerated. The autonomous disabled person views disability as an aspect of the self (5). There is a recognition that disability, like other aspects of one's individuality, has both positive and negative features.

An important aspect of autonomy for many disabled persons is the acceptance of vulnerability and of the need to ask for help (5-7). Independence is highly valued in the American culture. Independence is associated with strength, power, rugged individualism, and decisiveness, while dependence is associated with weakness, helplessness, selfishness, and indecision. As clinicians, we have multiple instruments available to measure the developmental milestones of independence. I know of no scales that chart in a similar fashion the emergence of our age-appropriate dependence behaviors. Such a chart might delineate appropriate ways of seeking attention, affection, and help. The prevailing spirit of independence in our society makes it difficult to ask for help. Dependence on others for the gratification of basic needs can produce much frustration. Not only is there a sense of powerlessness over the loss of personal control, this is frequently coupled with a fear of losing the protection and services provided by the caregiver. Loss of these services is more than an inconvenience; it may well mean being unable to eat, to get to bed to sleep, or to get to the bathroom. Thus, for many disabled persons the growth of autonomy is intimately connected with learning to adjust to being the recipient of help.

Autonomy also involves the risk of failure in living, loving, working, and playing. Too often we have kept disabled persons in protected situations to keep them safe and secure. However well-intended these actions, they have kept the disabled from experiencing normal developmental stresses (1,6). All of our lives we strive to achieve things we have never done before. Without risk, there is no possibility of achievement and life becomes as colorful as oatmeal.

Person-Environment Relationship

As our sense of autonomy develops, and we recognize our separateness from the environment, we also develop an appreciation of the influence of the environment on our behavior. Functional independence implies a measure of mastery over the environment. The lower one's competence and autonomy, the more dependent one is on the environment to fulfill basic needs. Environments may be characterized along a continuum of support for independent behavior. Our belief system thus incorporates levels of competence, levels of autonomy, and levels of environmental support for independence. Our basic premise is that independent behavior is a function of the competence and autonomy of the individual and of the behavior-evoking aspects of the physical, social, and temporal environment. I will now examine our beliefs about how the person and environment interact and how we use the environment as a treatment modality.

Lower Environmental Demands. Generally we go about our everyday activities without much awareness of the environment. This state of unawareness occurs as a result of a balance between our capabilities and the environmental demands. Our habits allow us to respond automatically and appropriately to a variety of situations. This person-environment balance yields a sense of controlled interaction with the environment. Disability may disrupt this balance. Clients come to us when competence has been reduced, or when normative standards for competence have not been achieved. The first therapeutic strategy instituted to raise competence is to lower the environmental demands. Environmental demands are lowered to make doing possible (8).

Lowering the demands of the environment is generally accomplished through a prosthetic approach (9). Prostheses are environmental supports that compensate for the deficits of the client. In implementing a prosthetic approach, our attention is directed to certain aspects of physical space (10). We consider the capacity of the physical structure to facilitate the occupation that is carried out in it. We assess the ease of moving from place to place and the extent to which a setting can be rearranged to accommodate new and different patterns of behavior. We take into account comfort and safety. Since many of the functional problems associated with disability can be circumvented by devices and appliances, we also look at technological resources. Lastly, we consider the clarity with which a setting indicates the behaviors that are appropriate in the area. Clarity lends an aura of predictability to a space and increases our preparedness to engage in activity.

In using the above features of physical space to reduce environmental demands, we discover that
knowledge of the individual is needed as much as knowledge of environmental properties. For example, what is or is not accessible depends on the competence of the client as well as the features of the facility or community. Thus, the characteristics that we have selected to conceptualize physical space, support our belief that independence is a function of person and environment in interaction.

When another person is used to compensate for lost skills, the prosthesis is social rather than physical. A wife, for example, may assist her disabled husband with personal care activities. More formalized support for independent behavior is demonstrated in the human services network. Individuals with varying levels of competence require different types of services. Familiarity with the services available in the communities where our clients reside allows us to recommend a package of services appropriate for a client’s level of competence.

Regardless of whether the prosthesis is physical, or social, its use by the client is related to skill training. Social prostheses depend on social skills in aide or agency management, while physical prostheses are related to motor skills. Attendants and services must be selected as cautiously as assistive devices, because they regulate the performance of functions critical to survival.

Lowering behavioral expectations is another strategy that we employ for reducing environmental demands (11). We acknowledge that the client is undergoing stress, and temporarily excuse the client from the normative requirements for independent living.

The lower one’s competence, the lower the environmental demands that can be met (8). For those who are newly disabled, the difference between an over-demanding and an under-demanding environment is slight. There is a fine line between protection from overwhelming environmental stress and exposure to environmental deprivation.

In occupational therapy, under-challenging environments are used as retrenchment or relaxation tactics. An individual who has just sustained a severe impairment may need a high level of support to overcome the sense of being overwhelmed. Lowering environmental demands to or below a person’s competence level may be justified and necessary on a short-term basis. However, the cumulative effects of low environmental demands discourage occupation and growth and generate feelings of dependency, boredom, underachievement, and lassitude. We believe that environments that consistently do things for clients that they can do for themselves are detrimental, since over-providing leads to atrophy of independent living skills (12, 13).

Increase Environmental Demands. In occupational therapy theory, the optimal environment for supporting functional independence is one that challenges present competence (14). In the treatment situation, challenge is achieved by increasing the environmental demands above the client’s functional level. The increase in demand should not be radical since this would again place the client in a condition of being overwhelmed. However, it should be sufficient to encourage the active exercise of adaptive strategies. Having first of all reduced environmental stress to the point where doing became possible, we now set out to increase environmental demands to build competence and autonomy. While the prosthetic environment supports clients’ weaknesses, the optimal environment supports clients’ strengths.

Our overall approach to increasing environmental demands incorporates several strategies. The first strategy involves the selection of the “just right” challenge as the treatment modality. We assist clients in choosing occupations most suited to the development of interest and mastery. Client performance is gradually raised by the selection and accomplishment of progressively more challenging tasks. We regard skill training leading to mastery as a particularly effective treatment technique because it increases the client’s competencies for managing the environment and it enhances the client’s expectancies for personal effectiveness (4).

Much of the occupational therapy process hinges on the “just right” challenge. We seek to engage clients in an occupation that is not too easy, and not too difficult, and yet is hard enough to engage attention and set into action the sequence of thinking, deciding, doing, and evaluating that leads to competence. We determine the “just right” challenge in part by assessing the degree of uncertainty that environmental stimuli contain for the client. Stimulus uncertainty is related to action because it elicits arousal and exploratory behavior aimed at resolving the uncertainty generated by the stimulus. We adapt to uncertain environments such as unfamiliar cities, buildings, or tasks by seeking knowledge about the environment and hence reducing the degree of uncertainty.

Stimulus uncertainty is the principle underlying the occupational therapy concept of graded activity. Humans have the capacity for internalizing the external environment by creating an image of it. It is this image in our heads that we
react to, not the external environment per se (15). We match our image of the environment with our image of ourself, and if the discrepancy or uncertainty about meeting the challenge is too great, we do not act. The therapist may well calculate the distance between the wheelchair and the bed as a mere 20 inches. But to the client that distance may look like the Grand Canyon and the client says, "No, I can't do it." The "just right" challenge is the one that stretches the client's competence and sustains a sense of autonomy.

Tasks are initially selected that keep failure to a minimum, since repeated failure can decrease interest and persistence. Later, the "just right" challenge is interpreted to include the risk of failure, since learning to cope with failure is a part of learning to cope with daily life.

The occupational therapy process generally involves the establishment of short-term and long-term goals. It is primarily through the attainment of short-term goals that we seek to sustain interest (4). Short-term goals act as guides for action and as markers of progress. We experience a sense of satisfaction when we aim for and master a desired level of performance. The satisfaction derived from the attainment of short-term goals can build intrinsic motivation. Long-term goals do not have the same incentive power. The discrepancy between current performance and long-term goals often generates disappointment. Even though skill development may take place, it is not accompanied by a sense of accomplishment and interest may soon wane.

In addition to selecting therapeutic occupation, we also seek to promote independence by populating the social environment with persons who value achievement. We carry out our activities in conjunction with other people. We live with others, work with others, play with others, and depend on others for things that we cannot do or cannot do alone. A client's behavior is profoundly influenced by the expectations others have for his or her performance (11). By incrementally raising these performance expectations, function can be improved. The spirit and skills of independence are nurtured by those close to the client—family members, friends, work associates, and therapists.

Over the course of treatment, we also seek to shape appropriate behavior through the use of role models. When no models are available who can demonstrate concretely that those with mental retardation or stroke can perform a task, it is easy to conclude that the task in question is among the impossible. Role models influence behavior vicariously, since the clients themselves observe the performance of others but do not necessarily execute any actions (4). Role models for occupation are provided by other clients, former clients, and the therapists themselves.

The most encompassing environmental strategy that we employ is the use of field mastery experiences. We send the client into the community to assist the client in developing daily living skills in normal environments. Field mastery experiences are preceded by opportunities for learning and practicing skills in simulated environments. To accomplish this, we bring into the settings where we work—settings that may be regarded as deprived for the support of daily living skills—we bring into these places the objects and attitudes from the community to encourage and sustain daily living skills. We contrive normal living situations by placing kitchens and bedrooms and hammers and typewriters in our clinics. We expect clients to be dressed, to come to "work" on time, to play hard, and to leave the workplace in an orderly manner. We put normal spaces in abnormal places in an effort to capture some of the conditions of ordinary life.

Recognizing that we do different things in different places, we supervise multiple kinds of places to capture daily life. Living environments are used to prompt self-care competencies. Play environments are used to encourage curiosity and exploration, and work environments to elicit industriousness. Different environments are set up to evoke different aspects of independent behavior and to divert the clients' attention from their disabilities to their abilities.

The use of multiple settings enables us to encompass the totality of productive occupations and to account for the temporal dimension of occupation as efficiently as the spatial dimension. It is not enough to be able to comb your hair and brush your teeth. All activities of daily living must be practiced until they are perfected, sequenced, and routinized in a manner that sustains the habits of functional independence.

The environments we manage have a growth orientation. We expect clients to develop and change. As their occupational performance improves, we transfer clients to situations with greater environmental demands. The occupational therapy process frequently begins in a play environment and progresses to a work environment. Through play, crafts, and games, clients find out what they can do with the environment and develop habits of craftsmanship and sportsmanship that
support work. Occupation commonly proceeds from crafts at the bedside, to work in the hospital ward, to work in the sheltered workshop, to work in the community. Each transition involves greater responsibility and more complex opportunities for decision making and problem solving. Thus, environmental change is used as a method both for evoking different occupations and for grading stimulus uncertainty.

No matter how well conceived our simulated environments are, however, they cannot replicate real life. They remain “protected” in subtle ways. The final transition is thus to the actual environment in which the client will live, work, and play. In the final phase of treatment, occupational therapy loses the capacity to structure the environment. We can suggest that a handicapped child be allowed to play with his or her peers after school but we cannot enforce that suggestion. Performance in an environment supportive of independence for disabled individuals may be very different from performance in an environment impartial to independence for disabled individuals. One measure of the overall success of the occupational therapy process is the extent to which the client can transfer the skills learned in our activities of daily living laboratories to natural settings. Another indicator is the degree to which we have educated clients so that they can act on their own behalf to redesign the environment to suit their requirements for functional independence.

Evolutionary Perspective
It is through the lens of history that I will explain the significance of our beliefs concerning functional independence. In describing these beliefs, I relied on early pioneers in occupational therapy, such as Eleanor Clarke Slagle, Louis Haas, and Adolph Meyer, because of the strong link between function and the environment in our early philosophy (16-21). I modernized and enriched some of our fundamental premises by using concepts from the behavioral sciences to articulate them more clearly. The exploration of our early philosophy resulted in a holistic philosophy, which takes as its central premise the healing value of occupation, and the pursuit of achievement emerged. The client interacts with and creates the environment and the environment interacts with the client and yields a level of occupation, and the pursuit of goal of intervention was to organize and balance the competencies of daily living in such a way as to yield a sense of autonomy and life satisfaction. This philosophy guided occupational therapy practice from its inception in the 1960s to roughly the 1940s (22).

During the next decade, we came under pressure to explain our intuitive notions about the influence of occupation on health in a scientific way. Like many health care professions, we embraced the prevailing philosophy of reductionism to guide our scientific development. Reductionism had the net effect of limiting our view of the client, the environment, and occupation. Instead of conceptualizing independent behavior as a molar event, involving a client and a broad contextual milieu, it became a molecular event, involving fragmented responses and equally discrete external stimuli. Three distinct models of occupational therapy practice emerged and each sought to explain functional independence in a different way. The kinesiological model viewed it as a result of musculoskeletal integrity and sought to improve it by increasing range of motion, strengthening muscles, and improving coordination. The neurological model saw functional independence as dependent on the integration of sensory input and sought to provide appropriate sensory stimulation. The psychoanalytic model saw independence emerging from the resolution of feelings and sought to encourage the expression of feelings through object manipulation (22).

Occupation was scaled down to match the kinesiological, neurological, or intrapsychic view of human nature. It became an opportunity for movement, stimulation, or emotion, but never all together as in a therapy that diverted the client's mind from the pain and dysfunction caused by disability to interest in life, and living, and livelihood through the creative processes of occupation. The image of joy projected by clients, who once again were able to do for themselves a very ordinary, taken-for-granted activity like writing a letter or completing a craftlike activity, became increasingly blurred. Skill training for self-care, work, and play was largely replaced by subskill training for objectives concerning factors such as eye-hand coordination, strength and endurance, and self-expression, and control. The weaving of everything together into a cohesive, synergistic whole resembling the fabric of day-to-day life was lost.

Thus, history reveals that the philosophical base guiding occupational therapy practice shifted from a holistic to a reductionistic orientation. Although reductionism continues to provide the dominant influence, there has been a growing awareness since the 1960s of the need to formulate a more adequate way of thinking about occupation and functional independence. Our old ways of thinking no longer fit
the facts. At the conceptual level, we have come to realize that theories dealing with fragmented aspects of human nature are inadequate for understanding a synergy such as occupation. Clinically, it has become all too apparent that the resumption of functional independence requires more than physical and mental restoration.

Although the current debate tends to center around the use of arts and crafts in treatment, the real controversy is more subtle than the use of arts and crafts. What is at issue is whether the problems experienced in daily living activities by disabled persons are best treated by a skills or a subskills approach. If the goal of treatment is to mainstream a disabled youngster, is treatment time best spent in practicing the skills needed to perform as a student, or in practicing the biological, psychological, or social subskills that are generic to activity?

In my opinion, the real solution does not lie in developing or using one approach to the exclusion of the other. The future solution lies in conceptualizing the conflicts between the two approaches as a constructive confrontation forecasting conceptual advancement. We are in need of a philosophical base that will allow us to synthesize the skill and subskill approaches.

The explanation we are searching for will allow us to understand the occupational nature of humans, dysfunctions in occupation, and remediation of those dysfunctions. Such a philosophy will interrelate the sensing, feeling, thinking, moving, and doing qualities of human nature. It will reunite the physical and psychosocial dimensions of occupation and explain the individual and environmental aspects of occupation. It will account for humans as explorers and builders of the environment as well as it does for humans as responders and reactors to the environment.

We sometimes conduct this search with the naïve hope that a new philosophy can be constructed by simply gathering together all the concepts that we have in our historical repertoire from our holistic and reductionistic belief systems. We are reluctant to acknowledge that a collection of concepts doesn’t make a philosophy any more than a heap of bricks makes a building. Science is a collection of concepts and facts that have been ordered and organized and tested for their compatibility.

The challenge of the 1980s is to sort through the conceptual tonnage that we have accumulated with the aim of organizing a philosophy of functional independence for disabled persons through occupation.

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