Occupational Therapy in France: An Historical Perspective

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Thanks

We'd like to thank all the people we've met along our professional paths, whether they've been cared for or accompanied, whether they're caregivers or students. They gave us the desire to write this book, to tell the story of occupational therapy in France, and to pass on what we have experienced, studied and analyzed: *doing, being, becoming, belonging* is what we wish for everyone.

We would also like to extend a special thanks to all those who reviewed our work, made suggestions and sharpened our thinking even further. Our thanks go to Laurent Bergès, Catherine Bourrellis, Mathilda Charret, Noémie Kauffmann-Luthringer and Éric Sorita for taking the time to make constructive suggestions. Other thanks go to our national association ANFE : Éric Trouvé, Catherine Laks and Nicolas Biard for believing in this project, and to Alisson Da Cruz Lima for her availability in document searches. We would also like to thank Amaury Derand, director of the De Boeck Supérieur editions for facilitating the publication process. Our warmest thanks also go to Henri-Jacques Stiker and Nicole Sève-Ferrieu, who gave us the gift of beautiful prefaces.

Forewords

Preface by Henri-Jacques Stiker

The history of occupational therapy that we are given to read here aims to place occupational therapy in the various social groupings in which it originated and developed. In this way - and this is the first original and relevant feature of the book - we do not simply follow the stages, postures and successive practices of a discipline, but are immediately and constantly in the history of the historical contexts relating to disability, which shape it and largely account for it.

This point of view justifies the authors' opening with a long chapter on the roots of occupational therapy in French history. Going back to Antiquity to the present day, through the great scans of historians, they borrow from many well-known works and references, but they prove their enormous and precise work of erudition and glean the elements that prepared the way for the emergence of this new therapeutic approach to disability, which can be dated to the early 20th century, even if the opening of specific schools and elaborate theories arose in the middle of the last century. In short, the book is a tool for general education on disability and its history, and even on history itself, through the prism of occupational therapy. The wealth of documentation and knowledge is impressive, as evidenced by the lengthy bibliographies that punctuate each of the book's main chapters.

These parts revolve around the notion of paradigm. Once the birth of occupational therapy is well established, we need to follow its evolution. The notion of paradigm is not so obvious. It's easy to say, for example, that the paradigm has changed. Most of the time, we don't know what we mean. The authors devote several pages to the subject. I myself reflected on this notion to differentiate it from that of references, models and theories, in the last chapter of my book on *Corps infirmes et sociétés (Crippled Bodies and Societies).* The paradigm is well defined by the authors, on pages 32 and following. I quote just one sentence: "Occupational therapy paradigms encompass not only theoretical aspects (concepts, values, models) but also practices (Kielhofner), theory and practice being closely linked". Indeed, the notion of paradigm refers to the use made of a theory or model; in other words, the success of a theory or practice, the fact that it becomes dominant, authorizes it to be considered as explanatory; it is a mode of explanation, or at least of representation, that is shared and widely used. The paradigm is not scientific in nature, but is accepted for its ability to explain.

The authors therefore develop three paradigms, corresponding to three major periods and developments in occupational therapy. The period between 1950 and 1980 can be characterized by the handicraft paradigm, while the second (1980-2000), given the conception of "the situation of disability" as the relationship between individual characteristics and an environment, is characterized by ecological activity. It's no longer just a question of acquiring the right gestures and assistive devices, but of situating oneself in a working and living environment. A third period and a third paradigm have emerged, which the authors call occupation (2000-2020), as a result of the changing demands of disabled people themselves, driven by a new social context. This word is undoubtedly influenced by the Anglo-Saxon term "*occupational therapy*", but it emphasizes, if I've understood correctly, the claim to be autonomous, to take charge, to be an actor - in short, everything that revolves around *empowerment.*

This paradigm is based on the bio-psycho-social model. The individual is determined by her/his bios, but only to a very limited extent in relation to everything that constitutes her/him as a psyche and as a social being. We're referring here to a whole series of works that demonstrate the complexity and systemicity of the situation of disability, including the highly relevant works from Quebec. In short, I would say that the craft activity that had evolved into situated work now demands to be perfectly assumed. The authors are well aware, of course, that the evolutionary process is not over. They mention ongoing research, for example on page 135. Without venturing a fourth paradigm, it's clear that they're on the lookout for it, and ready to conceptualize it when the time comes. I hope not to betray the authors' set-up, by summarizing in my own way the three paradigms that account for the recent history of occupational therapy.

I wanted to express my admiration for this work. A unique and groundbreaking work, it will be a reference work for practicing occupational therapists and, above all, for those in training or younger in the profession. I have learned a great deal from reading it, as will the many readers I hope will enjoy this important book. Not only does this work demonstrate a power of elaboration, erudition and historical sense, but it also provides, notably in its appendices, a wealth of information on the state of the art in France and internationally. To have such a work at hand is to acquire a valuable and effective working tool, first and foremost for those involved in occupational therapy, but far beyond that for all those who are sensitive to the issue of disability.

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Preface by Nicole Sève-Ferrieu

It's quite a feat to recount the evolution of thoughts and actions that highlight the evolution of the professional identity of French occupational therapy.

This historical development underlines both the slowness with which occupational therapy has emerged, and the speed with which it has matured. My occupational therapy diploma predates the publication of the first official program in 1971, and my professional career has involved me as much in the evolution of the profession (President of ANFE from 1980 to 1985) as in initial training (Director of ADERE OT school from 1988 to 2012) and continuing education (since 1985). Therefore, I know just how phenomenal the second half of this journey, spanning half a century, has been, and just how well the authors of this book have been able to grasp it and pass it on.

"Using work to care for people! Putting them back to work! You're not thinking about it! My family's opposition to my professional project on social and ethical grounds underlines the state of mind of part of the population at the end of the Second World War. My studies were medical. At Saint-Anne hospital, after passing through the many double-locked doors and passing sick women in slippers and long white shirts, twenty or so students conscientiously writing under dictation the contents of a large blue psychiatry book. In general medicine, they learn how to give injections, dispense medicines and pass the basin. They attend trauma surgeries. A doctor describes rheumatological diseases and the mechanisms of deformity. After each class, the question comes up: "So, what will you do with these patients when you become occupational therapists?.." Handicrafts, of course! Metalwork and carpentry are learned in boys' technical high schools; weaving with Marguerite Lemarchand, occupational therapist; porcelain painting, basketry and pottery[1] with craftsmen. Anatomy, biomechanics and physiology, subjects borrowed from masseur-physiotherapists, enable us to establish a link between activity and pathology. The link is special in that, for each "disease", we look for the ideal activity to treat it. It's our 3rd year, comprising 9 months of internships, that allows us to imagine what occupational therapy could be.

When I started working in an adult neurology rehabilitation department, three things struck me. I was employed as a physiotherapist and would be given tenure as such, as occupational therapy did not exist in the statutes of the Paris public assistance service. However, an "Ergothérapie" sign is displayed at the entrance to the department, which includes a lot of equipment (rattan, wool, clay, wood, metal, games, etc.), 2 rehabilitation rooms (with looms, a drawing table, a stand-up table, a bicycle saw, etc.), a fully-equipped kitchen, a carpentry workshop and a bathroom. Four colleagues work here. They are physiotherapists and do "gentle physiotherapy" because of their own lower back pain... Because they are caring, they teach me physiotherapy skills. I'm passionate enough to let them know that being active can be therapeutic. It wasn't long before the first "Diplômés d'État" (State Diplomas) from 1974 were appearing in the field.

Appointed Director of ADERE OT school by the French Ministry of Health in 1988, following in the footsteps of François Lecomte, himself an occupational therapist, and at a time when for

[1] Today, I'd talk about "metal", "wood", "rattan", "clay"... since it's the material and its transformation that interests the occupational therapist, not its purpose.

ten years occupational therapy schools were still officially run by doctors, I can testify to the metamorphosis in the training of occupational therapists.

We were adults at 21. Those years seemed interminable, so eager were we to take flight. And yet... On a human scale, with the first-degree program in 1971 and the "new" one in 1990, that's just about the time it took occupational therapy to move forward on three fronts. Firstly, it needed to draw on experience and exchanges in France, Europe and across the Atlantic to open up its thinking. Secondly, it had to free itself from the medical view that disability is the result of pathology. Finally, and at the same time, to integrate the environment into its conception of occupational therapy, to consider that it is "One", whether it is practiced in "functional" or "psychiatric" settings... and to adopt a decree of professional acts. We were emerging from adolescence.

Two more decades to reach maturity... Student selection and the form of the state diploma changed several times. Patient records were introduced. But it was the reengineering of occupational therapy training in 2010 that turned the profession upside down: the job and training guidelines became the framework for occupational therapists and institutes. Let's be clear: it's no longer a question of teaching methods, pathologies, or even the principles of re-education and rehabilitation... It's a question of training students to organize their knowledge and skills according to the models, acquire skills, learn about research[2] and obtain the title of Bachelor.

Occupational therapists put words to this identity by inscribing the profession in the sciences of human occupation.

Even if some of us are still witnesses of those bygone days, even if many occupational therapists have heard of those bygone years, students and professionals alike should be fascinated by this history of occupational therapy, whose rich bibliography and testimonials are exemplary.

It enables occupational therapists to discover where they come from, to take ownership of the stages in their maturation, and to understand the path that has led to their singular, contextualized professional identity.

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[2] Sève-Ferrieu "La transmission en question". Expériences en ergothérapie, 16e série, edited by MH. IZARD, Sauramps Médical, 2003

Introduction

1) A project for a distinct, contextualized professional identity for French occupational therapists

In most countries, the history of occupational therapy has been handed down from the adventure of American and then English *occupational therapy*. Indeed, English-speaking occupational therapists were the first to publish works on their origins: the relatively early universalization of their training often places them at the forefront of research and publications in our profession. Thus, to date, the history of occupational therapy in France has mainly been written in comparison with that of these English-speaking countries (Gable, 2008) However, despite our common origins - such as Pinel, the historical inspiration for occupational therapy in all countries, or the "*reconstruction aides"*, the very first American occupational therapists who came to France during the First World War - occupational therapy in our country is very specific to its context. Indeed, the profession had its official beginnings in a different period from the Anglo-Saxon countries, after the Second World War, and has evolved in a particular context that makes it quite singular and no longer derived from an Anglo-Saxon profession. The aim of this book is to shed light on the dynamics that have shaped French society, and the fields of health and disability, in order to identify how the idea of occupational therapy has taken root in France in its distinct form.

The need for a historical look at occupational therapy in France has been felt since the European congress *Ergo 2000* in Paris, whose theme was "Memory and Becoming". Indeed, research into the history of occupational therapy in France is not new. Yet the need to produce written accounts is all the more pressing now that the oral tradition passed down verbally and the memories of the profession's early days begin to fade with the passing of great pioneers, such as Jacqueline Roux-Lejeune and Paul Farcy. In recent years, therefore, the desire for a more comprehensive first book has materialized, with the collaboration of five occupational therapist authors with varied interests and profiles, particularly in terms of generation, region of origin and initial training.

This book not only serves as a work of memory and transmission but also provides a foundation for reflection on the construction of the professional identity of French occupational therapists. The aim is to bring together traces of our history at a time when memories are still vivid, and to problematize them in order to better perceive their complexity. Since the emergence of the profession, and with its development, the question of professional identity remains fundamental. This reading will show how, over the years, a coherent body of knowledge and skills has been developed, focusing on the link between human activity and health, in terms of risk assessment, treatment and prevention. It will therefore be of interest primarily to occupational therapists of all generations who would like a synthesis of the identity-related questions of the profession: how has the idea of considering different types of occupation as an approach, developed to promote health and quality of life in an inclusive and accessible society?

Moreover, occupational therapy, here as elsewhere, is rooted in a constantly evolving social and political context, which must be questioned. The history of occupational therapy and of occupational therapists should therefore be understood in connection with the evolution of medicine and allied health professions, as well as with health policies in a wider sense, the

development of scientific approaches, and the social and cultural environment. In this way, different members of the healthcare community will be able to find useful links to their own histories, as we have taken into account the interdisciplinary context of occupational therapy practices.

Dubar (2008) gives us a methodological lead through his definition of identity:

> "Identity is none other than the result, at once stable and provisional, individual and collective, subjective and objective, biographical and structural, of the various socialization processes that jointly construct individuals and define institutions." (p. 113)

It is in this spirit that this synthesis has been drawn up, to shed light on the evolution of occupational therapy in relation to the development of medicine, supported by a scientific approach, as well as our social, cultural and technological context. Our actions, thoughts and values are inspired by the civilization to which we belong, and are reflected in the organizations and institutions in which we practice.

2) The occupational therapist as part of a culture

A historical understanding of the profession must therefore be situated in the culture in which it emerged. Warnier draws on Tylor's 1871 definition of culture as "the complex totality which includes knowledge, beliefs, arts, laws, morals, custom, and every other ability or habit acquired by man as a member of society" (Warnier, 2007, p.5). Culture encompasses both beliefs (how individuals understand the world around them) and the practices, behaviors or attitudes guided by these beliefs.

When it comes to health, our culture shapes what is considered "healthy" or "ill", what should be treated and how. Indeed, the values and beliefs associated with illness and health are reflected in three components: the medical system, general population behavior and health policy (Elias in Lüschen *et al.,* 1995). Moreover, like the perception of health, disability is also a "product of its environment and social systems" (Ville et all., 2014, p. 11). Its representation is the result of thinking tied to a cultural context and a collective interpretation (Stiker, 1982; Gardou, 2014).

Thus, cultures and individuals are in a bidirectional relationship of co-definition, from which conceptions of health and disability are established. As a health actor in society, the occupational therapist interacts with these conceptions specific to our socio-cultural environment. They evolve in an environment with a particular vision that permeates their practice.

3) The methodology of this book

This book draws on a variety of sources: association newsletters and occupational therapy journals from 1961 to the present day, symposium proceedings, including the books published after the annual congress "Expériences en ergothérapie" in Montpellier from 1988 to 2019, dissertations and theses, various books and articles related to occupational therapy, all

interwoven with accounts of pioneers and the experience of former occupational therapists. These accounts, testimonies of professional lives, are unique, but this sociological approach makes it possible to identify collective phenomena that can provide a "segment of social-historical reality″ analyzed as a social object (Bertaux, 2010, p. 47).

We have sought to cross-reference different sources of information in an attempt to obtain as accurate and nuanced a picture as possible of the different periods we describe. But not all eras have seen the same quantity of written productions, and some have not reached us. The use of multiple sources was essential to avoid generalizing exceptional phenomena. Indeed, each source is limited in its ability to represent the history of occupational therapy. For example, articles in occupational therapy journals sometimes refer to rare practices that are not representative of common occupational therapy approaches in a given period. However, the publication of these articles highlights the value placed on these practices at a certain point in time and informs us about what was deemed worthy of interest. In this way, we have tried to put our information into perspective to better understand the realities of occupational therapy in different places and times. Another limitation, common to all scientific production, is of course the voluntary or involuntary selection of our sources according to what seemed most relevant to us. Aware of the limits of our research, this work is nourished by our many exchanges and critical reflections, throughout our collaboration over several years

Our aim was not only to bring together various key events in the profession, but also to problematize and give meaning to them (Bloch, 2018). On the one hand, to understand an event, we need to grasp its historical context (Morin, 1995) and avoid anachronistic judgments: particular occupational therapy practices made sense in their time, based on the needs and ways of thinking of that period. On the other hand, we sought to achieve a comprehensive view of the profession's evolution, to step back and identify the thread connecting the historical dynamics of occupational therapy. This distancing is not without interpretation, and carries the risk of leaving the imprint of a "political dimension" (Wirotius, 1999, p. 1). Indeed, the author points out that when members of a profession take an interest in its history and origins, the temptation is strong to glorify the past or instrumentalize it to defend the profession's contemporary interests. However, according to Wirotius, this historical research remains essential to establish a common professional identity.By shedding light on where we come from and making sense of our past, we can better understand and embrace our current commonalities and differences, and move forward together.

4) Presentation and organization of the book

In the first chapter, we examine the birth of rehabilitation at the roots of occupational therapy in France, before its official appearance after the Second World War. The second chapter explores the different schools of thought and ways of doing that have shaped occupational therapy since then. It provides an overview of the evolution of the profession and the directions it has taken over time. In particular, we describe three paradigms that structure historical periods based on key moments and dominant schools of thought at different times: from 1950 to 1980, from 1980 to 2000 and from 2000 to 2020. Three chapters explore each of these paradigms in turn.

Occupational therapy's roots in French history and the emergence of rehabilitation

We will first explore the historical roots of the profession, and examine the origins of the idea of having a sick person engage in a specific activity, either for recovery or for prophylactic purposes. This involves understanding what led to the emergence of our profession and the foundations that supported its development. The use of activity in therapy is as old as mankind itself (Dunton, 1918; Pierquin, 1980; Wirotius, 1999), but events that repeat throughout history do not always hold the same meaning over time or across different cultures. For Bachelard (1938), "all knowledge is an answer to a question" (p. 16), yet similar knowledge and practices may answer different questions in different eras. For instance, from antiquity to the 18th century, there are accounts of connections made between activity and health. However, drawing a clear link to rehabilitation and occupational therapy is challenging, as the development of knowledge during these periods is quite distant from current sciences and the valued ways of knowing nowadays.

From the end of the 18th century onwards, however, we find works that more directly influenced contemporary occupational therapy. Notably Tissot (1780) described activities that helped soldiers regain their health. Similarly, the writings of Pinel in psychiatry (1801, 1809) are still frequently referenced by many occupational therapists, including the founders of *occupational therapy* in the United States (Dunton, 1919) and the psychiatrist Levi Bianchini (1904), who coined the term "ergotherapy."

Later, the two world wars disrupted the established order and accelerated experimentation and progress in the treatment of war injuries. The goal was to rehabilitate soldiers so they could either return to the front lines or reintegrate the labour force once the war was over. It was after World War II, during the "Trente Glorieuses" period, marked by strong economic growth and technological advancements in daily life, that re-education and rehabilitation began to develop in France, as in many other countries. The arrival in France of *occupational therapists* from the United States and the United Kingdom convinced French doctors to establish training programs, and to help the occupational therapy profession to take shape. The first two OT schools opened in Paris and Nancy in 1954. The French National Association of Occupational Therapists (ANFE) was founded in 1961 thanks to Roux-Lejeune, and became part of the World Federation of Occupational Therapists (WFOT) in 1964. Finally, in 1970, the official State Diploma in Occupational Therapy was created.

The first chapter of our book focuses on the practices and knowledge that influenced the emergence of occupational therapy in France.

Occupational therapy paradigms in France

Secondly, we will examine how occupational therapy has evolved in terms of its representations and core values. Indeed, all practice is based on beliefs and knowledge that are more or less valued depending on the era. What occupational therapists consider to be "best practices" has evolved as the profession has addressed different societal issues, with different aspects or concepts considered as central to occupational therapy. Our aim is therefore to explore the different concepts and theories, i.e. different perspectives and articulations of knowledge, that have been valued and influential, shaping occupational therapy practice over time.

For this purpose, we will use the notion of paradigm. A paradigm can be defined as a synthesis of values common to a profession that guides its practice (Kielhofner, 2009). We will describe three main paradigms that have shaped the history of occupational therapy in France. We will use a a framework inspired by Kielhofner's work (2009), describing the history of American occupational therapists. In the United States context, Kielhofner identified three successive paradigms: the occupation paradigm, the mechanistic paradigm and the "return to occupation". These paradigms differ from those that have shaped occupational therapy in France.

Here, we provide a brief overview of the paradigms in American occupational therapy history, as they serve as useful examples.

The first American paradigm spanned from the early 20th century to the post-World War II period in the United States. According to Kielhofner (2009), this paradigm emphasized key values such as the human need for occupation, the therapeutic nature of occupations and the inextricable link between body and mind.

With the rehabilitation movement, the profession then shifted to the mechanistic paradigm (Mosey, 1071). Aligned with the medical model of the time, American occupational therapists viewed disability as a direct consequence of the patient's impairments in a linear manner. They therefore focused on restoring patients' motor or mental functions to reduce or eliminate disability. Assistive devices and environmental modifications were also used to compensate for any remaining limitations.

Starting in the 1960s, authors such as Mary Reilly and her students—Shannon, Burke, and Kielhofner—called on occupational therapists to "return" to occupation and "occupation-based" practices (Kielhofner, 2009). Gradually, American occupational therapists developed models of practice and methods to ensure that occupations became not only the goal, but also the means of intervention. They also advocated a person-centred approach, recognizing individuals as experts in their own disabilities (Schwartz, 2013).

In France, however, the profession's history does not simply mirror that of the United States, and our paradigms differ. However, it is important to note that the paradigms defined by Kielhofner have been very influential in historical research on occupational therapy in many countries. His framework has provided a widely used reference for understanding and explaining the profession's evolution. As such, these paradigms and perspective shound not be overlooked, as they offer valuable insights. Nevertheless, the historical context in which French occupational therapists have evolved is different, albeit interrelated. As we will see, this context has shaped not only how we understand the development of occupational therapy in France but also how we approach historical research in this book.

The second chapter thus draws on Kielhofner's description of American paradigms as a framework, but focuses on the singularities of occupational therapy development in France in terms of content.

From the 50s to the present day

The next three chapters continue exploring the three paradigms. Each chapter highlights the most influential societal and contextual factors shaping occupational therapists' thinking and practice during each period. We address themes such as the place of health and how disability was considered in society, the job market for occupational therapists themselves and for people

with disabilities, the place of activities in occupational therapy practice, and the development of assistive technologies and environmental adaptations.

Our approach is contextualized for each paradigm. For example, each era has its own language, we strive to remain faithful to the terminology of the time, even if certain terms are no longer in use today. Furthermore, we focus on the most prominent issues and events in each paradigm. By doing so, we illustrate how each period constitutes a distinct paradigm for occupational therapists and how transitions from one paradigm to the next build upon previous paradigms.

This first book on the history of French occupational therapy will not be exhaustive, but we hope it will inspire a desire to better understand where we come from, and encourage further research. Beyond reflecting on the path that has been taken, we aim for this book to be relevant to both current and future French occupational therapists by shedding light on where we stand today, where we are headed, and why. A strong, recognized and asserted professional identity enhances the impact and uniqueness of occupational therapy interventions, ensuring that everyone can participate in meaningful activities. In other words, such a well-defined professional identity strengthens the transformative potential of occupational therapy within French society.

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Chapter 1 Occupational therapy's roots in French history: what happened in the field of disability support before occupational therapists became involved as a profession?

As far back as human societies have been studied, the sciences have reported facts showing strategies used to avoid pain, illness and disability. These elements can be observed through the prism of the means of action on the individual himself, with the history of medicine, but also in relation to the human activities of each era and the social organization that constitutes a major part of the environment, which questions the notion of disability. A look at these different aspects will help contextualize the facts that led to occupational therapy. The emergence of occupational therapy is part of an evolution in society and in people's idea of health, which took shape with the establishment of the first two French schools in 1954.

More specifically, **occupational therapy is linked to the dynamics of re-education, readaptation, reintegration and rehabilitation**. Historically, these terms have often been used without a clear distinctive typology being established. The models of thought that led to their emergence are little studied. Rehabilitation is the subject of a number of publications, with authors focusing on different factors in line with their scientific specialization. From the Human Sciences, Montes (1991) evokes the return to work of the maimed at the time of the Great War, a period for which Bertschy (2011) in his article highlights the end of the "useless in the world". Zygart (2016) offers an analysis of the different types of rehabilitation that took place at the time. Stiker (2013) discusses rehabilitation at a time when social support legislation was developing after the armistice of the Great War. Authors of physical and rehabilitation medicine, in their respective publications, refer rather to the formalization of their specialty, around the Second World War (Frattini 2008, Hamonet *et al.*2005, Wirotius, 1999). What synthesis can we offer?

Through the prism of occupational therapy, **we have chosen to link three viewpoints**: firstly, the curative viewpoint of medicine on acquired deficiencies and constitutive anomalies; secondly, on the "care of the sick or infirm" by society, whose players are professionalizing to become assistants to the doctor (caregivers and paramedics); and thirdly, on societal organization in the face of disability, when the individual attempts to resume his or her social roles that have been put on hold. The criteria selected for this summary put into perspective the interaction between the evolution of care and the relationship to health, the place of disability in society, the evolution of technologies that enable the use of assistive device, and the relationship to work. For example, the acquired disability of a warrior is not treated in the same way as a "birth deformity" (a term long in use), and the wound of a war leader receives more attention than that of an aide-de-camp.

From a methodological point of view, each care profession, in its quest for legitimacy, puts forward precursors who are said to have laid the foundations for current practices, and enabled the stratification of know-how and knowledge up to the contemporary outcome presented with all the criteria of modernity. Occupational therapists have not escaped this construction, which has significant limitations: choosing an author by highlighting his or her work without taking into account the controversies of the time, making his or her writing an immediate generality

when ideas take time to penetrate society and consensus is limited, presenting facts in a positive continuum when history is made up of doubts and questioning. These forms of anachronism distort discussions through a shifted analysis that fails to take context into account. For example, the writings of Philippe Pinel (1809) are sometimes taken as a reference, without taking account of this time lag, which is clearly demonstrated by the vocabulary of certain passages: "Recreational movement or strenuous work stops the insane ramblings of the insane, prevents congestions towards the head, makes circulation more uniform and prepares a tranquil sleep." (p. 239). It's one thing to claim an inspirational filiation; it's quite another to assemble scattered facts to conclude that one profession is superior to others in different approaches to care. The main limitation of this chapter is that it does not sufficiently develop certain aspects of the interaction between the factors selected with regard to all categories of users and the current medico-social division, which would require a specific book.

This chapter is structured around the following question for each era: how did the different resources of care and assistance in society come together to create a coherent whole for occupational therapy?

1) Hypotheses before paper trails ?

Our knowledge of prehistory is based on bone remains discovered on different continents, which enable us to identify the disabling pathologies of the time (Charlier, 2009, Thillaud, 2006) and even raise the question of surgical objectives, for example on a modified skull (Aoudia-Chouakri, 2009). As far as paleoanthropology is concerned, social organization suggests that subjects with mobility difficulties may have lived within their various social groups. Activities were certainly organized around survival, and the notion of work has only recently appeared. In terms of compensatory technologies, the question was not posed in these terms: each period of prehistory is named by archaeologists precisely according to the technologies used: the Paleolithic with the Stone Age, the Neolithic with the Polished Stone Age, etc. The creation of equipment is one of the signs of evolution, and each user creates the tools he or she can to best facilitate the significant activities of the time. According to Fajal (1972), the first leg prostheses could have been made from animal limbs whose skin could have served as an attachment (Fig. 1). His hypothesis is supported by animal teeth that have been found to have been used as dental prostheses. (Tillier, 2009).

Fig. 1 - Extract from A. Fajal's thesis: leg prosthesis.

Few articles deal with the place of disability in these societies, but we're sure that cross-disciplinary work will lead to new discoveries. However remote this period may be, it provides food for thought about the social organization of people with diminished abilities in relation to the group, and the importance of specific tools which, in the world of disability, form the concept of assistive device.

2) Disability in Antiquity: a medicine tinged with beliefs

The various scientific disciplines have done little to explore the subject of disability in relation to care and caregiving in the different civilizations of this period. Works from this period are rare, and it is difficult to measure their audience.

Excavations have unearthed **compensatory devices**. A prosthetic toe was found in the tomb of an Egyptian prince. It is considered to be the oldest prosthesis. (Finch, 2011) (Fig. 2). For wheelchairs, authors cite the oldest representation painted on a Chinese sarcophagus six centuries BC (Kamenetz, 1969). However, this representation does not describe the mode of use or the status of the user. The user could be a prince, pushed by servants, especially as carriageable environments must have been rare outside palaces. These devices were therefore more likely to be used by high society.

Fig. 2 - Cairo Museum: prosthetic toe

In **Roman and Greek societies**, such devices existed, even though medicine was practiced in a dynamic strongly tinged with an animistic representation of illnesses, injuries and treatments. Some great names emerged, such as Hippocrates (-460, -377), who proposed a method of clinical observation and ethical rules, or Galen (129-210), who relied on reason and experience, giving priority to anatomical observation. In retrospect, these figures are considered to have changed the face of medicine, in a world, let's not forget, that pre-dates the invention of printing and the organization of the dissemination of knowledge by universities, at a time when reading was progressively considered a prerequisite for learning medicine (Marganne, 2010).

The relationship with the divine also had an influence on congenital problems, since in Greece there was a practice of abandoning in a discreet place a newborn baby with a specific bodily defect. According to Stiker (2013), three main categories coexisted, with congenital deformity exposed on one side, mental illness hidden but not excluded on the other, and acquired disease and infirmity treated and cared for on the third. Deafness and blindness brought with them other reactions specific to these societies, for which the word handicap did not exist. The terms used included a privative prefix (of health strength, of physical ability) or terms referring to social consequences (poverty, dependence, rejection...). However, Collard (2010) points out that: "The prince or leader with an infirmity retains honor and renown, especially if his crippled condition is the result of particular bravery" (p. 7).

On the battlefield, the number and concentration of wounded led generals to be concerned with the fate of disabled soldiers, with the gradual emergence of health services in Roman armies (Jacob, 1993). Here, the relationship with the gods gave way to the intervention of caregivers. Wounded soldiers with after-effects may be taken in by high-ranking civil servants or host families, who provide for their needs. We can hypothesize that this dynamic constitutes a form of "family rehabilitation or reintegration" with a welcome, care and mutual aid, especially as "the crippled" could take part in the daily work of the hostel. In other words, this activity is a way of helping people to participate and maintain their abilities. It should be noted, however, that mutilating wounds, for lack of asepsis and surgical solutions, often lead to death (Micarelli, 2018).

With the social structuring of these civilizations, the analysis made here shows the importance of three elements: the subject's social status, a different attitude according to the conditions in which health difficulties arose, and the moderate importance of care, which at the time was not able to cure. We can assume that people with disabilities spontaneously used tools adapted to their needs, an adaptation that would be called assistive device today. It is also likely that, in those days, social participation - since there was no social exclusion apart from the cases mentioned - was encouraged to the extent of the individual's potential, since any contribution to the group was to be welcomed

3) The Middle Ages: Christian charity for the poor with underdeveloped medicine, organized and implemented by clerics

The majority of the population, the serfs and villains who represented 90% of the French, were very poor. They lived in the midst of conflicts, malnutrition and epidemics that characterized the sanitary state of this period, when hygiene, as we understand it today, did not exist.

Charity towards those unable to work is the major fact of this period reported in the sociology of Disability (Ville 2020), in a society that values work in humility (Ars caritativa). "The charitable generosity of the rich is transformed into the subsistence of the poor" (Stiker, 2013, p. 93), among whom are people with disabilities to support themselves. They can apply for public or church alms by registering on the matricula, nominative lists that appear in the parishes of large cities (Lanotte, 2000). According to Stiker (2013) segregation was not apparent because

> "The most natural thing was that there were malformations. It was more than tolerance: it was reality with which we dealt as best we could, without wanting so much to change it through various techniques and treatments, without wanting to exclude it either." (p.83)

Names such as Queen Arégonde (516-474), who suffered from poliomyelitis, and Berthe au grand pied (720-783) named from her club foot, who gave birth to Charlemagne, illustrate this integration at the highest level. This "natural integration" removes the need for rehabilitation/reinsertion.

However, a number of people have **little capacity for begging** (Queruel, 2010). Plays tell of cripples being robbed after collecting alms (idem). At the same time, from the fourth century onwards, houses of hospitality appeared to welcome the poor, pilgrims and the sick. These gradually gave way to "Hostels Dieu". The crippled, who by their very nature could not be treated, were not always welcome (Le Blevec, 2010).

For historians **of technology** (Edgerton, 2013), evolution in this period remains sketchy, despite castles requiring methods and techniques for their construction. There is a long-time lag between the invention of a tool and its widespread use in society. Compensatory equipment appears in the form of crutches and wooden legs depicted in scenes of charity in period paintings, such as those by Bruegel in the transition period between the Middle Ages and the Renaissance. "Carts" for transporting the infirm are mentioned, but are rare and costly (Queruel, 2010). Buchet cites a prosthetic device from the seventh century "in the form of a double-pointed iron fork attached to the forearm by two leather straps" (Buchet *et al.*, 2009).

A Dominican dignitary's bezicles can also be seen in Tommaso da Modena's 1352 painting (Fig.3). Copyist monks had long used "reading stones" to compensate for the myopia that hindered their work. It was in these places of erudition and transmission of knowledge, including medical knowledge, that the ancestors of eyeglasses appeared in Italy, and were developed after the advent of printing in the 16th century. Technology was at the service of the nobility and the clergy, but the concept of assistive device did not exist: these were tools designed by users to facilitate their activity, in line with the preceding periods.

Fig. 3: Hugues de Saint-Cher, painted by Tommaso da Modena

The development of **medical and surgical** tools was limited by the small number of doctors and by religious prohibitions. Treatments could be spiritual, but also rational (bloodletting,

purging, diet, cupping) (Giraud, 2009), as well as remedies based on knowledge of simples, the name given to health-promoting plants. Although dissection was forbidden, anatomy was necessarily learned in the open by a few surgeons on the battlefields, as witnessed by the accounts of Guillaume de Saint-Pathus quoted by Queruel (2010).

The end of the Middle Ages paved the way for the Renaissance. The first medicalization of society can be seen in the advent of the first French university in Montpellier (1289), and later in the birth of the printing press, which disseminated medical knowledge outside monasteries (Nicoud, 2011). Tools for practicing medicine were developed and transcribed into treatises. Science gradually freed itself from the Church, whose charitable dynamic became difficult. Charity for all was called into question by increasing poverty and epidemics such as the Black Death of 1347 to 1348 (Ville *et al*., 2020). A distinction appeared between the good and the bad poor, those who had retained the ability to fight or harvest and those who had not. The infirm could be housed in hospices and leper-houses, along with the elderly, widows and orphaned children (Ville *et al*., 2020). Charity offices and a police force for the poor organized assistance in a kingdom that tended towards a new organization during the Renaissance: the "Grand renfermement" described by Foucault (1972).

As a result, this period is better documented with books and excavations that give us a better understanding of life at the time. The feudal order was organized around religion, with the majority of the population being very poor and receiving charity when they couldn't earn their bread by working. The social norm was for the rich to provide for them.

Medicine was underdeveloped due to a lack of doctors and books locked away in monasteries, with the idea fostered by the Catholic religion that a health problem could be the manifestation of a fault committed.

4) The early modern era, from the Renaissance to the Enlightenment

The Renaissance saw the gradual establishment of a new social order based on work and the prohibition of begging (Ville *et al*., 2020). Prison and forced labor were required for those who "didn't want" to work, and the general hospital (Royal Edict of 1656) was reserved for those who "couldn't" work... with the same underlying idea that they could be productive all the same, for example on the farms adjoining the hospitals.Thus began the period of the "Grand renfermement" (Foucault, 1972), when begging was reprehensible, whatever the reason: poverty, physical or mental inability to work. They became "useless to the world", having lost the social function that almsgiving once provided. Xénakis (2004) writes:

> "On May 14, 1657, at dawn, hundreds, thousands of women, men and children were taken by decree of the king, the "*Roi Soleil*", to the Hôpital Général Notre-Dame-de-la-Pitié, Bicêtre and La Salpêtrière. This was the great confinement. No one wanted to see the poor, no one wanted to see misery. The city and the whole country had to be cleaned up. We have to save the beggars from vice, idleness and impiety; we have to save them from crime and damnation" (p. 7-8).

The reigns of Henri III (1574-1589) and Henri IV (1589-1610) paid particular attention to one social group: soldiers no longer able to defend the kingdom (due to injury or old age). Louis XIV (1643-1715) had the sumptuous "*Hostel des Invalides*" built for them, for which they had

to pass an entrance examination assessing, among other things, their incapacity for service (Baillargeat, 1974). Within the framework of military discipline, they were encouraged to participate in troop life, and then to produce according to their potential in what would be considered under Louis XIV as one of the kingdom's most important factories (Bois, 1982). Studies have shown an increase in the life expectancy of these invalids compared to the rest of the population (Belmas 2018). A range of explanatory factors have been identified, such as better care and richer food (biomedical aspect). Other criteria point to an improvement through destigmatization in connection with an activity that maintains body and mind, provides for needs, works in a social space organized around a sense of belonging to a group (psycho-social aspect). Is this a first form of rehabilitation outside the family circle?

The medicine administered to these soldiers evolved, gradually moving away from a relationship with religion. Hypotheses and theories, however, were not entirely devoid of belief. Ambroise Paré, the emblematic figure of this period, replaced cauterization with ligature to treat "the wounds of harquebuses and other firebombs" (*Opera chirurgica*, 1594). He was able to draw on the work of anatomists such as Vesalius. Scholars also produced works on disease transmission (Fracastor), physiology (Fernel) and alchemy (Paracelsus). Knowledge was more widely disseminated thanks to the printing press. Knowledge was institutionalized within the Royal Academy of Sciences in Paris (1666) and the College of Surgeons (1667). The creation of Europe's first scientific periodical in Paris, "*le journal des sçavans*" in 1665, soon followed by others, spread knowledge. This dynamic permeated society beyond medicine, potentially paving the way for a greater role for education: people read to learn, which influenced the idea of educability for the entire population, including the infirm. This possible education movement lies between the curative medical approach and the social approach of benevolence.

In this paradigm of medical renewal, the invention of the microscope symbolizes both the creation of tools based on available technologies, and scientists' thirst to explore the living world through direct observation. The human body was seen as a machine whose workings needed to be understood. Science, arts and technology can intersect in the same workshops, such as that of Leonardo da Vinci, who published anatomy charts along with a number of means of facilitating human activity, such as gears. These have since found their way into the historiography of assistive device. Among the devices invented during this period is the wheelchair designed by Stephan Farffler (1633-1689), a clockmaker in Germany, which moves with a toothed wheel tricycle (Fig. 4). Similar gears appear on Grollier de Servière's wheelchair (1596-1689) (Grollier de Servière, p. 96, fig. 124).

Fig. 4 - Stephan Farffler tricycle

Literature relates the situation of Philip II of Spain, who, plagued by gout, had to be pushed on a wheelchair. It's worth noting that this mode of transport was the norm for sovereigns of the time, whether they had health problems or not. A description of an acoustic cornet can also be found in J. Leureuchon's "récréation mathématique" (1680)

In this mechanistic representation of human activity and bodily functioning, Ambroise Paré published his "iron hand" with gears and springs (Paré, p. 385): "Necessity has forced us to seek the means of imitating nature and making up for the defect of deprived limbs" (Paré, 1564, p.305) (Fig. 5).

Fig. 5 - Ambroise Paré : an iron fist

Historical research has unearthed the autobiography of "Exploits chevaleresques de Messire Goetz de Berlichingen à la main de fer" ("Chivalrous exploits of Messire Goetz of Berlichingen

with an iron hand"), who fought ardently with a prosthesis built by his craftsmen, before writing his memoirs, showing once again the importance of the soldiers' superior social group. (Delatre and Sallem, 2009)

Thus, in this period, the decline of ordered Christian charity, together with a new relationship to work, found, for example, in the Reformation (Luther, 1483-1546), led to the notion of people who could not work being "useless to the world" (Castel, 1997). This link with the importance of work was to be found in the first period of occupational therapy. In the eighteen's century, for example, the blind and deaf were grouped together in specific institutions (Ville *et al.*, 2020). In these places of hospitality, which are expansive for the State , participation in productive work was coercively sought by guards and monks. Did these activities also contribute to a form of effort retraining and skills development? We may hypothesize that this context, combining, on the one hand, a specialization of places by grouping together populations with similar symptoms in their relationship to work, and on the other, the need for monks and guards to organize productivity in the best possible way, enabled the observation of strategies and tools favoring production, and therefore the activity that underpins it.

Despite the harshness of the work and the harshness of the treatment, can we see this as a form of adaptation to work in institutions organized in monasteries, among other places, by those who also preserve the memory of science and care in their libraries? Once again, soldiers received special treatment, as part of the movement. They were grouped together at the "Hostel des Invalides". Archives show an improvement in living conditions and life expectancy compared to the general population. Among the factors that contributed to these results, some are worth mentioning for their contribution to occupational therapy thinking, such as the creation of on-site devices with prostheses, the organization of care in conjunction with that of a reputed factory[3] but also the carrying out of daily activities in the institution, which enabled exchanges between peers, the gradual opening up to society, outings and then marriages, leading to a destigmatization of the soldiers' social group, which had a poor reputation at the time.

5) From the Age of Enlightenment to the dawn of the twentieth century

The Age of Enlightenment, as its name suggests, is considered a period of great social and scientific progress. Syntheses, however, fail to take account of the debates, retaining only the salient facts, without making it possible to perceive their extent or their penetration into different social groups. For example, Ramazzini's first book on occupational illnesses, written in 1713 and considered a benchmark for occupational medicine and ergonomics, was not translated into French until sixty years later, and only made sense to insiders a century later (Patissier, 1822).

The sociology of disability focuses on the education of deaf and blind people, under the impetus of precursors such as Abbé de l'Épée, who created a school for the deaf and dumb, and Valentin Haüy, who opened what was to become the Institut national des jeunes aveugles (INJA) (Ville

[3] Lors d'une visite à la manufacture royale, Louis XIV est impressionné par les productions et commande un livre resté à la postérité https://lafabriquedeparis.blogspot.com/2012/12/les-manufactures-des-invalides.html

et al., 2020). They were not the first, notably Diderot with his letter to the blind (1749), and Rodrigues Pereire who did the same for the deaf in 1746 (Ville *et al*., 2020). However, their actions continued thereafter. De l'Épée and Haüy catered for the poorer sections of society, while others could request home tutors. In both cases, a personal fortune provided a modicum of support for their institution, which, by dint of communication, received some backing. Their work involved very few pupils during their lifetime. Both were also very close to the Church. The Abbé de l'Epée through his vocation and Haüy through his brother, making it likely that, despite the Enlightenment and the Revolution, the notion of Christian charity persisted in their schools. In Haüy's case, the relationship with work is clear, since the institution was even called the "Institut national des aveugles travailleurs" from 1800 to 1815. In terms of method, both report that they drew inspiration from what they observed by bringing together pupils with the same difficulties in one place, and are considered great pedagogues, later paving the way for special education (Button, cited by Ville *et al*., 2020).

These dynamics are embodied in the "reason of the Enlightenment", a model of thought that values experience in order to produce new knowledge. "It enables us to know and master the world, it initiates progress, and education is the way to access it" (Ville *et al*., 2020, p34.). Educability emerges with its corollary: the distinction between bodily elements and abilities, the latter being sensitive to specific pedagogies.

Among the populations that became educable, did the insane and invalid soldiers, who rarely appear in the social history of disability, experience a similar dynamic? The work and activities described by Pinel, who freed the insane from their chains (1806), and the activities and exercises proposed by Tissot (1780), a military surgeon, were landmark works, both for psychiatry and for motor rehabilitation. The methods oscillated between forced labor in closed institutions and activities that showed favorable results on "alienation" and "infirmities". A few quotations, even when taken out of the context of the very harsh life of the time and the gap between the author's account and the reality on the ground evoked by Pinel (quoted by Postel, 1981), suggest the use of activities:

> "One day, deafened by the tumultuous cries and extravagant acts of a lunatic, he was given a job in the country that suited his tastes, and from then on I talked with him without observing any disturbance or confusion in his ideas". (Pinel, 1809, p. 240).

> "Nothing is more ordinary than the healings wrought by this active life, while the alienation of the nbles who would blush at the work of their hands is almost always incurable." (Pinel, 1809, p. 241-242)

Tissot, a military surgeon, lists some twenty examples, including "a thousand other games, occupations or trades" for "the upper extremities of soldiers", such as the action of "sewing, sweeping, turning a crank, filing, digging earth, drawing water from a well, climbing trees..." (Tissot, 1780, p. 6). In a lesser-known work on the passions of the soul, Tissot writes about the links between the biological and the psycho-social, about the influence of passion on the "*machine*" (the correct term, showing the mechanistic conception of human functioning):

> "Such is the close dependence that exists between the physical and moral aspects of man, that skillful hands can use the former to help the latter, and the latter to help the former, and that everything sometimes depends on the use and combinations that a wise and learned practitioner can make of the two for the healing or preservation of man". (Tissot, 1782, p. 4).

The historical context is a harsh life, food shortages, forced labor for some, etc., yet these writings show an analysis of activities to adapt them for therapeutic purposes, and insist on both the motor and psychological meaning of activity design. The terms "re-education" and "rehabilitation" do not appear, but "educability" is referred to.

Education shows its limits, for example with Victor, the wild child from Aveyron, found in the wild at the age of nine and classified by Pinel as an "ineducable idiot" (Ville *et al*., 2020). Abbé Sicard, successor to Abbé de l'Épée, entrusted him to Jean Itard, considered one of the great pedagogues of the time. Itard published encouraging results before giving up after five years, without having succeeded in teaching the child to speak.

Is there an educational continuum common to these different dynamics, between methods aimed at people who have no access to conventional communication from childhood, others with "deformities of thought" at birth or afterwards, and soldiers who can no longer serve due to advancing age or acquired disabilities? This is the hypothesis we will adopt, in line with the spirit of the Enlightenment, to evoke the breeding ground for rehabilitation on the one hand, and occupational therapy on the other.

At the same time, the medical approach was also present. Jean Itard, recruited by Abbé Sicard to the Institution Nationale des Sourds-Muets de Paris (INSMP), was also a military surgeon and a pupil of Pinel. His therapeutic attempts to cure deafness were later controversial as "the most painful, the most barbaric, the most absurd and the most useless treatments" (Ménière speaking of his predecessor Itard at the INSMP, in Légent, 2003).

Despite the fact that students from all over the world came to Paris, few doctors practiced in the countryside (Bourdelais, 2005). Until 1892, patients could call on a "health officer". This title was introduced in 1803, after an examination designed to control the practices of charlatans. Hospitals only existed in major cities. They had not yet become the preferred place for diagnosis and treatment, despite the reforms of 1838, which created asylums, and 1851, which allowed a degree of management autonomy and authorized the use of private establishments, since there were not enough hospitals to care for the poor. Care had to combat the scourges of the time, such as epidemics (cholera and smallpox, for example), in a context of famine and malnutrition, with wars still frequent, and new types of industrial accidents caused by progressive industrialization. Health care was still imbued with the beliefs of past centuries, and with techniques such as bloodletting. For a long time to come, these were still provided by nuns (Calbera, 2003). As demand for medical care grew, so did the number of new practices, including those practiced by charlatans, which the 1803 law was designed to combat. History records that medical research drew on the physical sciences and chemistry. It was also interested in anatomical and clinical data, and in what was going on inside the "human machine", which it was better able to explore with the invention of the stethoscope, for example.

Against this backdrop, the need arose for auxiliaries to take over from good medical practice and care for users, whether sick, infirm or poor, always somewhere between confinement and education. Care was no longer just an act of charity. The most famous of these was undoubtedly Jean-Baptiste Pussin, considered to be Pinel's great inspiration, and a key player in the "liberation of the insane" (Juchet and Postel, 1996). The *enfermeries* of the Middle Ages (places where the recalcitrant were locked up in monasteries) gradually left their mark on the people in charge of these places, who became nurses. Their history shows the gradual emergence of a need to train dedicated nuns in hospitals, asylums, charity offices, and all structures in which suffering was cared for. Among the practices that developed were massages, medical electricity,

baths still practiced today, and others such as radium treatments and fortifying wines, which have now disappeared.

These techniques are part of a dynamic of medical specialization, an increase in the demand for care, in a society traversed by various currents of thought, such as eugenics and hygienics (Ville *et al.*2020). Eugenics propagates the idea of the degeneracy of the human race, and therefore measures to remedy it. Hygienism aimed to combat the health problems associated with poverty, linked to rural exodus and industrialization: unsanitary water and air, promiscuity, etc., which could be found in fictionalized form in the writings of naturalists such as Honoré de Balzac and Émile Zola. At the same time, the idea of orthopedics developed to correct deformed bodies. From *orthos* (right) and *paideia* (meaning "education of children"), orthopedics was institutionalized at this time (although methods of straightening were described as early as Hippocrates), and was later extended to adults. The title of the reference work sounds like a synthesis of the elements presented: "L'orthopédie, ou l'art de prévenir et corriger dans les enfans les difformités du corps. Le tout par des moyens à la portée des peres & des meres & de toutes les personnes qui ont des enfans à élever" (Andry de Boisregard, 1741).

In this panorama, with the alienism of Pinel's successors, hygienism and orthopedics, sports and gymnastic practices grew in importance, as did cures. At the dawn of the twentieth century, for example, gymnastics was introduced in schools, first for boys, then several decades later for girls. “Swedish" gymnastics was offered to soldiers and "good society" in rooms with mechanical equipment that would inspire mechanotherapy, among other things for the wounded of the Great War (Privat and Belot, 1916).

This environment led forerunners like Desiré Magloire Bourneville (1840-1909) to make the most of these dynamics to serve a particular public, in this case children categorized as idiots. He applied a medical-pedagogical method in eponymous institutions. He supported staff and family training (Misès, preface by Gateaux-Mennecier, 1989), and worked with Maria Montessori, the author who would inspire occupational therapists.

From the nineteenth century onwards, the presence of doctors increased, while that of nuns gradually waned. Access to healthcare expanded, based on the generous ideas of the French Revolution, which were never implemented due to lack of funding and political consensus. States, including France, want a healthy population. One of the reasons for this is the competition between the great powers of Europe, who are always ready to go to war, which requires a strong population and a substantial national product. Olivier Faure (1984) quotes from the official gazette: "The health of workers, which is so closely linked to the normal development of production, requires that medical assistance be made available to everyone. (Tallon, J. O. 28.4.72, quoted in Faure, 1984, p. 602). "The medical service for the poor is the repair shop for the most important tool of all, human tools". (Monod, J.O. 5.6.1890, quoted in Faure, 1984, p. 602)

These two quotations express the changing relationship to work since the Middle Ages, and the importance of national wealth. Everything is done to ensure that workers, whether recruited from industry, craft stores or agriculture, can produce at their best. This is part of a naturally structured social organization. In farming, for example, the older members of the family leave the hard work to the younger ones, while children who can't produce as much as adults participate according to their potential. It's easy to see why people with a disability, whatever the cause, should be encouraged to take part in the effort. In the absence of social protection, which only began in the late 19th century, their survival was at stake. Their "participation" in the workplace meant minimizing deficiencies, organizing tasks to compensate for disabilities,

and finding tools to facilitate performance. At that time, tools had not yet been standardized; they were made by craftsmen, and today's museums show all the varieties that might have existed.

At the same time, in this era of industrialization, authors such as Louis René Villermé (1742-1863) were concerned about the consequences of work, not least for children. They initiated a public health movement based on surveys that would influence French legislation: "*ease, wealth, i.e. the circumstances in which they place those who enjoy them, are truly the first of all hygienic conditions.*" (Villermé, 1989, p.168)

Between the demand for care, including orthopaedic care, the organization of psychiatry, ongoing medical specialization, new techniques, the legacy of the great names in education, a society concerned with the health of its citizens, the idea that attention should be paid to the poor who are unable to earn a living by working, the emergence of training for medical auxiliaries... what is missing to federate these dynamics towards an identified rehabilitation?

6) From the *Belle Époque* to the rehabilitation of war wounded (end of XIX^{e}-beginning XX^{e})

The Belle Époque (1871-1914) is described as a period of effervescence on all fronts: scientific (Marie Curie's invention of radiography), architectural (the Eiffel Tower), literary (naturalism) and artistic (Art Nouveau). These phenomena should not obscure the fact that they mainly concerned the affluent middle classes in big cities. Life expectancy remained at 50, and rural dwellers continued to live on small, unmechanized farms, rented out to landlords for the poorest, while industrialization was encouraging a rural exodus. These societal changes led to the introduction of assistance for the most disadvantaged (Prost, 2014).

The welfare state was the subject of several laws, despite opposition from a large section of French society. The Revolution had set out the principle of the State's social debt to those unable to provide for themselves in the Declaration of Human Rights. The mutual aid societies of the 18th century founded a local or corporatist solidarity based on voluntary work. The State took the initiative to improve protection, for example with the law of 1893 concerning "the hygiene and safety of workers in industrial establishments". The same year saw the promotion of "free medical assistance" for "all sick French people deprived of resources". This was followed by the 1898 law covering work-related accidents, as well as the 1905 law on "assistance for the elderly, the infirm and the incurable" and the 1910 law on workers' and farmers' pensions.

This state-led approach was part of a growing public concern for health. It was at this time that the first International Nomenclature of Causes of Death was published under the aegis of Jacques Bertillon, which would become the ICD in its 6th revision after the Second World War (WHO's International Classification of Diseases). Consumption of care and remedies increases. Public health became increasingly important, with vaccination campaigns, for example. High society emphasized physical activities, which penetrated leisure time: those who lived off their income enjoyed all kinds of activities, from canoeing to tennis. Gymnasiums appeared in spa towns, some of them equipped with equipment common to rehabilitation at the time (Petitdant, 2014). In this pre-war period, there were very few works on the specific nature of rehabilitation after injury.

This extract satirizes a spa town: *Mont Oriol*, Guy de Maupassant, 1887, p. 192.

The engineer had collapsed into a rocking chair, and placed his legs in the movable-jointed wooden legs attached to the seat. His thighs, calves and ankles were strapped down so that he couldn't make any voluntary movements; then the man with the rolled-up sleeves grabbed the crank and turned it with all his might. At first, the armchair swayed like a hammock, then the legs suddenly took off, stretching and curving, going back and forth with extreme speed. He's running," said the doctor, who ordered, "*Slowly, go at a walk...*"

... Paul Brétigny, who was choking with laughter, pointed out that the riders weren't hot, while the crank turners were sweating. If you switched roles," he said, "wouldn't that be better? The doctor replied gravely, "*Oh not at all, my dear. You mustn't confuse exercise with fatigue. The movement of the man turning the wheel is bad, while the movement of the walker or the squire is excellent*".

It was in this context that an article entitled "*Ergothérapie et Psychothérapie*" by Marco Levi Bianchini (1904a) was published in French in "L'iconographie de la Salpêtrière". This journal, founded by leading figures in neurology at the time, appeared under the direction of the most famous of them all: Jean-Martin Charcot. The author, an Italian psychiatrist, describes the outlines and results of psychiatric care as practiced in his establishment. He promotes a form of care that combines medication, interviews and therapeutic activities, which he calls "*ergothérapie*", a term coined by Levi Bianchini according to one of his biographers (Salvatore, 1995). His article refers to Pinel and presents his method as an evolution of the *open door* and *no restraint*[4] (Bianchini, 1904a), introducing an activity whose purpose is to "direct [the] morbid psychic and motor mechanisms, reorganizing them on the side of a precise finality" (Salvatore, 1995 p. 138). He introduces the interest of "re-educating the insane to movement and thought" (ibidem) simultaneously, using the example of educational gymnastics administered to children with tuberculosis. He applied his method progressively, adapting it to each situation, even going so far as to mention the beneficiaries' previous occupations. His study shows a reduction in mortality and recidivism, as well as a greater number of hospital discharges and "the somatic and psychic well-being of the chronically insane". He describes the organization of the hospital and specifies that "the alienist must never feel authorized to 'exploit' the work of the insane" (Bianchini, 1904a), thus anticipating the excesses that could be observed after the Second World War.

Another article, "*Ergothérapie de l'épilepsie*" (Ergotherapy of epilepsy), was presented at the Italian Psychiatrists' Congress in October of the same year, and later in an Italian journal (Bianchini, 1904b). His writings are reported in numerous bibliographic reviews of psychiatric journals in the English-speaking world (Bodin, 2014), even before Susan E. Tracy's *Studies in Invalid Occupation* (1910), considered in the United States to be the first textbook on *occupational therapy.*

The word "*ergothérapie*" is used in several works, and quoted by W. Rush Dunton, who is considered the father of American *occupational therapy*. In 1917, along with four other

[4] According to Benedict August Morel (1860): *Open door*: a form of foster care practiced in England. *No restraint*: abolition of coercive means in psychiatric institutions.

prominent figures, Dunton founded the *National Society for the Promotion of Occupational Therapy* (Dunton, 1919), the world's first occupational therapy association. In 1919, he wrote:

> "Various names are given, such as occupation, diversion, diversional occupation, occupational diversion, occupation and amusement, employment, work cure, occupational therapy, and ergotherapy (work=ergon, therapeia= therapy). The last is probably the best, and certainly the most scientific term, but as yet has not come into sufficiently general use, and the more simple term occupation will probably be used for some time." (p. 43).

Yet the term “ergotherapy” is found in two American dictionaries of the period, even though *occupational therapy* does not appear (Bodin, 2014). Work for the purpose of care and the word ergotherapy exist in other articles from the Belle Époque, applied to other populations. For example, to explain occupational therapy, Marie and Voisin (1911) write: "Ergo therapy is the logical corollary of ergo pedagogy for abnormal psychic children" (p. 114). They insist on psychomotor and psychosensory association, to make "work pleasant by bringing it closer to sports recreation in prudent, gradual doses" (ibidem). In another example, on the subject of juvenile delinquents, Sciuti (1911) mentions "the universally recognized moral advantages of ergotherapy."

Even if there is no consensus on the use of the word ergotherapy, the benefits of this method are recognized for many populations. It is administered without clearly identifying, in relation to current classifications, what is in the domain of neurology and psychiatry for example, what is similar to motor education, and what can be associated with gymnastics for health, which can become medical, curative or preventive in the event of an identified disease. While occupational therapy is mentioned, occupational therapists are not identified.

At the time, the concept of disease and disability was still very much based on a mechanistic representation of health. The specialization of medicine continued, with certain practitioners focusing on specific organs whose damage was considered to render the patient crippled and unable to work. For example, Cesare Lumbroso, the famous Italian psychiatrist cited by Bianchini as one of his masters, studied the possible relationship between skull shape and delinquency (Gramaglia, 2004). However, the authors who speak of occupational therapy insist on the interaction of physical aspects with other factors, such as the psychological aspect, the influence of the environment through activity conditions and the social factors of populations. They are not the only ones, but this fact is noteworthy. In the medical field, biomedical representation remains in the majority, and influences the granting of pensions within the framework of the aforementioned laws: the sum allocated is calculated on the basis of the percentage of "organic loss" (impairment), without taking activity or environment into account.

The notion of compensation as we understand it today is not consensual. Charles Julliard, a physician, presented this "discovery" as "habituation" (Julliard, 1916). His work won an award at an International Congress of Occupational Medicine. In it, he describes the factors that influence this habituation, those linked to the injury, but also other personal factors (intelligence, for example), environmental factors such as legislation, and the subject's social conditions. He then goes on to describe thirty-four cases of "early" return to work thanks to rehabilitation focused on the exercise of the trade, and cites one hundred and thirty situations from his own practice or other works. To convince, he presents his method for evaluating situations, taking into account the above-mentioned factors, and quantifies the results obtained in terms of reducing annuities thanks to his method. A chapter categorizes beneficiaries' situations according to occupation, providing elements of analysis of professional activity. His

numerous case studies are supported by photos, including one showing the use of a strap needed to handle a scythe by a carpenter with amputations of the first three fingers... without, of course, emphasizing that this is an assistive device: the concept is not identified, although adaptations of equipment are mentioned. *"Accoutumance produces such marvellous things, that one is amazed to see workers doing certain jobs with crippled limbs*" (Julliard, 1916, p. 25).

Fig.6 - Strap for holding a scythe (Julliard, 1916, p. 214)

On the eve of the Great War, most of the factors likely to create rehabilitation were available in French society, whether for children, industrial accident victims, soldiers, psychiatry... less so for the elderly, as life expectancy barely exceeds 50 years. The authors cited (Bianchini, 1904, Julliard, 1916) all refer experiences in other countries, showing that published studies take into account other systems of care and policies towards people unable to support themselves. Through the work activity approach, the authors take into account the analysis of this activity and the factors influencing it, which can be grouped into two main groups: factors specific to the individual, whether related to pathology (incapacities) or abilities, and extrinsic environmental factors. The interaction between these different factors is highlighted to emphasize the importance of training and of a doctor's supervision of the progression of activities as part of a therapeutic dynamic. However, as with other techniques, there are no studies to give an idea of the penetration of this method in French society. This is the case, for example, for physiotherapy, for which an association was founded in 1904 (Monet, 2003), for speech therapy, for which a consultation and a course were set up in 1903 by André Castex, at Hôtel Dieu (Héral, 2007), for osteopathy, for which Andrew Stil created a school in 1892, and so on. Each method was promoted by doctors who made it a specialty and tried to develop it further.

7) The First World War and the inter-war period

The war was supposed to be short, but it lasted, and the belligerents had to deal with a number of unforeseen events. France had to deal with the occupation of a third of the country, devastated by bombs, and agriculture had no more hands to feed the country because they were on the battlefields, as did industry, including the arms industry. The new weapons disfigure not only the "broken faces" but also the limbs of the combatants. Medical advances increase survival rates. Previously, these same wounded would die on the battlefield. The State was overwhelmed by the demands for pensions from soldiers unable to support themselves or to go and help out in the rear. Every family, every village tries to find solutions to the famine that is gradually creeping in, leading to rationing. These solutions included child labor, replacing men with women in the fields and armaments factories (known as "*munitionnettes*"), as well as in essential jobs such as transport, education and health care. Foreign workers, including those from the colonies, were also called upon to hold a gun or a tool.

It was against this backdrop that Édouard Herriot, mayor of Lyon, published an appeal in one of the major daily newspapers for the creation of vocational re-education schools (Herriot, 1914). He is regarded as the initiator of a movement that led, in June 1916, to the establishment of one hundred and twenty-two "re-education schools and centers". Numerous works have been published on what happens in these re-education schools, including the writings of W. R. Dunton in the United States. For these authors, from the world of politics, business and medicine, these schools responded to some or all of the issues mentioned above. A synthesis was published in 1917, under the auspices of the head of the army health service, focusing on

the health of wounded and crippled soldiers. Most of the authors discovered the benefits of therapeutic activity and referred to the experiences reported by the precursors. "*In any case, it was simply a matter of applying an idea that had already been implemented to exceptional circumstances*" (Herriot, 1914). The word "rehabilitation" is increasingly used to describe this method (Zygart, 2016), which, according to authors of this era, is administered earlier and earlier after the acute phase (Bodin, 2015).

The rehabilitation dynamic of the time underpinned several concurrent projects: a means of recovering from injuries, developing compensation for activities, giving new meaning to the lives of people weary of war, its horrors, its immobility in the trenches and the immobility caused by treatment... and ultimately preparing their return to life in their villages and families. It's worth remembering that most soldiers were artisans, workers and farmers, rooted in a life of toil that kept their hands busy at all hours of the day and year. Those at the front developed what is retrospectively called "trench art", fashioning works from bullets and shell barrels. They also spent their time writing famous "*poilus* letters", some of which describe the meaning they gave to these artistic activities (Petitgrew *et al.,* 2017). These letters show that they saw their families on rare furloughs and worried about their fields or workshop.

There are disparities in the application of these methods, but the consensus was published in 1917 as a recommendation by the authors of this rehabilitation, coordinated by Justin Godard in charge of the Army Health Service, and therefore of the Invalids Institute, which had already experimented with what can be considered a form of rehabilitation in 17th-century in France. The work was also translated into English for American counterparts preparing for war, with W. Rush Dunton (*Federal board for vocational education*, 1918) among the leading figures on the working groups.

The consensus can be presented along five main lines:

1- An assessment of the situation, which includes a psychological component, social elements on the previous situation, including occupation and family situation, as well as functional assessments: several authors have invented machines to better assess a subject's strength, endurance (fig. 7) and skills for a given occupation. This can be understood as a focus on disabilities, but also on the positive side of abilities.

Fig. 7 Dr CAMUS's ergograph dynamo for measuring hand flexion force. Galtier Boissière 1917 p 87

2- The development of prostheses with tools which, according to their inventors, can replace grips of all kinds. Assessment is therefore also situational, analyzing behavior in the face of the work to be done, with or without adapted tools, and in inter-relations with the workshop group.

3- Care organized around functional recovery, but also with the development of compensations and motivation through productive activities. "It is this voluntary influx which, better than electricity, heat or vibrations, remains the specific, adequate stimulus which, by its intensity and frequency of action, above all hastens the return of reduced or abolished motility". (Camus, 1917, p16). Some doctors are campaigning for activities to be carried out as soon as possible after the acute phase, even in bed (fig. 8).

Fig. 8 - Rehabilitation in bed Camus,1918 p131

4- The creation of specific equipment which is now part of the ISO classification of assistive devices recognized by the WHO (World Health Organization). Some of them also concern everyday life (fig. 9).

Fig. 9 - Galtier Boissière fork knife 1917 p318

Others are in common use, such as using a wire stretched over two stakes to enable a blind soldier to line up rows of seeds. The mechanization of agriculture is cited as a factor that will enable the "crippled" to have sufficient yield in the fields to earn a living.

5- A systemic approach to the situation of the wounded that goes beyond the curative aspect to integrate other elements of the disability situation, as we emphasized in the assessment. The new-found morale, dignity and motivation of crippled soldiers who are once again able to earn a living.

Over and above the consensus, some authors praise this method, asserting the superiority of these doctor-prescribed work activities over other types of motor rehabilitation such as mechanotherapy. Privat (1916) speaks of the inadequacy of the latter, while Julliard (1917, p. 72) presents work as the best of active exercises. For Camus: "*It is now necessary to adopt a more complete approach, addressing sometimes the locomotor apparatus, sometimes the sensibility, sometimes the sensory functions, often the subject's psyche, awakening the motor images that are so important, stimulating his will*" (1917, p. 13). For some, mechanotherapy was reserved for bourgeois salons, with sessions too short to achieve the goal of a return to daily life, and involving the repetition of movements unrelated to daily activity on machines that were difficult to adjust correctly (Privat, 1916). Moreover, it was impossible to import mechanotherapy equipment from the leading manufacturer of the time (Zander), due to their high price and the fact that they were manufactured in enemy countries. Prof. Bergonié of Bordeaux, to whom we owe "passive ergotherapy" (Bodin, 2014b), publishes a study on the superiority of agricultural work. He writes: "*These general principles having been laid down, and agricultural work being one of the forms of cure, an outdoor ergotherapy, how have we organized it so that it is as effective as possible, i.e. that it gives, in the shortest possible time, the highest yield in cures*?" (Bergonié, 1917b, p. 436). It should be remembered that the word "*ergotherapie*" existed at this time, but was used by a number of authors with different meanings. No link has yet been established between these authors and the first French schools of occupational therapy after the Second World War. The rehabilitation dynamics described did not lead to the creation of any specific training to supervise these activities.

On the other hand, links have been established with American *occupational therapy.* Numerous writings show the links between their association, the first in the world, and similar dynamics in Canada and England. The authors highlight two social movements, the *Art and Craft Movement* and the *Settlement Movement,* at the end of the 19th century (Levine 1987). The former was an artistic movement nostalgic for the pre-industrial era, which denigrated the repetitive work of manual laborers in favor of that of craftsmen. The second had social ambitions for the impoverished, often immigrant, populations of the big cities in the age of industrialization, creating shelters in which activities were organized to improve know-how and manual education. In addition to this culture, two of the precursors, T.B. Kidner and W.R. Dunton, were involved in the development of rehabilitation and vocational re-education projects for American soldiers whose country was preparing to enter the war in 1917. A project was drawn up based on allied battlefield experience, including the French program presented in the above-mentioned reference work, translated into English under the title "*Physical and occupational re-education of the maimed"*. Some of these French authors are referenced by

Dunton and by other English-speaking authors publishing on the history of *occupational therapy*, notably Bourillon (médecin) (Dunton, 1919; Fridland 2007, p. 9) and Jules Amar (director of the research laboratory on occupational muscular work at the CNAM, Paris) (Fridland, 2007; Quiroga, 1995; Wilcock, 2001). J. Amar was made an honorary member of the American *Occupational Therapy* Association in 1918 (Creighton, 1992).

The American health service created a specific title for professionals caring for war wounded: "reconstruction aides". They were involved in mechanotherapy, electrotherapy and balneotherapy, as well as in the work that *occupational therapists* included in the history of occupational therapy in their country (Low 1992, Gutman 1995). A romanticized story recounts details of the everyday life of these professionals, the first occupational therapists, in the American camp in Rouen (France) (fig 10).

Fig. 10 - Reconstructing soldiers

What happened after the First World War? Historians of rehabilitation medicine (Wiriotius, 1999; Hamonet *et al.,* 2005) give no details of this period. They position the "real" birth of rehabilitation after the Second World War, which led to the creation of the Chair of Rehabilitation by Prof. André Grossiord (Frattini, 2008). Louis Pierquin and Andrée Roche, respectively medical director of the Nancy School of Occupational Therapy and occupational therapist in charge of training, considered that, with the progress of science and the occupational drift observed after the Second World War in certain institutions, what had been done before had not been achieved (1958).

In 1919, a law was passed to finance listed assistive devices. In 1922, the nursing diploma was created, institutionalizing the need to train medical assistants in five specialties: masseur nurse, hospital nurse, tuberculosis social hygiene visiting nurse, childhood social hygiene visiting nurse, and asylum nurse. Many of today's professions can find inspiration here.

In context, a worldwide crisis began in 1921, culminating in 1929. Many re-education institutions were closed. With manpower once again plentiful, it's possible that the least productive people were pushed out of the world of work.

After the legislation concerning relief for work accidents, the focus gradually shifted to professional reclassification and the prevention of occupational risks. In 1921, the *Fédération des Mutilés du Travail* (FMT) was created; in 1924, the law of April 26 required companies to recruit disabled war veterans; in 1929, the *Ligue pour l'Adaptation des Diminués Physiques au Travail* (LADAPT) was created. The law of May 14, 1930 gave work victims the right to free admission to vocational rehabilitation schools set up by the military. Then, in 1945, with the creation of Social Security, all employees could be insured against the consequences of illnesses and accidents unrelated to work but depriving them of their earning capacity (Direction de l'information légale et administrative, 2015). Disabled people or their families set up associations, foundations and charities that provide either strict care, or care combined with rehabilitation towards training or work. Among the best known are the *Association des paralysés de France* (APF), founded in 1933, and the *Fédération des établissements de réadaptation professionnelle et de leurs organismes gestionnaires* (FAGERH), founded in 1944. Gradually, the majority of people admitted to these establishments were no longer war veterans, but people suffering from tuberculosis or poliomyelitis.

8) The Second World War: diverting work towards destructive dynamics

The Second World War and its atrocities blurred the lines: "Arbeit Macht Frei" (work makes you free), the motto of Nazi extermination camps, and the STO (Service de Travail Obligatoire). Extermination included all Jews, but also left-wing activists, homosexuals and the disabled. Eugenic practices were implemented to ensure that bodies with no work possibilities were "put aside". In France, Alexis Carrel, surgeon, biologist, far-right activist and French eugenicist, campaigned for eugenics and the systematic killing of disabled children. All this raises many profound questions about our humanity and our relationship to work. How can we continue to conceive work as a social act in its finality (Laborit, 1985) when we reject its purpose? How can we accept correction camps and rehabilitation through work when we question what has happened and is happening in the USSR, Russia and China to millions of human beings (political opponents, homosexuals, discriminated populations)? These issues are part of global social policy, and the French are sensitive to them. In France, after the occupation of the country, the focus was on reconstruction. The social protection system, with the introduction of Social Security and wage increased, significantly cushioned the effects of the war.

In English-speaking countries, *occupational therapy* developed from experiments in psychiatry, and from *Reconstruction aides*, non-specialized medical auxiliaries implementing doctors' prescriptions from 1917 onwards. These auxiliaries gave rise to two main professions: *physiotherapists* (*masseurs kinésithérapeutes* in France since the creation of the diploma in 1946) and *occupational therapists*. *Occupational therapy* became institutionalized in North America and Great Britain, with publications and schools. It was professionals from these training courses who came ashore during the Second World War, mainly with the American health service.

The links between the birth of rehabilitation around the Great War, the development of *occupational therapy* in English-speaking countries, and the methods put in place after the Second World War with the birth of occupational therapy still deserve to be studied (fig. 11 to 14: example of a means of rehabilitating French and American soldiers during the Great War and image from the first book on occupational therapy in France in 1967). The dynamics of reconstruction after the Liberation, with its medical, social and legislative initiatives, and a technology that had evolved considerably, were to provide the right ingredients for the emergence of occupational therapy in France.

Fig. 11 - Pedal cutting saw: work for the lower limbs Galtier Boissière 1917 p 278

Fig. 12 - Rehabilitation saw from the American rehabilitation journal Mock H.E.1919 p14

Fig. 13 - Dumoulin, Précis d'ergothérapie, p. 105 and 104 (1967)

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Chapter 2 Concepts and paradigms in occupational therapy

The history of occupational therapy has been shaped by evolving paradigms, influenced by occupational therapists' practices and their broader contexts, including societal changes, technological and scientific advancements—particularly in medical and social sciences—and developments in other professions. In scientific disciplines, a paradigm encompasses various perspectives or points of views, established theories, and knowledge recognized and valued by the scientific community at a given time. These schools of thought and values are rooted in a specific time and societal context. They dominate the ways of thinking of a given period and determine the questions that scientists consider worthy of attention, as well as the 'appropriate' methods for addressing them (Kinsella, 2012; Kuhn, 1970). As an 'occupation' and later as a profession[5] , occupational therapy paradigms encompass not only theoretical aspects (concepts, values, models) but also practices (Kielhofner, 2009), with theory and practice being closely intertwined. Indeed, the shared values and beliefs of occupational therapists at any given time are reflected in the norms of practice and the emerging discourse.

1) What reflective and practical dynamics have shaped occupational therapy, allowing us to identify the successive paradigms of the profession today?

In the field of health, all practices are based on beliefs and a certain conceptualization of knowledge. For example, as we saw in the previous chapter, in the Middle Ages, medical knowledge and practices were based on religion. During the Renaissance, they were more rooted in the observation of nature in general. By the 19th century, medical knowledge became specialized, focusing on studying the elements of a problem in isolation (Castiglioni, 2019; Weisz, 2006). . We note that the value and acceptance of a form of knowledge, assumed to be superior to other types of knowledge, are strongly influenced by the social climate and power dynamics of a given era. Gradually, these ways of thinking are taken for granted and become consensual knowledge. Practices are based on this knowledge until it is called into question.

Similarly, occupational therapy has been influenced by various schools of thought. In the United States, Kielhofner (2009) proposes a definition of paradigm that applies particularly to the profession, incorporating both the dominant ideas in occupational therapy theory and practice. The notion of paradigm encompasses the "worldview" of occupational therapists, as well as the philosophies and theories of the profession that are found in frames of reference and

[5] We draw on Freidson's (1988)) distinction between occupation and profession. "According to Eliot Friedson, one of the key definingcharacteristics of any profession is the possession of legitimate, organized autonomy. He argues that, in the case of medicine, this autonomy derived from two core defining characteristics: prolonged and specialised training in a body of abstract knowledge and a service orientation. He argues that whilst medicine possesses all of the characteristics that define a profession, paraprofessional occupations are encouraged to take on these professional attributes. " Earle and Letherby, *The Sociology of Healthcare*, 247.

models of practice (Feaver et Creek, 1993). For occupational therapists, it is essential to understand the influence of dominant ideologies on their daily practice (Morel-Bracq, 2017). For instance, the study of previous paradigms enhances our understanding of the current one. Indeed, a new paradigm emerges in relation to the one that precedes it— either by integrating and evolving its theories and practices in novel ways, or by rejecting them to develop new, opposing theories and practices.

How did occupational therapists develop an original and relevant approach to the various scientific and societal trends of their time?

Kielhofner (2009) examines paradigms through three interelated aspects: 1) the societal issues or challenges that occupational therapy is believed to address; 2) what occupational therapists consider to be good practice, an effective approach to care, and why; and 3) what is considered to be at the core of the therapeutic objectives of every occupational therapist (Kielhofner, 2009). When determining whether a given period constitutes a paradigm retrospectively, it is essential not only to analyze what is happening within the profession but also to reflect on its connections to the broader societal context.

On the one hand, a paradigm involves a reflexive analysis among peers of what is, or has been considered "good practice" at a given time. We can observe the most common practices of a period and the justifications for them, exploring the reasons why the majority of occupational therapists deemed it effective to work in such a way. The standards of an era are also reflected in training curricula, which crystallize what is considered "good" or useful to teach new occupational therapists.

On the other hand, the paradigm situates occupational therapy within its historical and social context. It involves studying the social role of the profession and its status.We observe what grants legitimacy to occupational therapy at a given time: what purpose do occupational therapists serve, and what societal need do they meet? We also consider the influence of context on occupational therapy: how illness and disability are perceived, the scientific and technological advancements of the time, and the position of occupational therapy relative to other professions.

Paradigms are shaped by the specific era in which they emerge and, simultaneously, serve as markers of the passage of time. From a methodological point of view, paradigms can be studied retrospectively: occupational therapists analyze their past, and identify dominant schools of thought, which enables them to consider a particular period as corresponding to a specific paradigm.In so doing, they give meaning and make connections between the different occupational therapy practices that have come and gone. It is also possible to study the current paradigms of occupational therapy by considering the prevailing ways of thinking today, which allows for projections into the future of the profession.

The evolution of paradigms throughout history was first described by American *occupational therapists*, particularly by Kielhofner (2009) in relation to their own history. His work has influenced numerous authors who reference his findings (Bauerschmidt and Nelson, 2011; Dunne et al., 2018; Lohman and Peyton, 1997). . However, each country has its own unique trajectory shaped by cultural markers and socio-political structures. For instance, the development of occupational therapy in France is rooted in the distinctiveness of its history, particularly with the early roots of therapy through activities by Pinel, as well as being a site for the battlefields of the two world wars, which influenced the rehabilitation movement, and the country's welfare state model with social security. Thus, while there are similarities between

the history of French occupational therapy and the paradigms described by Kielhofner, as well as with the history of occupational therapy in England or Canada, our history is not a mere replication of that of American occupational therapists.

In this chapter, we will use an analytical framework inspired by Kielhofner (2009) in terms of structure and approach, although the content will, of course, be different. This framework will focus on the three points mentioned above: 1/ the societal needs met by occupational therapy, 2/ the practices valued, 3/ the central focus of the profession at different times in the history of occupational therapy.

The use of the plural "paradigms" invites us to consider, on the one hand, their succession throughout history and, on the other hand, to identify multiple schools of thought that coexist at a given moment. Not all conceptual models and practices are consensual. Paradigms emerge within debates from which we attempt to extract the key issues of each era. They present themselves as a synthesis, rather than a dogma that would have standardized all practices without contestation. Occupational therapists and occupational scientists tend to prefer and value the plurality of approaches (Feaver & Creek, 1993; Kinsella, 2012). . Paradigms reflect the dominant ways of thinking and practicing occupational therapy at a given time. Thus, paradigms are described in terms of historical, chronological and continuous periodsfor the purpose of simplification ; however, the evolution of the profession and these concepts and paradigms is a fluid process, not segmented or homogeneous across all of France (an event at a specific place and time may have repercussions much later and differently depending on the region).

In this chapter, we will briefly introduce three paradigms of occupational therapy in France. Each of these paradigms will be described in greater depth and contextualized in the three chapters that follow. The three paradigms outlined in this work center on the different occupational therapy training curicula published in the Journal Officiel (i.e., the French government's official publication of laws, decrees and regulations). Indeed, we have chosen to focus on the different training programs, as they represent a common foundation in France. Although interpreted differently in various locations based on local resources in training and field placements, the training curicula, designed by occupational therapists and approved by the Ministry of Health, constitute a form of national standardization of the profession. We thus consider these programs as representing the peak of a certain conceptualization of the profession at a given moment. A program establishes and crystallizes official ways of thinking and practicing occupational therapy. It is not seen as a break with the past, since it is based retrospectively on acquired experience. The development of the curricula is a lengthy process involving multiple ministries and depending on other professions as well. The occupational therapists contributing to such development are recognized by their peers and build on practices already recognized. The program represents what is considered important to pass on in the training of future generations. A new curriculum also gradually influences the practices of existing occupational therapists, through student internships. When it is deemed that the current curriculum no longer aligns with evolving occupational therapy practices and the broader societal context, a new and lengthy process begins in order to develop the next curriculum, based on what is considered "new practice", "better" than what was done before, or more up-to-date.

We describe an initial period spanning from the post-World War II era to the early 1980s, with the first national training programs in 1971 and 1972. The second period covers the 1980s to 2000, with the second curriculum published in 1990. Finally, the third period extends from the early 2000s to 2020, with the training program of 2010.

2) First paradigm: The benefits of craft activities

Several dates can be considered as the official birth of the occupational therapy profession in France. These include the creation of the first occupational therapy schools in Nancy and Paris in 1954 and the first mention of occupational therapists in an official government document. This document stated, "One occupational therapist for every twenty patients" in a "functional rehabilitation center" (Decree of September 29, 1953). Other key events include the creation of the French National Association of Occupational Therapists (ANFE) in 1961, and the establishment of the State diploma for occupational therapists in 1970. The first official training curriculum was introduced in 1971 (for the first year of training) and 1972 (for the second and third years of training). It is not necessarily about settling on a precise date as the official start of occupational therapy. However, we do recognize that these various events contributed to the emergence and institutionalization of occupational therapy in France. These events took place at the same time, in the aftermath of the Second World War. They are contemporaneous with what Wirotius (1999) describes as the creation of rehabilitation in France. This concomitance of key events leads us to consider this period as that of the beginnings of the profession of occupational therapist as we know it today in France.

Societal needs met by occupational therapists

The post-war period was one of economic development and reconstruction, with significantlabor force demands (Bantigny et al., 2015; Lejeune, 2015).. In this context, the return to work of "disabled people" is encouraged, particularly those injured at work (due to the intensification of industry), and those injured in road accidents(due to the increase in the number of private cars) (Charret, 2015; Méot, 2009) . Moreover, the first paradigm saw the beginning of the deinstitutionalization of chronically "disabled" people. Until the 1970s, these individuals were placed in specialized institutions where they were fully cared for over the long term, often isolated from society (Dal'Secco, 2019). However, a change in mentality began to take place with the 1975 law "in favor of disabled people", which encouraged their integration into mainstream environments (Direction de l'information légale et administrative, 2019). Thus, during this first paradigm, rehabilitation developed (Wirotius, 1999) and occupational therapists trained at the Nancy and Paris schools—both founded in 1954—responded to a societal need by facilitating access to or continued presence in mainstream environments for "disabled people", as well as supporting the return to work for those who were able. The first occupational therapists also worked with children, particularly those with cerebral palsy and sensory impairments (Decree no. 67-43 of January 2, 1967; Decree no. 70-1332 of December 16 1970). Finally, new therapeutic methods were also developed in psychiatry, such as institutional psychotherapy, which encouraged the use of activities in therapy (Oury & Depussé, 2003; Robcis, 2016; Tosquelles, 1967). Although within this paradigm, occupational therapy in mental health was practiced primarily by psychiatric nurses rather than by occupational therapists trained in the first OT schools (Chardron, 1983).

Valued practices

Within this paradigm, craft-based activities (e.g. weaving, basketry, pottery, woodworking and leatherworking (Donnadieu report, 1974)) were central to occupational therapy practice. Therefore, occupational therapists were trained to develop strong technical skills in these activities (1971 Curriculum). Craft activities were used to serve a biomedical goals, such as reducing physical impairments or addressing difficulties related to creativity, self-expression,

and social interaction (Pierquin et al., 1980; Pierquin & Roche, 1964). In this context, activity was used as a means to an end. In physical medicine, it was intended to distract the patient in a way that conceals analytical work on a specific function. The therapeutic objective was determined by the prescribing physician. The hierarchy of doctors was therefore important, since the biomedical objective and the prescription legitimized occupational therapy practice, as well as the use of craft activities, which were often undervalued in the medical field (Pierquin et al., 1972).

Indeed, there was ambivalence towards craft-based activities, which were sometimes claimed as unique to occupational therapy, but which could also earn occupational therapists the jeers of other professionals (Charret, 2016). Biomedical objectives could also be called into question. For example, early occupational therapists mentioned other, vaguer but less biomedical objectives of their practice: "getting people moving again", "finding out how to palliate a reality that isn't working well", "repairing shattered lives", "helping people organize their lives", "getting the person to talk" (Charret, 2016).

During these two decades, occupational therapy was primarily practiced in workshops within institutions (Pierquin and Roche, 1964; training program, 1971) and was typically conducted as group therapy (Clavé, 1974; Pierquin and Roche, 1964; 1971 program) . Occupational therapists also manufactured assistive devices and adapted material for rehabilitation (e.g. games used in therapy) and for patients' daily lives Charret, "Les "bricolo-thérapeutes" en action".

Key concepts

In this first paradigm, occupational therapists showed little interest in developing theories specific to their practice (Charret, 2016). In fact, the "theoretical" knowledge used was borrowed from other disciplines. On the one hand, during their training, occupational therapists integrated medical knowledge (anatomy, physiology, pathology, etc.), which was considered "theory," and had to connect it with the technical skills they acquired with manual activities. Thus, the therapists' reflection focused on identifying the most appropriate craft activity to reduce the targeted impairment or disability: this was sometimes referred to as the "handicap-work concordance principle" (Pierquin et al., 1980, p. 6). On the other hand, towards the end of the paradigm, publications began to appear in which occupational therapists linked their practice to psychiatric and psychotherapeutic theories such as those of Freud, but also the work of Winnicott (Bedos *et al*., 1974 ; Pelbois-Pibarot, 1979a, 1979b ; Pibarot, 1978) . It is important to note that, at this time, psychoanalytic theories and psychodynamic models were dominant among psychiatrists and occupational therapists in France. However, these theories were not adopted uniformly, and remained far removed from certain training and practice settings, which were more focused on functional rehabilitation, as in the Nancy region.

3) Second paradigm: Towards context-adapted activities, to live in one's environment

The second paradigm is characterized by a greater focus on people's environment in occupational therapy (Cheron and Soldano, 1990; Pelbois-Pibarot, 1982b, 1982a; Ruette and Allas, 1996; Simon and Pelissier, 1986) . This shift is due to a change in the approach to disability that began in the 1970s (Madiot et al., 2021). In fact, during this decade, we observe

the early stages of a transition towards what are known as "bio-psycho-social" models of disability, which recognize that disability results not only from the individual's impairments but also from the environment in which they live. For example, Hamonet, Magalhaes, de Jouvencel and Gagnon introduced the concept of the "situation of disability", suggesting that " disability lies at the intersection of medicine and anthropology, between the notion of pathology that causes disability and that of society, which creates situations of disability" (Hamonet *et al*., 2001 ; Morel-Bracq, 2009, p.42) . The adoption of these models and theories regarding disability in occupational therapy was be gradual and sometimes ambivalent or uneven across publications and practices (Blancher, 1991; De Tienda, 1984). Nevertheless, this marks the beginning of the second paradigm.

Societal needs met by occupational therapists

These two decades saw the repercussions of the 1973 oil crisis, particularly in terms of a restricted job market for both "disabled people" and occupational therapists themselves (Antonin, 2013; Boyer and Petit, 1984; Ecrement and Laidebeur, 2010) . Society began to reassess the importance of work, and the number of hours dedicated to leisure increased, especially in the 1970s and 1980s, continuing until the mid-1990s in France (Bickel et al., 2005; Pronovost, 2014). Additionally, medical advancements led to the survival of individuals with more severe and chronic disabilities, who were receiving occupational therapy treatments (Belio and Destaillats, 1993; Pawlak et al., 1989; Ruette and Allas, 1996; Simon and Pelissier, 1986) . As a result, occupational therapists no longer necessarily focused on helping patients return to or maintain employment, which had become less central in society at the time, particularly for individuals with more severe conditions. Instead, occupational therapy practices aimed at facilitating access to ordinary living environments.

During this paradigm, people with disabilities continued to transition out of long-term medical institutions (Dal'Secco, 2019); as a result, medical interventions, particularly those of occupational therapists, expanded beyond institutional walls, notably with the emergence of the first occupational therapists in private practice (Besson, 1990 ; Carlino, 1999 ; Dorso-Nolet *et al.*, 1992 ; Ruette and Allas, 1996 ; Sentilhes-Monkam, 2005) . On the one hand, hospital structures became less central to healthcare. Associations like the APF (Association des Paralysés de France) created home care services where occupational therapists were employed as early as the 1980s (Weymann & Gaurier, 2019). On the other hand, occupational therapists working in institutions extended their practice to patients' homes (Carlino, 1999; Ruette and Allas, 1996) .

Valued practices

In this paradigm, occupational therapists gradually adopted a bio-psycho-social approach to disability, viewing it as the intersection between the person's functional abilities and the limitations or opportunities of the environment. Occupational therapists' interventions therefore aimed at achieving a better match between these two factors. On the one hand, occupational therapists "sought to improve deficient functions, promote personality restructuring or develop residual abilities for the person's functional or relational adaptation" (1990 curriculum, p.26): in other words, they worked on impairments to enhance function and enable participation, which was later described as a "bottom-up" approach (Brown et Chien, 2010).focused on making the environment more accessible (Dorso-Nolet et al., 1992; 1990 curriculum; Decree No. 86-1195 of November 21, 1986).

During these two decades, occupational therapy practices became more formalized, with the growing use of assessments (Bourrellis, 2006 ; décret no 86-1195 du 21 novembre 1986).These assessments were often biomedical and borrowed from other professions, but occupational therapists' own assessments were also developed, particularly in connection with the growing focus on the environment and the person's situation (Dorso-Nolet et al., 1992).. Additionally, the 1990 curriculum called for more clinical reasoning and reflection from students (with written reports) and less emphasis on memorizing knowledge without analysis. This marked the beginning of a gradual shift toward a profession that documents its practices, as would later be seen in the occupational therapy patient records (ANAES, 2010).

In this paradigm, craft activities were still used, but they coexisted with playful, even sports-related, activities, as well as the use of emerging new technologies in society at the (Belheur, 1986; Bickel *et al.*, 2005 ; Bourrellis, 2006; Cheron and Soldano, 1990; Martin, 1995; Pawlak *et al*., 1989) . Occupational therapists became increasingly critical of the "double discourse" surrounding craft activities, which highlighted the playful and distracting aspect when addressing the patient but focused on achieving biomedical objectives when addressing medical professionals (Lang-Etienne, 1987; Pibarot, 1996) . In the previous paradigm, activities had to meet a biomedical objective while being attractive or entertaining for the patient. Whereas in this second paradigm, the activity must have meaning and be consistent with the patient's daily life; the meaning of the activity is a key factor in its effectiveness in therapy, beyond the patient's motivation (Pibarot, 1996).Finally, during this period, occupational therapists advocated for a personalized approach, laying the foundation for what would later become the person-centered approach (Cheron and Soldano, 1990)."

Key concepts

In the second paradigm, activity was not central to the definitions of occupational therapy. Instead, it was regarded as a tool, a therapeutic means or a support for the therapeutic relationship, rather than an end in itself (Cheron and Soldano, 1990; Pelbois-Pibarot, 1981, 1982a; Person, 1984, 1990). This was consistent with the 'bottom-up' approach we mentioned in the section on valued practices.

Nevertheless, the second paradigm saw the concepts of independence and autonomy gain prominence (Bourrellis, 2006). According to Detraz (1992, p.1) "The aim of occupational therapy is to help individuals with disabilities achieve or maintain the highest level of autonomy within their environment". Various articles from that period differentiated between autonomy and independence, but both were presented as important objectives in occupational therapy (Cheron and Soldano, 1990; De Tienda, 1984; Le Gall and Ruet, 1996; Pelbois-Pibarot, 1981; Schwarz, 1991; Turlan, 1997, 1998a, 1998b) .

Lastly, occupational therapists beganto take an interest in the theories underpinning their practices. On the one hand, they examined models that explain and theorize disability, such as the International Classification of Handicaps (Azéma, 1993; Blancher, 1991) and gradually adopted a bio-psycho-social approach. On the other hand, occupational therapists became increasingly curious about models specific to occupational therapy practice developed across the Atlantic, such as the Model of Human Occupation (Castelein and De Crits, 1990; Kielhofner and Burke, 1980; Ruet, 1993) or the Canadian Occupational Performance Measure (Canadian Association of Occupational Therapists, 1997; Law et al., 1996) , especially from the late 1990s onwards (Morel-Bracq, 1998).

4) Third paradigm: From activity to occupation

The third paradigm is characterized by the openness of French occupational therapists towards Europe and the practices, models, and research developed internationally, particularly through participation in conferences and congresses held in France and elsewhere. Occupational therapists became interested in the foundations of their practices and developed their own tools, thus engaging occupational therapy in a process of professionalization (Freidson, 1988).

Societal needs met by occupational therapists

In this third paradigm, society has aimedto be more inclusive of people with disabilities or health issues, recognizing their ability to make decisions for themselves and promoting their integration into "ordinary" environments (2002 law on patients' rights and the quality of the healthcare system, 2005 law on equal rights and opportunities, participation and citizenship for people with disabilities). The person-centred approach and the work of occupational therapists on environmental accessibility thus has become increasingly relevant (ANFE, 2000).

The French medical system embraced a neoliberal trend whereby health is no longer considered a common good, but rather an individual responsibility (Brissaud, 2021; Farias and Rudman, 2019; Pierru, 2008) . In this neoliberal trend, the healthcare system increasingly became a market "remotely controlled by the State" (Brissaud, 2021, p. 27), and healthcare costs have been passed on to users, who must be made "responsible" (Brissaud, 2021; Pierru, 2008) . This neoliberal trend was particularly evident in the laws introducing a logic of productivity in the medico-social environment (2007 Hospital Plan) and the concern to reduce costs with the development of prevention, outpatient services and the shortening of full-time care periods (2009 HPST law, 2016 law for the modernization of the healthcare system). Occupational therapists' practices have had to align with the healthcare system; for example, they engaged in patient education (2010 program) and the field of prevention (Morel-Bracq, 2019; Morel-Bracq *et al.*, 2019 ; Soum-Pouyalet, 2019) . However, occupational therapists have also been critical of the neoliberal shift and the individualistic approach to health: we have seen the emergence of political and social occupational therapy (Guihard, 2001; Lorand and Morel-Bracq, 2020; Trouvé *et al.*, 2019 ; van Bruggen, 2015) . That is, the profession gradually moved towards action that goes beyond individuals to address the societal environment and combat occupational injustices at the community level.

Valued practices

In this latest paradigm, the "formalization" of practices (Bourrellis, 2006, p. 38) continued with tools such as the occupational therapy patient record in 2001 (Orvoine, 2001) or the occupational therapy diagnosis (Dubois et al., 2017). Occupational therapists began to base their practices on theories and research specific to the profession. On the one hand, there has been an interest in conceptual models (Billiaux, 2016; Morel-Bracq, 2004, 2009, 2017) , although their adoption in practice has remained uneven. On the other hand, 2004 onwards, occupational therapists' interest in research became more concrete with the introduction of a research initiation thesis as part of the requirements for obtaining the State diploma. This initiation aimed at developing a reflexive and research-based practice (Jacques & Morel-Bracq, 2003). Additionally, an increasing number of occupational therapists pursued post-graduate education, such as master's and doctoral degrees, following their State diploma, which is equivalent to a bachelor's degree.

In line with the previous paradigm, occupational therapists have recognized the bio-psycho-social causes of disability. Therefore, they have not solely focused on reducing individuals' impairments but have also considered their physical and social environments (e.g., family) (Destaillats & Sorita, 2001). They have taken into account the person within their daily life context (Coumeff, 2006; Larricq, 2020; Saragoni *et al*., 2018) and have aimed for integration into "ordinary" environments. For example, occupational therapists working in psychiatry have gradually adopted the movement of psychosocial rehabilitation (Hernandez, 2007, 2016). However, these two decades have marked a transition from a bottom-up approach (from impairments to participation) to a top-down approach (rehabilitating directly through and for activities that are meaningful to the person) (Brown & Chien, 2010). The approaches have remained varied, but there has been a trend towards a practice more centered on occupations as both the goals and means of therapy (Morel-Bracq, 2011)

In this paradigm, we note that the technical skills involved in activities used in therapy became less important than the meaning these activities hold for the clients. There has been a shift towards using daily life occupations (Alexandre and Leconte, 2014; Esbens *et al*., 2018 ; Larricq, 2020; Mignard *et al*., 2005 ; Ribas, 2014; Saragoni *et al*., 2018) rather than craft activities which have sometimes become far removed from the daily realities of the clients.

Key concepts

Bio-psycho-social models of disability, which were not yet consensual in the second paradigm, have become prominent in the latest paradigm both within and outside occupational therapy. For example, the Disability Creation Process (DCP) (Fougeyrollas, 1986) and the International Classification of Functioning (ICF) gained increasing prominence. The World Health Organization (WHO) adopted the ICF in 2001.

In line with these bio-psycho-social models of disability, there has been a noticeable shift towards new terminology and concepts such as "life habits" or "quality of life" in the literature. This shift demonstrates a move towards more conceptual and theoretical thinking, and a less biomedical approach to health and disability by occupational therapists over the past two decades (ANAES, 2001; ANFE, 2000; programme, 2010). In addition, a key aspect of this latest paradigm is the introduction of concepts, models and tools, developed for and by occupational therapists; notably, the Canadian Model of Occupational Performance and Engagement (CMOPE) or the Model of Human Occupation (MOH) (Morel-Bracq, 2017). Occupational therapists have shown a growing interest in scientific research, particularly research that supports and theorizes their practices. For example, activity has become a key concept, and French occupational therapists have gradually adopted the term "occupation." It is no longer just used as a means (ANFE, 2000); it has become the goal of occupational therapy practices (2010curriculum). Occupational science has developed theories and conceptualized occupation. French occupational therapists have gradually taken an interest in this science since the 2000s. It was integrated into the 2010 curriculum and gained popularity with the 2016 translation of the book "Occupational Science for Occupational Therapy" (Pierce, 2014). Occupational therapists have also embraced additional concepts developed in occupational science such as occupational justice (Durocher et al., 2014; Townsend and Wilcock, 2004) or occupational balance (Ung, 2018; Wagman et al., 2012)).

5) Conclusion

This chapter has explained our approach to the history of occupational therapy in France. We defined three paradigms by analyzing the needs met by occupational therapy, the practices valued and the key concepts at each period. We identified a first paradigm centered on the benefits of craft activities, from 1950 to 1980; a second paradigm opening up towards more context-adapted activities, to live in one's environment, from 1980 to 2000; and a third paradigm of transition from activity to occupation, from 2000 to 2020. Defining these paradigms enables us to take a problematized, contextualized approach to the evolution of our profession, and gives meaning to the different events, ways of thinking and practicing occupational therapy identified over time. While this chapter gave the reader an overview of the paradigms and the transitions from one to another, the following chapters will examine each paradigm in greater detail to deepen the reflection.

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Chapter 3 1st paradigm 1950-1980: the benefits of craft activities

1) Introduction

In the post-war period, a number of factors coincided, enabling the profession to be established with diploma training. As described in the previous chapter, the roots of occupational therapy can be traced back to various earlier events, but it was this period that saw the birth of the profession as we know it today. The key words here are "creation" and "construction".

The early days of occupational therapy were marked by the ambition to gain knowledge and recognition for the profession. The collective creation of a national association, ANFE, in 1961, and the awarding of a state diploma were milestones of the period. With the first two schools opened in the 1950s, one in the 1960s and five in the 1970s, the number of occupational therapists gradually increased and spread throughout France.

Initially, occupational therapists worked mainly in adult rehabilitation centers and children's centers. In psychiatry, the presence of qualified occupational therapists was rare, even though many psychiatric nurses "did" occupational therapy (Chardron, 1983). Positions have to be created and a place found among other established professionals, which is not always easy.

The profession emerged and developed in line with what was happening in society at the time, notably the changing view of the disabled person and the laws that followed, the place of women in the job market, and changing lifestyles following the advent of new equipment, particularly household appliances. These societal changes were reflected in the content of training, the definition of occupational therapy and occupational therapy practice at the time. At the time, manual, craft and artistic activities formed the core of the profession.

2) Social and technological context

At the start of this period, the country was rebuilding after the Second World War, and needed a large workforce. Employment was plentiful, and France needed to be equipped: overtime was a good way to buy new capital goods. This was the period of the "Trente Glorieuses" (1945-1973), with significant industrial, economic and demographic growth : society is changing.

Industrial production and household consumption increase in parallel. New objects appeared and took their place in everyday life. We discover the television set, which gains in fascination despite its initially high price, making it inaccessible to all (two months' salary for a worker in 1960) (Gaillard, 2012). In just a few years, household appliances developed considerably, making everyday life easier. During the 1960s, most households acquired a refrigerator, a washing machine and other time-saving appliances for the housewife. More people bought cars (Méot, 2009), and the first supermarkets were opened. Young people increasingly left the countryside to work in the city. The urban population rose from 59% to 73% between 1954 and 1975 (Zancarini-Fournel**,** 2016, p. 734). A housing crisis ensued, to which the government responded with a program of *Cités d'urgence*.

Following industrialization, the time devoted to work diminished (Bouvier and Diallo, 2010) and the population began to favor outdoor, physical and cultural activities, as well as travel, even if there remains a certain inequality in access to these activities. Workers took up less costly leisure activities, such as fishing and hunting, and sometimes benefited from union-organized vacations. Camping also became very popular in the 1950s-1960s (Zancarini-Fournel**,** 2016)**.**

Leisure activities are gradually becoming an integral part of daily life, transforming lifestyles. Activities traditionally considered productive and necessary to the smooth running of the home, such as DIY, gardening and needlework, are in decline (Bickel *et al.* 2005). Yet in mainstream schools, these activities are still taught and differentiated by gender. Girls tend to be taught domestic activities such as sewing, while boys are taught vocational activities such as agriculture and industry. In occupational therapy, manual activities will remain the predominant means used throughout the period, and are often offered on a gender-specific basis.

In the 1950s, society was still structured around family life. This period was characterized by the return of women to home, after the Second World War when they had played an important role in replacing men in economic activities. Women were considered "queens of the home", and the education of young girls was still geared to making them good wives. But little by little, women's role in society changed, and in the 1960s, they began to take on more salaried jobs: "Between 1959 and 1964, 485,800 women entered salaried employment″ (Maruani and Méron, 2012, p.51), enabling households to benefit from extra pay, notably for new household appliances, and in return, to save time on household chores and be able to work. This trend was to continue in subsequent decades, even if it wasn't until 1965 that women were allowed to work without their husbands' consent (Law no. 65-570 of July 13, 1965). At the time, professional status was a strong social marker, "testifying to membership of a social class, which is strongly indicative of a level of income, a way of life and a value system" (Mermet, 2013, p. 294).

At the time, not all professions were open to women, or considered "suitable" for them, but occupational therapy was one of the "accessible" jobs. Occupational therapy was a salaried profession in both public hospitals and private establishments, often run by foundations, charities or associations. Like nurses, the majority of occupational therapists are women: 95% in 1970 (Pierquin *et al.*, 1972), and most come from "good families" (Charret 2015a, 2016a), giving rise to gender dynamics in the professionalization of these paramedical groups (Diebolt, 2011). In the United States too, occupational therapists are predominantly women, and the profession is considered a "feminine" field (Frank, 1992). In contrast, young men tend to train to become masseur-physiotherapists.

Among occupational therapists, some girls, initially attracted by medicine, chose occupational therapy because the length of study was shorter and the job, in a care environment with fixed hours, made it possible to combine family and professional life (Charret, 2015a). At the time, it was not customary to have children before marriage (Munoz-Pérez and Prioux, 2000) and the average age of marriage for a woman was 22-23 (Desplanques and De Saboulin, 1986). A number of female occupational therapists leave their job to look after their children full-time.

During this period, living conditions improved thanks to the introduction of Social Security and social protection, as well as the Guaranteed Interprofessional Minimum Wage (SMIG) introduced by the law of February 11, 1950. During these years, life expectancy rose from 69 to 78 years for women and from 63 to 70 years for men. The birth rate rose, and infant mortality fell from 5.2% to 1% (INSEE). At the same time, a revolution in pharmaceuticals had been

underway since the end of the war, with the development of drugs such as antibiotics in the 1940s, neuroleptics and antidepressants in the 1950s, and non-steroidal anti-inflammatory drugs in the 1960s. The polio vaccine helped bring down the number of cases after the mass vaccination of 1957, when the number had peaked at over 4,000 cases.

In 1959, the Debré Law (1958) created university hospital centers (CHU). Hospitals became places of professional practice and research, bringing together practitioners and academics with a triple mission of care, teaching and research. The years that followed saw massive investment in medical research. The budget allocated to research increased considerably, from FF 54 million in 1954 to FF 1.4 billion in 1984 (INSERM).

In the 1960s, the effects of industrialization were felt in certain environments. The Thirty Glorious Years (*Trente Glorieuses*) were not so glorious for the whole population. The number of farms fell by 30% between 1955 and 1975. Product prices rose, but purchasing power fell for farmers. Workers demanded better working conditions: for example, among dockworkers, workplace accidents were five to seven times higher than among other employees **(**Zancarini-Fournel, 2016, p. 742). The number of specialized female workers rose sharply, but working conditions did not improve. It's worth noting that, following work-related accidents, it's mainly manual workers who find themselves in rehabilitation centers in Nancy, a region with a large number of steelworkers (Raggi, 2013).

The sometimes highly unequal living conditions prompted reactions from certain groups: farmers, workers and students. Underlying discontent for years, with numerous strikes starting in 1953, led to "widespread insubordination" in the "1968s" (Zancarini-Fournel 2016, p.742). The events of May 1968 turned French society upside down, marking a break in political, social and cultural history.

How these events influenced occupational therapists and occupational therapy remains unknown. No information appears in occupational therapy journals. The creation of the state diploma certainly occupied all energies. It was at this time that the Confédération des étudiants français en ergothérapie (CEFE) was created. The federation's aim was to bring together students from the three schools in existence at the time, and "to bear witness to a student presence and demonstration, both vis-à-vis the public authorities and the professionals" (CEFE, 1971). The idea was to share experiences and provide students with professional and social support.

Among the effects of the post-Sixties on the field of disability, the *Comité de lutte des handicapés* was formed in 1972 by militants close to the *Front Libertaire* group, wishing to oppose the annual street collections organized by the main disabled people's associations. Its journal *Handicapés méchants* was founded in 1973. Many articles concerned work and the demand for a decent wage, as illustrated by headlines "*Nous n'avons pas choisi d'être mendiants*" and "*Entrée interdite aux chiens et aux IMC*". The movement to defend the handicapped originated from the *Centre des paralysés étudiants*, itself part of the *Union nationale des étudiants de France* (UNEF) movement. These two movements supported the struggle of disabled workers at a meeting of *Centres d'aide par le travail* in Besançon in 1975, to demand a salary equal to the minimum wage. Disabled people demand to be heard and consulted by all bodies: they want to control their orientation. (Handicapés méchants, Auerbacher, 1982; Hernandez, 2019).

The 1970s transformed women's lives in terms of equality, freedom and independence. The Act of June 4, 1970 on parental authority put an end to women's subordination to the power of the

"head of the family". The Law of December 22, 1972 introduced the principle of equal pay for men and women. Evolving ideas on marriage and sexuality upset mores. In 1974, the introduction of the "Veil" law, supported by feminist movements (Desmoulins, 2015), demonstrated a commitment to fighting discrimination against women and granting them a certain freedom to decide what is best for them.

The mid-1970s saw the end of the *Trente Glorieuses*. In October 1973, the onset of the oil crisis led to a rise in unemployment, which exceeded one million by 1975. Occupational therapists do not seem to have been influenced by these economic issues in their professional development. On the contrary, this was a time when the profession benefited from its new official status, and the number of occupational therapists grew with the opening of several schools.

3) The beginnings of structured occupational therapy training

Setting up the first two schools

The first two occupational therapy schools opened in France in 1954, in Paris and Nancy. They were both private and shared with physiotherapy schools. After two years' study, students were awarded a private occupational therapy diploma (André *et al.* 2004). The training was strongly inspired by the rapidly expanding Anglo-Saxon occupational therapy movement, and the first trainers were English. Indeed, after the United States, it was the United Kingdom that opened its first occupational therapy school in 1930. There was strong demand for English training between 1940 and 1960, particularly from Scandinavian students (Wilcock, 2002). Those trained became "pioneers" in the field and were called upon to train students in schools, particularly in France.

The Nancy School emerged from a plan to establish a ″general policy of rehabilitation in the Nancy region″ (André *et al*., 2004, p. 12). The *Institut Régional de Réadaptation* was founded in March 1954.

Jacques Parisot, Dean of the Faculty of Medicine, was Chairman of the WHO Executive Committee, giving him "a privileged observer's position (...) to grasp innovative trends and adapt them to the regional context″ (André *et al*., 2004, p.8). Clearly aware of the problem, in 1942 he set up the "Commission de reclassement des diminués physiques" (Commission for the reclassification of the physically disabled).

In 1954, on Parisot's initiative, several doctors, including Louis Pierquin and Henri Poulizac, took part in a study trip to England. They discovered English rehabilitation, which inspired them to set up a school for rehabilitators (André *et al*., 2004, p.14)

They set up the Nancy School of Physiotherapy and Occupational Therapy as "private, non-profit association" under the French law of 1901 (Gable, 2000). Twenty-three physiotherapy students and five occupational therapy students attended the school for the first time in 1954. Pierquin became director.

The courses are taught by professors from the Faculty of Medicine, doctors from the Institut Régional de Réadaptation, physiotherapists and *Occupational Therapists:* Mlle P. Everett, M. H. Hopker and A. Russel (André *et al*., 2004 p. 121,125). Andrée Roche, an English-qualified

occupational therapist in charge of the Nancy occupational therapy department, coordinated training until 1963. Paul Farcy, a graduate of the second Nancy class of 1956-58, was technical director of the Nancy School of Occupational Therapy for twenty-seven years (André *et al.*, 2004). After fifteen years, fifty-four occupational therapists graduated from the Nancy School (André *et al.,* 2004).

Fig. 1 - Paul Farcy (André et al., 2004, p.126).

The Paris school was created on the initiative of Pr Fèvre, Vice-Dean of the Centre Hospitalier de l'Hôpital Necker-Enfants Malades, and Pr Hindermeyer, a specialist in children with physical deformities. Hindermeyer, who himself suffered from polio as a child, had been treated at the William Rusk Institute (USA) and seems to have been introduced to *occupational therapy* during his hospitalization, hence his sensitivity to this profession, which he supports in order to set it up in France. The managing director was Pr Pellerin, Head of Department at the Hôpital des Enfants Malades, and the technical director Geneviève Rémond, a former ambulance driver and military nurse (Charret, 2016b). Ms. Rémond was already director of the physiotherapist training program set up in 1946 following the creation of the masseur-kinésithérapeute state diploma. She remained director until 1970, she was succeeded by Rosine Cazenave. The teaching team also includes Marguerite Lemarchand, who trained in England at Dorset House**,** and Jacqueline Lejeune, who completed her French training with an American *Occupational Therapist* diploma

The course, located at Hôpital Necker-Enfants Malades, is entitled "*Cours de gymnastique médicale et de Rééducation fonctionnelle*". When it opened, the course lasted nineteen months, with internships during the vacations. In 1962, this was extended to twenty-eight months. The 1962 Paris school program was inspired by one that Jacqueline Roux-Lejeune brought back to France following her participation in the 5th WFOT meeting and World Congress in Philadelphia in October 1962. At the time, France was only an associate member of WFOT (Mendez, 1986). To become a "full" member, it was necessary to revise its curriculum, as WFOT had judged the French occupational therapy program to be too inadequate in terms of psychiatry teaching, as well as the length of internships in general. This investment in psychiatry also comes from the United States, where Willard and Spackman have been advocating the presence of occupational therapy in "the care of persons affected by both physical and psychosocial conditions" since the 1940s. At a time when occupational therapy essentially met a demand for rehabilitation of physical injuries, Willard and Spackman advocated the presence of occupational therapists in several fields, including psychiatry (Mahoney *et al.*, 2017).

Fig. 2 - Promotional photo (a priori the second or third) of the Necker-Enfant Malades hospital given by a pioneer.

In an interview with her in 2012, Marguerite Lemarchand explained that she had been teaching at the Paris school since 1956. Originally from England, she trained for three years in occupational therapy at Dorset House in Oxford, England. Initially attracted to physiotherapy, she eventually chose occupational therapy for its ‘innovative’ and ‘social’ aspects, combining rehabilitation with manual activity. She completed her studies in 1952 and arrived in France after spending a year working in England. She joined an occupational therapy department already set up by another Englishwoman at the Saint-Cloud rehabilitation centre. In her opinion, English occupational therapy was more psychologically and socially oriented than in France, where she discovered occupational therapy with more ‘functional’ objectives, similar to those of physiotherapists who focus on precise movement.

She was asked by the founders of the Paris school to teach occupational therapy. According to her, the school initially called on American women. She agreed to teach occupational therapy in functional rehabilitation. She used the weaving technique to explain rehabilitation to the students: the activity that rehabilitates a specific movement.

The role of the first teachers was to pass on know-how, and this was inspired by Anglo-Saxon occupational therapy. At the time, there were no French-language manuals on the use and treatment recommendations of occupational therapy. They had to rely on their own experience and learning, without any particular pedagogical knowledge. Their aim was not to conceptualise, but to explain their practices.

Fig. 3 - Marguerite Lemarchand with Lisbeth Charret during an interview in 2012

The school of physiotherapy and occupational therapy opened in **Lyon** in 1965 as part of the university. Between 1971 and 1974, five more occupational therapy schools opened, following the creation of the occupational therapist state diploma and the publication of school accreditation conditions and the official curriculum. These schools were located in **Montpellier** (1971), **Rennes** and **Berck** (1972), **Créteil** (1973) and **Bordeaux** (1974).

Teaching

In Paris, students start with a month's internship in the morning in the infirmary. According to interviews with pioneers (Charret, 2012), this is a selection process to see if students can cope with the hospital environment. Students observe the activities of nurses and caregivers, and sometimes find themselves performing nursing acts such as intramuscular injections.

During the early years in Paris, theoretical instruction by doctors or psychologists took place in an amphitheater at the hospital or in the "Pavillon Brun", or sometimes even in a local cinema, the Studio Bertrand. Psychiatric training is provided at Hôpital Sainte-Anne by psychiatrists, who bring in patients on a stage for clinical instruction. Craft techniques are taught by craftsmen in the city or in vocational high schools, optimizing learning in a place with all the tools available to learn technical practices and guaranteeing the quality of teaching (Charret, 2015b).

In Nancy, teaching is organized in the same way as in Paris, although psychiatry seems to be taught less. As Nancy was located in an industrial region, occupational therapists received patients from industry. Metalworking was an important aspect of occupational therapy training, and at the time, occupational therapists offered activities related to the patient's job. As professional reintegration was an essential objective, as part of their studies, students took part in a one-month internship in a factory to learn about hiring conditions, work and the concerns of the working world (André *et al.,* 2004, p.126).

In 1962, the curriculum of the Paris school included some 700 hours of manual activity teaching, providing a solid grounding in techniques. This knowledge enables the school to distinguish itself from other paramedical professionals in France. The mastery of manual activity and craft techniques is a specificity that no other healthcare professional can claim. Despite the layman's aspect and the fact that this knowledge is not based on scientific knowledge, occupational therapists manage to find a "legitimate" place in the medical world.

The first year of training is organized jointly with masseur-physiotherapists, since both courses include the same medical disciplines. Thereafter, each profession reinforces its specificity in separate courses. For occupational therapists, this involves the study of craft techniques and the kinesiology of the trades. Students have the impression that teaching is split in two: practical knowledge and theoretical knowledge, without necessarily any links between them. They have the feeling that they are building their own craft, with theoretical knowledge of pathologies, anatomy, joint physiology and body function, as well as psychology, on one side, and the teaching of manual, craft and artistic activities on the other.

This feeling of division between two "blocks of teaching seems to contribute to the difficulties encountered in developing a consensual professional identity. Some occupational therapists are more interested in medical knowledge, and others in manual and creative activities (Charret, 2015b). As a result, the reflection of the profession can create very different and blurred perceptions around the "core business".

When the first national program was introduced in 1971-1972, following the creation of the state diploma, the duration of studies was extended to three years. In this program, the focus shifted from knowledge of working conditions and the ability of students to deal with the hospital environment, to their ability to work with patients "in situ". Validation of internships is based on two criteria: the work carried out during the internship, assessed by department heads, and an end-of-internship test before the department head and an occupational therapist. The program also calls for a better balance between psychiatric and motor rehabilitation internships, recommending "if possible" a psychiatric internship in the first year.

4) A strong link between occupational therapy and work

Work-related legislation

During this paradigm, an arsenal of legislation on vocational retraining influenced the activities of occupational therapists. The Law of August 2, 1949 generalized reintegration assistance to all severely disabled people, with the creation of a compensation allowance for workers. It also gave them access to vocational training. The decree of November 29, 1953 created departmental commissions for the orientation of the disabled, to recognize their aptitude for work or the possibility of professional re-education. In 1957, Law 57-1223 of November 23 on professional reclassification introduced the term "disabled worker", with a definition of the status of disabled worker, the introduction of employment priorities (theoretical quota of 10%), the definition of sheltered work and the creation of the Higher Council for the Professional and Social Reclassification of Disabled Workers (Direction de l'information légale et administrative, 2015).

Work-related practice areas

For people with disabilities, the hope of finding a job is high, especially as new professionals are emerging in the field of re-education and rehabilitation. In some places and regions, occupational therapists offer rehabilitation with training sessions. They work in rehabilitation centers, such as the Charleville-Mézières center opened in 1965, with the aim of "ensuring the professional reintegration of the handicapped treated" (Wagner *et al.*, 1968, p.16). The majority

of residents are manual workers, and the patient's objective is to return to his or her previous job.

According to the authors, "it is during the admission visit that the doctor, in agreement with the occupational therapist, decides which workshop the patient will be placed in, after which the occupational therapist explains the medical case to the instructor" (Wagner *et al.*, 1968 p. 18). The occupational therapist draws on her/his knowledge of physical and gestural analysis to draw up an assessment of abilities, and then on her/his medical knowledge to pass on to the workshop instructors. As part of the various workshops, the occupational therapist suggests activities based on the patient's previous work, such as gardening for a farmer used to working outdoors. Otherwise, the "handicapped" is offered a variety of jobs (basketry, weaving, sewing, typewriter, cooking, pottery, decorating, painting, wood, metal, welding, wood lathe, gardening, masonry). The occupational therapist's role is to assess gestural, psychological, social and professional needs, and to act as an advisor.

CAT (*Centre d'aide par le travail*) were also developed, thanks to the November 23, 1957 law on the reclassification of disabled workers. At the time, there were six thousand places in CATs (Baret, 2012, p. 68), now known as ESATs (*Établissement et service d'aide par le travail*), CRPs (*Centres de reclassement professionnel*) and sheltered workshops. Occupational therapists gradually joined these social teams.

Whatever the sector of intervention, many occupational therapy activities are based on professional or artisanal gestures, sometimes in a combination of functional re-education through work and global effort re-education.

Training occupational therapists to work with

Students are trained in vocational rehabilitation, and work is presented as a therapeutic tool. An example is given in the *association's Bulletin*, of an internship carried out in 1957 by occupational therapy students at André shoes factory (*Bulletin ANFE*, 1963**,** n° 4).

In 1963, ANFE (the French association of occupational therapists) alerted occupational therapists to the problem of professional reintegration as a goal after rehabilitation: "Could we remain indifferent in the face of the serious concerns for the future of the very people we have just helped?" calling on occupational therapists to inform social workers and doctors so as to intervene at an early stage in the necessary reclassification *process (Bulletin ANFE,* 1963, no. 4). The experience of the Institut régional de réadaptation in Gondreville is testimony to the need to get disabled people back to work. The slogan "the physically handicapped must not be professionally handicapped" aims to qualify the handicapped in order to gain economic autonomy (*Bulletin ANFE*, 1963, n° 3).

Fig. 4 - André et al., 2004, p 67

But it's not always so simple to orient the various disabled people towards jobs, and it's not always possible, despite the re-education and rehabilitation program, to get them into employment. Some people suffering from poliomyelitis, accidents at work or on the public highway, or people with visual or hearing impairments, can hope to work or return to work. On the other hand, for those hospitalized in a psychiatric unit, professional integration in the mainstream is more problematic.

In 1967, F. Bloch-Lainé submitted a report entitled "*Étude du problème général de l'inadaptation des personnes handicapées*" to the Prime Minister. This report paved the way for the 1975 Orientation Law. The 1975 laws are considered the first laws for disabled people in France.

Law 75-534 of June 30, 1975 on the orientation of disabled people sets the legal framework for public action, defining the rights of disabled people to work, to a minimum of resources, and to educational and social integration. It emphasizes the importance of prevention and screening for disabilities, compulsory education for disabled children and teenagers, access for disabled people to institutions open to the general population, and maintaining them in an ordinary working and living environment wherever possible. The law entrusts recognition of disability to separate departmental commissions: for young people from 0 to 20, the CDES (commission départementale de l'éducation spéciale) and for adults, the COTOREP (commission technique d'orientation et de reclassement professionnelle from 20). This law was supplemented by Law 75-535 of June 30, 1975 on social and medico-social institutions, which regulated the creation, financing, training and status of personnel working in the sector's establishments and services.

The OT training programs of the 1970s testify to occupational therapists' interest in the analysis of work-related gestures and the methodology for helping disabled people enter or re-enter the workplace. In the first national training program (1971-1972), students were placed in situations that were as environmentally-friendly as possible, in order to experiment with professional gestures (Pierquin *et al.,* 1980). For example, students learn woodworking and metalworking techniques using machine tools in vocational high schools. They are also trained in safety conditions. The idea is to get to know a worker's environment and master professional gestures.

Vocational rehabilitation is also an important topic for occupational therapy students. In 1971, at a meeting of the *Confédération des Étudiants Français en Ergothérapie* (CEFE), neuropsychiatrist Dr. Lamarche was invited as head physician of a transitional facility (*Centre de Postcure et de Réadaptation Sociale Agricole de l'Ouest*, in Billiers). The facility offers agricultural socio-professional training for mentally ill people leaving psychiatric hospitals, and therefore focuses on activities of daily living and work. “Knowing that for human beings, the professional side is crucial” he says, work is at the heart of success. This is the way to integrate patients into society. "The trainee (patient) goes through three progressive stages: observation, rehabilitation and preparation for life outside the institution”. Over and above the ability to perform professional tasks, the aim of placing patients in ecological situations is also to facilitate their social reintegration:

> "Through the rigors of work, the notion of order and hierarchy of values, the patient reconnects with reality. Once this stage has been completed, he or she will reconsider his or her own individuality and his or her relationship with normality and the outside world. This stage is essential for personality restructuring and future reintegration" (CEFE, 1971).

The opening of the new occupational therapy schools meant that there were a few more professionals available to work with both children and adults, in both functional rehabilitation and mental health, but very few with the elderly at that time. For example, when the Bordeaux School of Occupational Therapy opened in 1974, there were only eight qualified occupational therapists in the whole Aquitaine region: five in child rehabilitation, one in adult rehabilitation, one in adult psychiatry in a private center, and one "occupational therapist instructor" to open the school.

5) Early writings and inspirations in occupational therapy

In the early years, occupational therapy students and recent graduates had few written occupational therapy references on which to draw. After ANFE was founded in 1961, the first bulletin was published in 1962. Initially published twice a year, these newsletters enabled the association to exchange and share information.

Early association newsletters, and later journals, show that pioneers were inspired by occupational therapy "abroad" in reviews, presentations at international congresses or internships abroad (*ANFE Bulletins*: 1962; 1963; *Journaux d'ergothérapie*: 1968; 1970; 1973; 1975; 1976; 1977; 1978). The importance of sharing practices and methods transcends national borders. Occupational therapy in rehabilitation centers in eastern France, for example, is noted for its high standards, as described by an English occupational therapist who took part in visits to these centers.

Fig. 5 - Bulletin de l'ANFE, 1970, 4

Some occupational therapists draw inspiration from documents distributed by WFOT, notably the explanatory writings on setting up an occupational therapy department (Organization of an Occupational Therapy Department, 1958) by the American Association of Occupational Therapists (West and Clark, 1951).

Fig. 6 - Document WFOT Archives ANFE

In the United States, the first edition of Willard & Spackman's *Occupational Therapy* was published in 1947. Reissued to the present day (13th edition published in 2019), this book is a "*must-have*" for students of every generation, sometimes dubbed "the occupational therapy bible" (Mahoney *et al.,* 2017). This first book written by *Occupational Therapists* comes out thirty years after the **1917 founding *the National Society for the Promotion of Occupational Therapy*** **(**NSPOT), which became the *American Occupational Therapy Association* (AOTA) in 1921.

To our knowledge, the first occupational therapy book to appear in France, "*Précis d'ergothérapie*", was written by a Belgian doctor from Charleroi, J. Dumoulin, in 1967.

Enthusiastic about the method, which he claims "gives the best results in rehabilitation centers", he specifies that in Europe "no major rehabilitation center or regional hospital is conceivable without an occupational therapy department", citing Nancy and Pierquin as "a model of its kind" (Dumoulin, 1967 p. 11). Its content reflects the fields in which occupational therapists find themselves in the clinic: occupational therapy in orthopedics, with patients suffering from rheumatoid arthritis or poliomyelitis, cerebral palsy, pediatrics, domestic work, pneumology and psychiatry (Dumoulin, 1967).

Gradually, a number of French occupational therapists are taking up writing, particularly in occupational therapy journals. When they publish, they write about their practice to share their experience: very often, they describe the activities they set up for a specific pathology.

A 1974 book by F. Bedos, S. Moinard, L. Plaire and J. Garrabé describes a method of working with puppets in psychiatric occupational therapy, tested at La Verrière, near Paris. Result of Suzanne Moinard and Liliane Plaire's final dissertation in occupational therapy, it is presented in the *Journal d'ergothérapie* (1975, no. 14) as the "first book written by occupational

therapists", even though doctors also contributed. This can be seen as a way of establishing the role of occupational therapists in a field where few qualified occupational therapists are practicing, certainly because occupational therapy, as a method, is already embraced and practiced by many nurses.

In 1976, 1977 and 1978, the Saint-Genis-Laval team of occupational therapists initiated a series of articles on occupational therapy for "tetraplegics" following further training in Lyon. Journal no. 19 featured "*Tétraplégique au stade alité" (Équipe d'ergothérapeutes de Saint-Genis-Laval*, 1976), preceded by a proposal to publish all of the training days if occupational therapists expressed an interest, and this is indeed what happened shortly afterwards.

Then, Dr Nahon and Piera published an article on "*Rééducation de la préhension et autonomie du tétraplégique traumatique complet*" (Nahon and Piera, 1977) and in the following issue, Claude Desplanches wrote an article entitled "*Ergothérapie du tétraplégique au centre de Kerpape, essai de méthodologie*" (Desplanches, 1977). In 1978, Dr. Thevenin-Lemoine published an article entitled "Para et tétraplégiques, troubles de la statique pelvienne en fauteuil roulant. Their cutaneous consequences".

The aim of these articles is to enhance knowledge, particularly medical knowledge, and to share practical experiences that are difficult to find in books. They also show the areas in which occupational therapists of the time were working within their institutions.

It wasn't until 1978 that Isabelle Pibarot's first conceptualization of occupational therapy, "*Dynamique de l'ergothérapie, essai conceptuel*", appeared. Introducing her article, she almost apologizes for its content, noting that:

> "This article is certainly a little difficult at first. But it is appropriate for our profession to find the foundations of its practice; this explains the conceptual and analytical character, albeit succinct, of the discourse. It could be an opportunity for occupational therapists to exchange ideas, and a field for research into the ergon generated by the body-matter encounter" (1978, p. 3).

Fig.7 - Extract from Pibarot, I., 1978, p.6-7.

The following year, she continued her reflection with two articles on "Entering occupational therapy" (Pelbois-Pibarot 1979a, 1979b), one on psychiatry and one on functional rehabilitation, emphasizing that this was not a model but a source of inspiration for "the early occupational therapy relationship" that occupational therapists may encounter in their very diverse practices (Pelbois-Pibarot 1979a, p. 5).

Finally, in 1980, Pierquin, Professor of Rehabilitation, and J.-M. André, Professeur Agrégé de Rééducation, both from the Nancy Faculty of Medicine, together with P. Farcy, Occupational Therapist and Director of the Nancy OT School, published the first French occupational therapy book exploring the various fields of practice, in the *Abrégés* collection published by Éditions Masson. In this book, the authors focus on objectives by which occupational therapists can identify their role and tasks. These objectives relate to functional disorders, rehabilitation of movement, rehabilitation of expression and restoration of independence. The principle is to "cure function by exercising function" (Pierquin *et al.*, 1980, p. 5). The "major rules" are: "*a)* the medical prescription*, b)* the examination of the disabled person by the occupational therapist

is vital*, c)* knowledge of the work or occupation is of equal importance, *d)* the choice of therapeutic activity... this is the decisive moment of his action″ (p.7).

Fig. 8 - Pierquin et al., 1980, p. 165: Occupational therapy for cardiac patients. Choice of activities

At the end of this period, we observe different approaches between regions: the Paris region, more focused on psychiatry and children, the Nancy region on functional rehabilitation. This diversity also hinders the development of the collective consensus needed to strengthen the core business and professional identity.

6) Assistive devices

The period after the Second World War saw little development in assistive devices : although there were inventions, they were not available to the average person. Occupational therapists created and produced assistive device which, according to Pierquin, defined as "tools, instruments, special arrangements enabling certain disabled people to carry out various activities which, without such recourse, would remain beyond their reach" (Pibarot, 1970, p.15).

The very first issue of the ANFE Bulletin, in January 1962, included three short articles on "The problem of seats", "Seats for Milwaukee" and "The seats Flambeau", as well as a "technical documentation" on glues. Articles on assistive devices and orthotics are published, such as one by the team at the Centre de rééducation motrice in Fontainebleau, which reports on the use of a new material in occupational therapy: *Polysar*, used to manufacture assistive device and/or apparatus (*Audic et al.,* 1972).

Fig. 9 - Audic et al., 1972 p. 10

Fig.10 - Manufactured toilet booster seat. Archive photo IFE ADERE

These articles were sometimes written by doctors such as Professor Hamonet (Hamonet *et al.,* 1973). They peppered occupational therapy journals throughout the 1950-1980 period. As early as 1978, Jean-Pierre Belheur envisaged the role of electronics in the technical achievements of occupational therapists, and provided a set of technical courses (Belheur, 1978 a, 1978 b, 1978c, 1979a, 1979b, 1980), the aim being to design and manufacture electronic adaptations to make the disabled person independent. However, the vast majority of occupational therapists did not go down this road (Belheur, 1986). However, occupational therapists invented, designed and manufactured a variety of assistive devices, as illustrated by fixed pen splints and a retractable unicorn (Desplanches, 1977). This problem-solving approach has certainly contributed to our nickname of "bricolo therapists".

7) Activities in practice and training

Activities

In this first paradigm, craft and creative activities are at the heart of occupational therapists' professional activity, whether in adult and child rehabilitation departments, or in psychiatric institutions. Occupational therapists attach a therapeutic quality to these activities, and they constitute a practice that is unique to them. Some of the pioneers became occupational therapists precisely because they were interested in the use of these activities in the health field, all the more so in a social context marked by a craze for craft activities and "hippy" values.

Fig. 11 - First class of Montpellier, IFE Montpellier archive photo, courtesy of M-H.

Presentations by Lemarchand, Chapron and Farcy at the 1962 Philadelphia Congress shed light on the choice of occupational therapy activities at the start of the profession. Lemarchand describes French specificities, such as cooking, for "the rehabilitation of the physically diminished housewife" and the topicality of craft work in internships, making a link with learning in occupational therapy schools:

> "During their studies, occupational therapy students become familiar with wood, clay, metal and weaving, and during their internships in the different provinces of France learn, both about the creative variations these materials offer, and about the therapeutic possibilities of their use.″ (Lemarchand, 1963).

These are essentially craft and manual activities, as described by Dumoulin (1967). Each activity is linked to a specific rehabilitation objective. According to Pierquin *et al* (1972), the techniques most commonly used at the time were carpentry, ceramics, basketry, weaving, mechanics, light work, cooking and home workshop, and photography.

Fig.12 - Objects created by occupational therapy patients.

Photos from the IFE ADERE archives

The *Journal d'ergothérapie* publishes articles on the manufacture of adaptations, assistive device and orthoses, on activities such as metal or leather working, electricity and electronics, accompanied by numerous advertisements for craft techniques. The widespread use of "technical data sheets" is testimony to this. There are ones on clay modeling (Isenstein, 1964), wood carving (Drezen, 1970), molded leather (Blanc, 1974), Batik (Sabat, 1975, 1976), lampshades (Blanc, 1976; Filloulhaud, 1976), Indian weaving (Van Heuverswyn, 1977). Between 1970 and 1976, a "Metal" data sheet by Duca (1970) is included in every issue.

Pierquin *et al*. classify these activities observed in occupational therapy departments according to their objectives: "essential basic techniques" (ceramics, basketry, weaving, carpentry, ironwork), "complementary techniques" (leather, paper, cardboard, string, ink...), "adaptive or independence techniques" (activities of daily living, housework) and "mental health expression techniques" (drawing, painting, puppetry) (1980, p. 8). This classification reflects the 1971-1972 training program.

However, occupational therapists are gradually discovering the use of other activities as a means of rehabilitation, particularly with the development of technology. In 1972, two occupational therapists from the Nancy region went on a study trip to the United States, where they were astonished by the activities and situations they observed, which were still far removed

from French practice: the use of a computer for files, elderly people using walkers in public places, an occupational therapist playing ball with psychiatric patients, a program of manual techniques supervised by occupational therapy assistants, and stereotyped objects made by patients (Hildwein and Steininger, 1972).

The choice of activities

For the 1962 Philadelphia Congress, Chapron and Farcy presented a paper entitled "Modification and application of occupational therapy according to the customs of different countries". They justified the use of manual activities on the grounds that most patients in the Nancy area came from industry and were therefore "manual workers", so they proposed "valid techniques to capture their interest". The aim of occupational therapy at the time was not simply to learn, or return to, a trade, but "to use the resources already existing in the person" (Chapron and Farcy, 1962).

Fig. 13 - Occupational therapy activities in 1967

Réf : Dumoulin, 1967, p. 108 *Réf Dumoulin, 1967 p. 231*

Dumoulin (1967) reinforces these values of the time, pointing out that the "choice of occupation" or trade is adapted to the age or sex of the person, and places great importance on the interest of the activity. If the occupational therapist uses cutting to re-educate, it must be adapted: "a child prefers to cut paper, a woman to cut textiles and a man something else" (p. 32).

Women's place in society and gender issues also permeate the activities on offer. Marz and Farcy (1967) describe how occupational therapists prepare for work and vary their program "according to the groups of handicapped people considered"**.** They give the example of the housewife:

> "The training of women in household activities, this unique or second profession, is unreservedly the exclusive domain of occupational therapists. It's up to us to restore the woman's place in the family home, through the use of certain means and the repetition of daily activities" (p.8).

The therapeutic aim of craft activities: a medical objective hidden behind a creative and entertaining activity

The approach used in practice is that of re-education-rehabilitation: occupational therapists seek to involve patients in activities to improve their potential by reducing disability.

The activity is chosen for the purpose of productive work, to overcome the handicap. It is prescribed by the doctor, meets the person's needs and is chosen by the occupational therapist according to the patient's tastes.

The aim is to improve abilities, not the object itself, even if the quality of the work is stimulating. Dumoulin classifies occupations according to the material used (textiles/wood/metal...) but also according to their quality as "stimulating" (numerous and varied movements) or "sedative" (stereotyped movements) (Dumoulin, 1967, p. 34).

Each activity is linked to a specific rehabilitation objective. As Pierquin puts it, an activity is given "a specific character″ by "choosing a precise activity to cure a given disorder", with the aim of a return to normal life (Pierquin, 1968, p. 9). Marz and Farcy (1967) note that the occupational therapist "must always propose a creative or utilitarian activity.″ (p. 6) adapted to the individual case of the disabled person. When movement recovery seems difficult, the occupational therapist must find a way to adapt the tool (e.g. adapted looms) so that movements correspond to the desired postures. "Postures need to be carefully studied. Effort must be measured out, resistance appreciated" Marz and Farcy (1967, p. 6.) Manual activity is essential for its therapeutic value, and should be preserved as much as possible.

In psychiatry, occupational therapists at La Verrière, near Paris, introduced puppets and marottes as early as 1964 (Klockenbring, 1987), and described occupational therapy as being based on two opposing poles: that of rehabilitation, where work is said to be therapeutic, and that of occupational therapy, where expressive and creative activities can heal. ″So, in fact, it's a form of psychotherapy in which the relationship is established through an intermediary or mediator object. This is similar to the transitional object described by Winnicott". (Bedos *et al.*, 1974, p. 12).

Throughout this period, activity analysis was mainly based implicitly on the biomechanical or psychodynamic model: i.e., a kinesiological or symbolic analysis. Essentially, it's a question of identifying how and why a given activity might enable a person to combat motor deficiencies or psychic difficulties due to pathology, and recover functionality.

A decline in the use of craft activities

In 1971, the first official training program in France described occupational therapy as a rehabilitation method "using work in the most general sense of the word". Knowledge of manual and artistic techniques remains important in practice, and is reflected in the training. To these techniques can be added adaptations, assistive devices and orthoses, which are commonly performed by occupational therapists. But this definition brings variations in the use of activity in occupational therapy.

In 1976, Kerpape occupational therapists published an article presenting the playful use of rehabilitation cones: "Therapeutic indications of the game with cones" (Tournier *et al.,* 1976). The article presents the rules of the game, followed by therapeutic indications for different pathologies: hemiplegia, children with cerebral palsy, upper-limb amputees and quadriplegics. The analysis is very much focused on the corresponding rehabilitation needs, since the game is really just a form of entertainment.

Fig.14 - Working on finger extension with a checkers game adapted with Velcro (1976) Photo d'archives IFE de Bordeaux

Gradually, however, there was a move away from the craft activities used in occupational therapy workshops in rehabilitation centers. A written report bears witness to the evolution of the occupational therapist's role since its origins, while responding to the demand for a cost evaluation of craft activities. It reveals activities that are "more expensive than in other rehabilitation services", and a paradigm shift towards new practices (Leduc, 1989, p. 49). The author, a former potter and occupational therapist from the second graduating class of the Nancy OT school, acknowledges that "therapeutic occupations" are disappearing in workshops at the expense of other, less expensive activities (analytical assessments, bead-stringing, educational games), and notes that occupational therapy in its craft form has completely disappeared in other sectors, such as cardiology. He concludes that craft-type activities have not sufficiently

demonstrated their therapeutic profitability: budget restrictions are drawing attention to these activities, which require investment in terms of the cost of technical and human equipment (Leduc, 1989).

Thus, at the end of the first period, there was a change in the use of vocational-type craft activities in occupational therapy workshops, certainly due to budget restrictions, but also to shorter hospitalization times.

8) The challenges of the period: knowledge, identity and a professional role

The challenges in these early years were to raise awareness of a new profession, create jobs and gain official recognition. Recognition by doctors was particularly important, as occupational therapists worked solely by "carrying out treatments on medical prescription" (Paris School training program, 1956). To share experiences and guide new French occupational therapists setting up in the field, the national association ANFE translated into French the document, *Organisation of an occupational therapy department*, proposed by the WFOT in 1958.

Definition of objectives and initial areas of intervention

The pioneers publish articles or speak at conferences with medical promoters to explain the profession. This explanation is done either by distinguishing it from masso-kinésithérapie :

> "The basics of training are more or less the same as those taught at the École de masso-kinésithérapie (anatomy, kinesiology, physiology, medical and surgical pathologies). To these we add the study of professions, work and workers, and finally the use of professional gestures in therapy. Theoretical courses and practical demonstrations are supplemented by factory internships". (Pierquin *et al.*, 1956, p.180);

or according to the pathologies treated:

> "Occupational therapy is not only work retraining, let alone vocational guidance or training. It is essentially therapeutic, as its name implies. The work proposed to the injured person is chosen on the basis of the handicap, not the future profession" (Pierquin and Roche 1958, p. 8).

In 1967, the ANFE published a special issue with the intention of "giving an idea of the whole range of their art, indications and modalities", in order to achieve two goals: firstly, to create a legal order recognizing the practice of occupational therapy by the public authorities, and secondly, to gain acceptance and adoption by the medical profession. In his introduction, Pierquin calls on occupational therapists to convince the public of the specificity of occupational therapy, "the 'occupational' or distractive, social or professional aspect". The writings testify to the multiplicity of places of intervention and the search for the role and specific place of the occupational therapist, the search for a professional identity.

Marz (Roche) and Farcy (1967) define the occupational therapy of the time as :

> "Work therapy, in the broadest sense of the word, whether for children, adults, the elderly, handicapped or suffering from a variety of ailments, the primary means of occupational therapy remains useful activity, that which has a practical interest in addition to its therapeutic efficacy. Therapy is achieved by making and producing things. Games, materials, tools, classic or adapted machines are the intermediaries" (p.4).

Occupational therapy is active, as opposed to inactivity or passivity. It stimulates energy, willpower and the desire to recover, while at the same time distracting, and therefore requires "adherence on the part of the subject". According to the authors, the work itself has a curative effect, which is enhanced by the therapist-patient relationship, "the link between which is the material".

In psychiatry, the mission is to seek and create conditions for adaptation to the outside world. Using work of increasing difficulty, it can help "restructure the personality", and according to psychiatrist Paul Sivadon, "the aim of treatment is to restore the patient's social value as completely as possible" (quoted by Marz and Farcy, 1967, p.3). However, depending on the place of work, intervention has different objectives, as testified by an occupational therapist practicing in a psychiatric clinic: "the patient in a clinic has other requirements than the patient in a large hospital" (Buscher, 1967, p. 38). The author proposes only short-term activities, due to the shortness of the stay, and explains offering basket-making (reassuring for depressed patients), wood carving, batik, weaving on small looms, pottery and pewter jewelry. The aim is to re-socialize and keep patients occupied for as long as possible, without creating too many constraints:

> "We try to treat him as a very precious person with great care, to avoid any clashes, to pass on many of his whims, and above all not to show him that we're watching him, while reassuring him, all the same, with our presence". (p. 39).

The occupational therapist focuses on the occupational aspect, "not asking too personal questions, even if the patient tries to talk about his problems, but referring him to the doctor" (Buscher, 1967, p. 40).

Other occupational therapists attest to their work: with children with cerebral palsy, proposing games to re-educate gestures with a view to independence (Roux, 1967), with tuberculosis patients in sanatoria (Jolain, 1967) with the aim of social reintegration, or in psychotherapy. In geriatrics, residents had to be persuaded to come because "they had not come to be rehabilitated, let alone to work" (Balleydier, 1967, p. 54). Sometimes at home, a rare experience at the time, the occupational therapist advocated "trying to understand and reach the patient as he is now and as he is becoming". (Sister Marie Aline, 1967, p. 70). In the "Occupational Therapy-Orientation Workshop", occupational therapy is seen as "professional work" to enable patients to "recover the gestural and substantive skills of their former profession" (Chenal, 1967, p. 82). The occupational therapist assesses the patient's gestural, technical and behavioral skills.

Occupational therapists are trying to raise awareness of the profession, professional activities and places of practice, but are coming up against a lack of understanding of the profession. Pierquin and Roche bear witness to this in the Encyclopédie Médico-Chirurgicale

> "Still little-known among our country's doctors and rehabilitators, and apparently the most recent of the functional rehabilitation methods, "ergotherapy" or "occupational therapy" is nonetheless the indispensable complement to "kinesitherapy" or "movement

therapy". It is used to treat deficiencies of all kinds, but particularly those resulting from musculoskeletal disorders or mental illness. It is therefore practiced in functional rehabilitation departments of general hospitals and the centers annexed to them, in psychiatric hospitals and establishments for the mentally deficient". (Pierquin and Roche, n.d).

A limited number of occupational therapists

Explaining the profession on its own is not enough to convince people of its benefits, it is necessary to demonstrate in practice in the field. The problem is the scarcity of occupational therapists. In total in 1969, fifty-four occupational therapists were trained in Nancy (André *et al.*, 2004). In Paris, a new class is welcomed every year. Photographs show between eight and twelve students in the first classes, but this number gradually increases. It seems to be approaching thirty students in the classes of the 1960s (Charret, 2016a).

A survey carried out by ANFE in 1969-1970 identified around 150 occupational therapists working in France (Pierquin *et al.* 1972, p. 73). This corresponds to 0.3 practicing occupational therapists per 100,000 inhabitants. In comparison with other professions, in 1966 there were 78,000 qualified nurses, or 158 per 100,000 *(*Franceinfo, "Dans les années 1960, les infirmières racontaient déjà les difficultés de leur métier").

What's more, according to a map showing the location of functional rehabilitation centers employing occupational therapists, the distribution of practicing occupational therapists is essentially limited to the Île-de-France and Eastern regions (*Bulletin de l'ANFE*, 1962, 1), which is a further obstacle to national recognition of the profession.

A job search service was set up at ANFE in 1963. One hundred and twenty rehabilitation centers throughout France are contacted to list job vacancies. ANFE asks people to report when a position has been taken. This enabled them to "keep the file up to date and not offer the position to someone else", particularly occupational therapists from other countries who were looking for work in France (*Bulletin de l'ANFE* 1963, 3).

Initially, these offers were few in number: between one and four in the first bulletins up to 1968. In December 1968, there were twenty-seven offers, thirteen of which were identical to those in April. Does this increase reflect a greater supply than demand, less mobility on the part of occupational therapists, or simply that the hiring information had not been updated? Let's not forget that back then, information didn't circulate at the same speed as it does today: the newsletter came out twice a year, and all communications were by post.

Psychiatry

In 1967, Marz and Farcy noted that occupational therapy is "frequently used in psychiatry" (p. 3), which is probable, but certainly not by occupational therapists who have graduated from occupational therapy schools. We're talking about occupational therapy in psychiatry, but not necessarily of occupational therapists. Moreover, if a congress on occupational therapy held in Mayenne in 1960 was attended by 200 participants, this meant that other professionals were "doing occupational therapy" (Chardron, 1983).

When occupational therapy students have to do their internships in psychiatry, many of them do so in occupational therapy workshops run by psychiatric nurses. The aim is to offer

handicrafts to patients, and the importance of listening, activity, expression and the environment are all present.

A few years later, at CEFE's 2nd national congress in 1971, students declared that internships could take place anywhere in France, especially in the third year. On the other hand, psychiatric internships were carried out in the Paris region, even for students from Nancy (CEFE, 1971).

In *Journal d'ergothérapie* no. 7 in 1972, sixty-seven positions in forty-nine departments were offered in France, plus ten in Canada and three in Switzerland. Of these in France, only six were in the field of psychiatry, and only in the Île-de-France region. It seems that qualified occupational therapists are hardly ever hired in psychiatric hospitals. In Pierquin's 1980 book, mental health occupies just twenty-seven pages out of two hundred and fifty.

Perhaps the students weren't sufficiently trained in psychiatry? In the *Bulletin de l'ANFE* in 1962, 2, two occupational therapists mention having taken courses in psychiatry at the Hôpital St-Anne in Paris, and are beginning to receive patients in their workshops. According to testimonies, to work in certain psychiatric establishments, such as La Verrière in the Paris region, it is necessary to take specialization courses in psychiatry focusing on psychoanalysis.

In 1968, the first editorial of ANFE's *Journal d'ergothérapie* proposed a charter to be followed in each issue: a general article, an article relating to various fields, a technical article and two articles devoted to problems encountered in occupational therapy. It's highly likely that the themes are determined by ANFE's president, who is also the Journal's editor. Thus, we regularly find articles on occupational therapy in psychiatry between 1970 and 1975, when Philippe Vaur was President of ANFE and working himself in psychiatry. During this period, several psychiatrists also published in these journals in support of occupational therapy. In 1968, Jean de Verbizier, medical director of the Institut de Psychiatrie La Rochefoucauld in Paris and member of ANFE's Honorary Committee, wrote the introduction to a paper by occupational therapists on "an industrial-type workshop in a psychiatric day unit" (Berta *et al*., 1968).

In 1968, Dr. Leblanc, psychiatrist at L'Eau Vive, gave another account of occupational therapy in psychiatry. Surprised by the absence of occupational therapy in the psychiatric field in France, while "*Occupational Therapy*" seems to be very well developed in this field in Anglo-Saxon countries, he winks at the difficulty of fully understanding what an occupational therapist can offer: "I found mention of a variety of jobs ranging from folding envelopes to milking cows, as well as other less folkloric activities, such as brushing, basket-making, weaving, etc." (Leblanc, 1968, p. 22). For the author, occupational therapy is associated with handicraft techniques; the occupational therapist proposes the action, the object, but also a relationship, and it is thanks to this relationship with the object that the occupational therapist's work becomes therapeutic. In his view, the occupational therapist's role is to work as part of a team. The activity is not therapeutic in itself, but serves as a means of psychodynamic therapy.

In 1970, Dr. Jean Garrabé, then director of the Institut Marcel Rivière in La Verrière, near Paris, spoke of the place of occupational therapy in institutional psychotherapy. He recalls that on March 15, 1960, a ministerial circular defined a policy of continuity of care in which, in his view, "occupational therapy is one of those that can be used most consistently in inpatient and outpatient institutions" (p. 29).

This was followed for several years by publications by occupational therapists : "La terminaison de la relation soignant-soigné et l'anxiété à la séparation" (Vaur, 1972), "L'importance de l'ergothérapie en pathologie mentale" (Lamarche, 1974), "L'ergothérapie en psychiatrie...

question de méthodes" (Barbier, 1974, 13), "Marionnettes et marottes : méthode d'ergothérapie projective de groupe" (Bedos *et al*. 1974, 14), "L'alcoolique" (Vaur, 1975a), "Le travail et sa symbolique psychiatrique" (Vaur, 1975b).

The work of the occupational therapist in psychiatry then took different directions, with "work activity" or "craft activity" as its objective. Conceptualization began with R. Barbier's 1974 article "ANFE occupational therapist", which drew on the writings of Friedman, Marx and Tosquelles:

> "Unlike the handicraft instructor or the foreman, the occupational therapist is never content to be the one who makes people do things or shows them how to do things. He's always the one who "helps" to do. I forget who said: "The occupational therapist is the cane". And depending on the climate created (or not), he finds himself intimately involved in this relationship that links him to the patient through the object (p. 3). It's a relationship that grows and changes as the restructuring process progresses. (Relationship: occupational therapist-object, then occupational therapist-object-patient, then finally object-patient-object). (This object perceived in all its symbolism, having a shape, a volume that can be touched, which serves a purpose and represents an exchange value...). The occupational therapist knows the material, and the patient needs to feel that the occupational therapist knows the material, and it is through this material perceived and shaped by one, and progressively by the other, that a relationship is established, and a language can be born and developed in the patient". (Barbier, 1974).

At the end of the period, occupational therapists began to become more involved and to find a place in psychiatric institutions, with the support of psychiatric doctors who were convinced of the benefits of occupational therapy.

A place on the job market among other professionals

At the outset of the profession, Pierquin (1968) notes that ″the young occupational therapy, barely born, is beset by enemies who do not want to destroy it, but to take it, on the pretext that it is already part of their own domain" (p.7). In his view, occupational therapy needs to define and situate itself in practice.

But in the field, it's not easy to find a place. There are sometimes tensions with other professionals, in particular physiotherapists, who obtained their state diploma in 1946, and who feel threatened by occupational therapists.

Some people wanted to qualify occupational therapy as a specialty of physiotherapy, and combine the two professions into one. To this end, a decree dated August 22, 1962, made a new curriculum compulsory for masseur-physiotherapists, including 50 hours of occupational therapy (Pierquin and Roche 1964, p.7). ANFE objected, arguing that this was too short for training and too long for information. In Nancy, Pierquin and Roche advocated official recognition of an occupational therapist diploma, with a view to improving cooperation between the professions (Pierquin and Roche, 1963).

Moreover, physiotherapists are critical of the use of manual and artistic activities by occupational therapists. According to the pioneers, the activities are a source of devaluation (Charret, 2012). The activities used by occupational therapists are perceived as less "noble" because they have no scientific value, even if they do have therapeutic value. As a result, physiotherapists sometimes refer to occupational therapists as "bricolothérapeutes", associating

occupational therapy tasks with lay practices. This problem is known and encountered beyond our borders at the start of the profession (Charret, 2011), notably at the origin of the profession during the 1914-1918 war (Pettigrew *et al.,* 2017)

The doctors who founded the schools wanted equality between the two professions, stating that the occupational therapy profession was a "complement to, not a replacement for" the masseur-physiotherapist profession (Pierquin *et al.,* 1958, p. 224). Certainly, for doctors, it's interesting to keep several "para" professions around the medical profession, especially as occupational therapists look after patients in aspects of daily life that seem to be neglected by the medical world (Charret, 2017)

For several years, these tensions were at work. When the official curriculum was introduced in schools, the French Federation of masseur-physiotherapists was concerned about the "attempt to divide up the profession"[6] after the publication of the June 1972 decree on the curriculum for the occupational therapist state diploma, and succeeded in getting a restrictive law passed[7] . ANFE joined forces with doctors and the Syndicat national des rééducateurs en psychomotricité to oppose the monopoly of masseurs kinésithérapeutes in rehabilitation, and won the case.[8]

Conflicts at the outset probably created a division of labor, implicitly, by physically dividing up the patient: occupational therapists would intervene on "the top" of the patient's body and masseurs-physiotherapists on "the bottom". Several pioneers also explain this organization by the fact that occupational therapists use "manual" activities and masseurs-physiotherapists take care of "walking" (Charret, 2016a).

The quest for recognition and official status

In the late 1950s, occupational therapists began to band together to defend the profession and gain official recognition. J. Lejeune (sp. Roux), a double graduate from France and the United States, founded the Association Nationale Française des Ergothérapeutes (ANFE) in 1961, in collaboration with other pioneers such as R. Cazenave and M. Lemarchand, supported by the Nancy team. J. Lejeune becomes ANFE's first president. Mademoiselle Chapron became treasurer and Mademoiselle Tirard general secretary.

One of the first objectives was to define occupational therapy, which ″takes on a different face depending on the Center where it is practiced". “It is necessary," says M. Mavel, delegate of the Paris School, "to pursue a triple goal: medical, technical and psychological″. (Bulletin de l'association, 1962).

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[6] ANFE archives. Extract from an article published in Le Figaro on November 27, 1972. "*Les masseurs-kinésithérapeutes decide on the principle of a petition campaign*".

[7] ANFE archives. Extract from bill 2668 by the Committee on Family, Cultural and Social Affairs article 1.

[8] ANFE archives. Correspondence between ANFE and the Syndicat national des Rééducateurs en psychomotricité. Letters of support from Pr Pierquin to Dr Charbonneau, Director General of Public Health, and to the President of the National Union.

At the General Meeting on March 25, 1962, the steps taken to create a state occupational therapy diploma were described, including the fact that M. Pringent, in 1959 in the Revue de l'UNIOPS, had made the request to the Ministry:

> "... Urges the creation of a State diploma in Occupational Therapy analogous to that of masseur-kinésithérapeute instituted by law no. 46-857 of April 30, 1946. The profession of occupational therapist is explicitly enshrined in the Order of September 29, 1953, by which the Ministry sets the conditions for the opening and operation of functional rehabilitation centers and services" (Lejeune, 1962).

ANFE is working to obtain a state diploma, also using WFOT documents (ANFE Archives). J. Lejeune (sp. Roux) is convinced that legitimization of the program and official status with a state diploma would be easier to achieve with international support (Charret, 2016c).

The criteria for WFOT membership were established with the aim of guaranteeing the quality of professionals in all areas of occupational therapy, with "minimum standards" (Mendez, 1986). At the World Congress in 1962, the WFOT envisaged extending studies to three years, and this is also the goal that French occupational therapists are aiming for. As President of ANFE, J. Lejeune wrote in the *Association's* 1963 *Bulletin*, with great enthusiasm and hope for the Association's future, "1962 will have been a decisive year for our Association... We have a clear path ahead of us. Difficult, yes, but clear." (Lejeune, 1963).

After rebuilding the teaching program, ANFE became an active member of WFOT at the 1964 meeting in Israel (Mendez, 1986). This event was welcomed as a victory in France, as it marked the first step towards official recognition.

In those years, the profession was booming, thanks to the political actions of ANFE, the founders of the schools and the support of many doctors. In 1964, five of the seven members of ANFE's Board of Directors were doctors. The reading committee was made up of two doctors and two occupational therapists. On the other hand, the Board is made up entirely of occupational therapists, allowing for a certain degree of autonomy. In *ANFE Bulletin* No. 5, 1964, it was recommended that every occupational therapist should ask his or her Chief Medical Officer to write an article, as these were considered "valuable documents". By 1972, fourteen professors and physicians were on ANFE's Honorary Committee, and five were on the Board of Directors (ANFE, *Journal d'ergothérapie,* April 1972, 7). This support is beneficial, and even strategic, in gaining official recognition.

In 1967, ANFE began the process of obtaining a state diploma. A group was formed at the Ministry of Health, comprising health officials, the founders and directors of occupational therapy schools in Paris, Nancy and Lyon, doctors, and J. Roux-Lejeune as President of ANFE.

In 1970, occupational therapists obtained their state diploma, and in the four years that followed, five new occupational therapy schools opened their doors: Montpellier in 1971, Berck and Rennes in 1972, Créteil in 1973, Bordeaux in 1974, making a total of eight schools throughout France until 2009.

The creation of the state diploma was eagerly awaited. J. Roux-Lejeune, President of ANFE, announces in her editorial that this decree, signed on November 6, 1970, is a short text which "weighs heavily on the future of our profession". "It rewards 15 years of work by the schools and 10 years of effort by our Association" (Roux-Lejeune, 1970).

Occupational therapists who graduated before this date are entitled to equivalence. After July 1977, it's too late to have your school diploma recognized (*Journal of Occupational Therapy*, 1976, 19).

9) Conclusion

In contrast to the history of occupational therapy in the United States, where the beginnings of occupational therapy were in the field of psychiatry (West, 1992; Schwartz, 1997; Licht, 1948), the start of occupational therapy in France, with qualified occupational therapists, was in the field of functional rehabilitation

At the 6th International Congress of Physical Medicine in Barcelona in 1972, J. Roux, P. Farcy and Prof. Pierquin reported on a survey carried out in 1969-1970 that counted some 150 practicing occupational therapists (out of 300 graduated in 15 years) from the three schools of Paris, Nancy and Lyon. Of the 75 responses obtained, occupational therapists dealt with "cerebral palsy and neurological conditions (40%), traumatic conditions (20%), psychic conditions (10%)" (Pierquin *et al.,* 1972, p.73). 44% were under 25 years of age, and only 10% of occupational therapists had ten years' experience (*Journal d'ergothérapie,* 1970, 4). At that time, there were 23,000 occupational therapists worldwide (WFOT). In 1977, ANFE launched a survey of its members to update the state of practice in France, in order to defend the profession among the many paramedical professions and give it "the place it deserves" (*Journal d'ergothérapie,* 1977, no. 24)

After almost twenty years of existence, in 1971 the first classes began to follow the official occupational therapy curriculum, and the first state-qualified occupational therapists, "DE", graduated in 1974.

In early 1979, in her editorial for the *Journal d'ergothérapie*, editor-in-chief Florence Delagarde evoked a promise and an obligation when she announced a new form for the journal, with Masson taking over publishing. "We're leaving behind the artisanal era... for a transition to noble publishing". Improving the quality of the journal was a hopeful step towards making occupational therapy better known and "making a greater number of people aware of its problems, techniques and possibilities" (Delagarde, 1979). But occupational therapists are also called upon to share their experience! The journal invites occupational therapists to write "studies" on all areas of occupational therapy.

After a period in which the profession was being set up, in search of official recognition and a collective professional identity, as Pibarot evokes when she writes ″Our profession seeks its identity" (Pibarot, 1979b, p.42), the future looked promising, with the creation of a state diploma and eight occupational therapy schools spread across France. However, at the end of this period, the profession was still fragile. There is a need to communicate and further establish the core business and professional identity

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Chapter 4 2e paradigm 1980-2000: Towards more context-adapted activities, to live in one's environment

How many occupational therapists were there in France in 1980? Perhaps 900, mainly in the Paris region and eastern France.

In 1974, there were 8 occupational therapists in the Aquitaine region, 5 of whom worked with children and none in geriatrics. In 1984, there were 30 occupational therapists in the department of Gironde and around 26 in the 4 other departments, making a total of around 56 occupational therapists in Aquitaine, including 2 or 3 in geriatrics.

4185 occupational therapists in France were registered in the ADELI file in January 2001.

1) Introduction

In this chapter, we focus on the period 1980-2000. Occupational therapists, still few in France, are called upon to work with people suffering from increasingly complex pathologies, such as traumatic brain injury, but also in the field of geriatrics, which is beginning to attract the attention of doctors and decision-makers.

According to Rozenn Botokro, "The early '80s were marked by two simultaneous phenomena that enriched each other. On the one hand, the gradual questioning of the medical model, and on the other, the diversification of occupational therapy practice settings." (Botokro, 2006, p. 9). Occupational therapists are gradually moving out of institutions, first to accompany people in their living environment and adapt their environment, then, later, to explore private practice.

After outlining the social, technological and medico-social context of these two decades as it shapes occupational therapy, we will consider the development and impact of the official texts that provide a framework for the practice and training of occupational therapists.

We will then look at the activities implemented by occupational therapists during this period, the evolution of activity teaching and the way they are analyzed.

Finally, a timid opening to occupational therapy abroad heralds the next period.

2) The social and technological context

In May 1981, François Mitterrand, a Socialist, was elected as President in France after twenty years in opposition. Jack Ralite, a Communist, became Minister of Health from 1981 to 1983. His ideas for "health centers" where doctors would work with paramedics, and for the abolition of private practice, were not accepted by doctors, but had an impact on the 1986 decree for professional acts of occupational therapists, which gave them no professional monopoly and restricted them to treatments provided by a health or medical-social establishment or service.

It was during this period that doctor-patient relationships were turned upside down: the paternalistic approach of doctors had to change! By often being better informed than doctors about the Acquired Immune Deficiency Virus at the start of the epidemic, AIDS patients upset medical knowledge (Barbot *et al.,* 2000). The AIDS epidemic, which began in 1981 (discovery of the virus in 1983, prevention measures launched in 1986, AZT treatment in 1986 and tritherapies in 1996) (AIDES, 2017) and the contaminated blood affair (1983-1999; legal proceedings: 1992-2003) (Chauveau, 2011) undermined confidence in the medical profession and politicians. Thanks to the action of patient associations and new communication technologies, "patients" are investing the field of medical knowledge in what concerns them and demand to be heard and taken into account. According to N. Dodier (2005), AIDS is becoming a vector of therapeutic modernity.

Also, according to Mermet (2006), contraception, thanks to the pill authorized since 1967, enables women:

> "To access a more satisfaying professional life, a richer social life, and a more fulfilled couple life. For the first time in history, women were no longer determined by their procreative function. Since the 1980s, magazines, literature and advertising imagery have accompanied and accelerated the changing role of women." (p.112)

This development will revolutionize the place of women, including occupational therapists, in society.

This period in France was also marked by the technological development of use (Edgerton, 2013), particularly of micro-computing, in the social and professional environment. The Minitel was tested in the department of Ille-et-Vilaine in 1981, and marketed by the PTT (Post office and telecommunication) in June 1982: electronic directory, games and services. By 2000, the Minitel was being used by one French person in two (25 million users).

1982-83 saw the launch of consumer VCRs and camcorders, as well as laser-player compact discs, which would become more accessible in the 90s.

In 1985, Laurent Fabius's "Computing for all" plan introduced many primary school pupils to the beginnings of microcomputing, with a few games and educational exercises on Thomson's TO7 and MO5 (a French brand), recorded on audio cassette but without a hard disk.

Occupational therapy schools began equipping themselves with computers for secretarial work in the late 80s.

At the Centre Hospitalier Universitaire occupational therapy school in Bordeaux, the secretary received a computer in 1988, and in 1991, the CHU installed one in the director's office with a 40 MB hard disk: an unheard-of luxury!

Throughout this period, communication was by post and landline telephone only. Faxes arrived in the 1990s.

The first website went online in 1993, but it was not until a few years later that Amazon began to buy books online, and e-mail access became widespread (in the OT schools in 97-99).

Computers spread throughout society in the 90s (companies, banks, universities... and then public services and families). The creation of the CICAT (Centres d'information et de conseil en aides-techniques) in the early 1990s was based on the development of computer networks.

In 1999, you could check your email on the French service "Caramail" (forerunner of Gmail) and as one blogger says: "No 15GB storage yet (you were only allowed 10MB) in the cloud but to send your 10 monthly emails, the service was more than enough!"

https://www.blogdumoderateur.com/journee-type-internet-en-1999/

At the end of the 90s, the first cell phones also began to spread.

Finally, we're expecting the Y2K bug... which won't happen!

3) The medico-social context and its impact on occupational therapy

The question of work in the world of disability

Uncertainty about employment appeared. Rising unemployment put the place of work in people's lives into perspective, especially for the disabled. In the 80s, crafts (pottery, weaving, silk painting, etc.) were still part of leisure activities, and seemed a natural fit for occupational therapy. In 1982, the legal working week was reduced from 40 to 39 hours, with a fifth week of paid vacation. Leisure activities expanded, and people began to look for ways to improve their health: well-being and quality of life (Le Moigne, 2010). A rebalancing is taking place between work and leisure activities, as well as gardening and DIY at home.

The job market is also affected for occupational therapists themselves. For example, the health crisis of 1983 slowed job creation due to austerity (Warlouzet, 2018). On the other hand, out-of-hospital work is on the rise.

In France, psychiatry has been governed by the principle of sectorization since the law of December 31, 1985: a circular had asserted this desire for sectorization as early as 1960, which some departments had already put in place. Henceforth, each geographical area is clearly defined, corresponding to a given service in a reference hospital establishment, and covering a population of around 70,000 inhabitants. Geographical origin thus determines the place of care. In the 1980s, extra-hospital structures attached to the hospital were created in these sectors: occupational therapists began to work both in and out of hospital. Some psychiatric hospitals had traditionally maintained professional activities as an occupation, and some are beginning to organize these same activities - gardening, for example - with a view to professional integration (Dumas, 2004). However, many people under psychiatric care still do not have access to the mainstream workplace. Defer *et al* (1994) report that psychiatrists are wondering:

> "What meanings can we attribute today to the use of work as a therapeutic means within a care institution, when it has often deserted plausible representations of a reinvested out-of-hospital existence for many of our patients, and is no longer guaranteed to the healthy?" (p.1).

Finally, and paradoxically, these people find in the CAT (*centre d'aide par le travail*) a place of insertion (Person, 1997).

On July 10, 1987, Law no. 87-517 in favor of the employment of disabled workers introduced an obligation for companies with more than 20 employees to employ, on a full-time or part-time basis, 6% of them. The AGEFIPH (*Association Nationale pour la Gestion du Fonds pour l'Insertion Professionnelle des Personnes Handicapées*) was created to manage the fund for the integration of disabled people in the private sector. Created in September 1988, it is subject to State control and brings together trade unions and associations of disabled people. Some occupational therapists are also active in this field (Dubourg, 1989).

The ministerial decree of October 27, 1989 set up the Services of special education and home care (SESSAD). The *Association des paralysés de France* (APF) had already been running home care and education services for almost ten years, offering children occupational therapy that respects and takes into account their family and school environment. Similarly, the Fédération APAJH (*Association pour adultes et jeunes handicapés*) runs a wide range of facilities: *Instituts Médico-Éducatifs* (IME), SESSAD, *Centres d'Aide par le Travail* (CAT), *Foyers d'Accueil Médicalisé* (FAM) and *Maisons d'Accueil Spécialisées* (MAS), organized around four areas: childhood-youth-schooling; social life; professional life; and long-term dependence. The schooling of children with disabilities is one of the founding battles of the Fédération APAJH. For example, it integrates care centers at the heart of schools, so that the medical and paramedical team, and in particular the occupational therapists, can intervene as close as possible to school life situations. As for the Professional Life Division, the Fédération APAJH is committed to a multi-faceted approach to work (mainstream and sheltered environments), which it sees as an important factor in enabling people with disabilities to achieve full citizenship.

On a daily basis, medical and paramedical teams are confronted with the difficulties faced by each disabled person on the road to employment (Balluais *et al*., 1994). Since 1992, the Comète France association has been federating various teams nationwide to support patients in physical medicine and rehabilitation centers, in order to facilitate their return to employment in an ordinary environment. This support, provided by multidisciplinary teams, aims to promote the social and professional integration of disabled people. Within Comète France, the LADAPT association is initiating the early integration approach it had modeled back in 1969, for the care of brain-damaged persons. This system enables the person's professional project to be drawn up and implemented as soon as he or she has undergone treatment and rehabilitation. Created in accordance with the circular of July 4, 1996 on the medical-social care and social reintegration of people with brain damage, the UEROS (*Unités d'évaluation, de réentraînement et d'orientation sociale et professionnelle*) is another system that complements the resources available to these people. UEROS have a triple mission: 1/ cognitive re-education, 2/ evaluation and development of autonomy in social life, 3/ evaluation and development of work capacities and professional reintegration of people with brain damage who have failed to integrate. Indeed, the challenges of social and professional integration are extremely difficult to meet due to the impairment of executive functions, corresponding to the abilities needed for a person to adapt to new, i.e. non-routine, situations for which there is no ready-made solution. True to its commitment, in 1997 LADAPT launched the "*Semaine pour l'emploi des personnes handicapées*" (Disabled Employment Week), which takes place every November.

Whether in Comète France, in UEROS or in vocational training centers (CFP), occupational therapists are called upon to support people in maintaining or returning to work, or in retraining for new careers (Le Montagner, 1996; Barre, 1997; Franconie and Morand, 1999).

The growing complexity of pathologies and the interweaving of medical and social issues: the problem of hospital discharge

In the late 70s and early 80s, medical advances enabled a greater number of injured and elderly people to survive. The question of how to care for brain-damaged people with severe head injuries as they returned to life raised many questions, and medical and paramedical rehabilitation teams shared their experiences at conferences and training courses (Lyon, 1980; Bordeaux, 1982; Hyères, 1983).

A major symposium on "Activity and the Elderly" (November 23-27**, 1982**) was organized in Lyon by ANFE, with Nicole Sève-Ferrieu as president and Isabelle Pibarot and Dominique Suchet (vice-president of ANFE and member of the *Conseil supérieur des professions paramédicales*), occupational therapists from the Lyon region. The book "*L'activité et la personne âgée*" *(Activity and the Elderly*) is edited by ANFE, and includes texts by politicians, doctors, psychologists, sociologists and occupational therapists.

Fig. 1 - Publication for the Lyon Colloquium on "Activity and the Elderly"

It shows the growing interest in this growing segment of the elderly population, which requires increasingly specialized and costly care. The Plancade report (1999) shows that the share of healthcare expenditure has been rising since the 1950s, that the average cost of medical care is four times higher after the age of 70, and that demographic ageing is accelerating.

In connection with this symposium, a number of articles appeared in the *Journal d'ergothérapie*, questioning the place and role of occupational therapists with the elderly (Pelbois-Pibarot, 1982; Suchet, 1982; Calmels, 1984).

In March 1985, inspired by Quebec occupational therapy, a home visit as part of a partnership with the Bordeaux University Hospital inaugurated the "Papa-Bouscat" project to help elderly people return home (Campillo *et al.,* 1987).

But geriatrics is not yet a major focus for occupational therapists.

In 1985, the *Journal d'ergothérapie* devoted four issues to traumatic brain injury. In this issue, numerous articles written by occupational therapists presented the pathology, the various disorders and their rehabilitation, the question of assessments and longer-term outcomes, but no article specifically targeted interventions outside institutions or the return to "ordinary" life, as practice was essentially intra-hospital. We will have to wait a few more years to see these experiences of a return to ordinary life outside institutions (Picard, 1996; Lacoste-Debray *et al.,* 1997).

Fig. 2 - Occupational therapy and the environment

In **1986,** the book coordinated by Lucien Simon and Jacques Pelissier (1986) demonstrated the growing interest of occupational therapists and rehabilitation physicians in life outside institutions. A small insert in the *Journal d'ergothérapie* (1986, p. 135): "Many subjects are dealt with in this book, including: the contribution of occupational therapy to neuropsychological rehabilitation in adults, occupational therapy and the traumatic hand, reintegration of low back pain sufferers, the physically handicapped child at home", demonstrates the attachment of occupational therapists to interventions linked to pathologies, rather than to the environment, but perspectives are changing.

As soon as intervention becomes structured with patients suffering from complex pathologies, the question of discharge arises, calling into question the commitment of occupational therapists (Lacheny, 1989). However, teams were beginning to take shape, as at L'Hospitalet in Loir-et-Cher department: a special issue of the *Journal d'ergothérapie* was published in **1990** (Vol. 4) entitled "*Retour à domicile du grand handicapé physique*" ("Return home for the severely physically handicapped"). Similarly, the SCAPH 38 autonomy advisory service for disabled people, set up in Grenoble in 1988, was a pioneer in the field of social integration (Memin *et al.,* 1991). Occupational therapists are beginning to join homecare teams.

Fig. 3 - Mutualité française (1994) Integration of an occupational therapist in a SSIADPA (homecare service for the elderly) 1992-1994. National experiment.

Taking the environment into account means that occupational therapy can be practised in a wider range of settings. In psychiatry, for example, "*occupational therapy can be carried out outside the psychiatric institution, in other places or at different times from hospitalization, and on an individual rather than a group basis*" (Defer *et al.,* 1994, p.1). Also, the 1990 training program states that, as part of occupational therapists' work on the environment and its accessibility, "industrial and commercial companies (as employers as well as producers), local authorities and associations can call on the services of occupational therapists" (Order of September 24, 1990); even if this is more of a wish than a reality at the time.

For occupational therapists, it's a period of gradual openness to the non-institutional care environment and integration into the city (Marty, 1995; Maurin, 1995; Detraz, 1997).

The complexity of cognitive disorders and their impact on everyday life are raising questions for occupational therapists. With neuropsychological problems becoming more and more prevalent, the first book written on this subject by a French occupational therapist was published in 1995: "*Neuropsychologie corporelle, visuelle et gestuelle"* (Sève-Ferrieu, 1995). It was to inspire many occupational therapists, as Guillemin (1996) attests:

> "This book, written by a senior occupational therapist, reflects her experience in the field. Following a review of neuropsychological functions in "healthy" humans, the author analyzes dysfunctions in adult hemiplegics. In my opinion, this book is a real guide to the day-to-day management of adult hemiplegics, with its wealth of exercises, analysis of drawings and rigorous approach to management (principles of management, assessments, objectives, materials to be used)." (p.88)

In the transition between the ICIDH (1980) and the ICF (2001), the problem of the separation between health and social in France

In the literature of the 1980s, occupational therapists seemed to perceive disability as arising directly from patients' impairments and incapacities (De Tienda, 1984). Medical progress meant that many occupational therapy patients survived without being cured, and the question of leaving the institution with impairments and incapacities became crucial. However, some authors recognized that disability is also a social fact, that it can be relative and emerge in "confrontation with society" (Cheron and Soldano, 1990, p. 50). The International Classification of Disability published by the WHO in **1980** was not translated into French until **1988**. French occupational therapists then discovered it: "This document is fascinating for the wealth of observations to be noted and the synthesis it allows." (Blancher, 1991, p.42).

Occupational therapists appreciated the link between impairment, disability and social disadvantage.

In France, the health and social sectors have always been very separate, although attempts have been made to bring them closer together. For example, during this period, occupational therapists, who were trained and employed in the health sector, were not listed as social workers, and encountered numerous difficulties in working in social structures.

This compartmentalization between health and social care is evident at all levels. Access to, or return to, work, which has long been an important objective in occupational therapy, lies precisely at the interface between health and social care, and poses a problem: which side should occupational therapists be on? In psychiatry, where occupational therapy is still mainly "done" by psychiatric nurses, some psychiatrists are proposing to split up the occupational therapy activity, as described by Defer *et al.* (1994):

> "Occupational therapy methods will have to continue their cultural revolution and untangle the confusions that weave themselves around the notion of work. A new terminology would perhaps lead to a useful partition: we would stop assimilating under the same term two types of activity:
>
> - one offered to patients as part of a therapeutic project;
>
> - the other, which meets a precise social definition and which may eventually represent a testimony to the reintegration of a mentally ill person into ordinary life." (p. 6)

It's interesting to note here that the concept of “situation of disability” arose from a joint reflection between a "medical rehabilitation department with Claude Hamonet (professor of physical medicine and rehabilitation and later anthropologist), urban planners and the *Association des Paralysés de France* in Créteil, in the early 1970s (Hamonet, 2009). At the same time, Pierre Minaire (a medical doctor and professor of functional rehabilitation in Lyon) took part with Philip Wood (a British rheumatologist and professor of public health) in drawing up the International Classification of Handicap commissioned by the WHO (Minaire and Cherpin, 1976). The ICIDH was widely criticized for establishing a direct link between impairment and disability, without taking sufficient account of the environment, unlike the notion of the "situation of disability". In the early 80s, anthropologist Patrick Fougeyrollas developed the Disability Creation Process (DCP) model in a systemic spirit (Fougeyrollas, 1986). The DCP is particularly well understood by occupational therapists, and is used in the development of the “*Dossier du patient en ergothérapie*” (patient’s file in Occupational Therapy) (ANAES, 2001). These criticisms of the ICIDH forced the WHO to work on a new version, which became the International Classification of Functioning (ICF), endorsed by the WHO in May 2001 and published in French in December **2001**. Occupational therapists were following the development of this revision and were interested in the change in vocabulary. "In 1988, disability was seen as a necessary transition between impairment and disadvantage. The revision's schema places this dimension in terms of activity, as an intermediary in the interactions of the process." (Bodin, 2000, p. 21).

4) The legal framework for occupational therapists:

The problem of context in psychiatry: the hospital statutes of April 80

Decree no. 80-253 of April 3**, 1980** on hospital statutes regulates the recruitment of occupational therapists in the public sector. At the time of publication of this decree, ten years after the creation of the State Diploma, there were still very few occupational therapists DE (with a state diploma), while many psychiatric nurses were "doing" occupational therapy in psychiatric hospitals. In fact, occupational therapy students still spend most of their psychiatric internships with psychiatric nurses who run craft workshops.

When the April 1980 text was published, psychiatric nurses working as occupational therapists in public hospitals were given the opportunity to submit an application to obtain the equivalence of the occupational therapy diploma. They then had until April **1983** to apply for integration as psychiatric occupational therapists. Many of them passed the exam, but in the end, few asked to be integrated, as this had its drawbacks: Veil bonus abolished, retirement age postponed, etc. In practice, many nurses remained in their posts, all the more so as the Public Health Code stipulates that the professional acts of nurses include "*individual or group sociotherapeutic activities*" in the field of mental health.

In 1983, Christian Chardron, one of these psychiatric nurses, published "*Faire de l'ergothérapie en psychiatrie : un témoignage professionnel qui éclaire et réhabilite même la notion de travail thérapeutique*", based on his equivalence written work. In it, he recalls the heyday of occupational therapy, holding a major congress on the subject in 1960 at his psychiatric institution in Mayenne, as well as the steps he took to develop the "therapeutic" aspect of the activities on offer (Chardron, 1983).

Also in 1984, in the Lyon region, Jean Michel published his book "*Savoir-faire, savoir être 'ergothérapeute' en psychiatrie*", in which he questions the limits of the profession with art therapy and socio-therapeutic activities.

In this context, the boundaries between the work of psychiatric nurses acting as occupational therapists and that of DE occupational therapists are blurred: titles and proposed activities are similar. According to Chardron, if at the outset, nurses propose activities with a view to stimulation, concentration goal, "occupation", production... subsequently, they try to develop the "therapeutic" aspect of these activities with reference to the dominant psychodynamic model, based on psychoanalytical theories.

Occupational therapists benefit from similar training in psychology and psychiatry, but often lack the experience of nurses who are twenty or thirty years older.

Indeed, the two official training programs for the state diploma in occupational therapy (1971-72 and 1990) emphasize the importance of psychodynamic psychology and psychoanalytic theories in the psychology and psychiatry courses. However, these teachings take up much less space than the theoretical and practical teachings linked to the functional aspect (anatomy, physiology, ergonomics, pathologies, internships...). Because of their training, occupational therapists question the therapeutic value of certain activities carried out in psychiatry: making objects for the hospital fair, participating in hospital maintenance activities to enable the hospital to live in autarky, the usefulness of the allowance (*pécule*)... But on the other hand, they are not sufficiently trained in psychoanalysis, which would require many hours of training

to be recognized as legitimate by psychiatrists to participate in psychoanalytically-inspired psychotherapy. The opinions of occupational therapists differ: for some, we are psychotherapists (Castano 1988), for others, we are not psychotherapists (Bergeret and Meyer, 1989).

The boundaries between the actions of occupational therapists and nurses are still sometimes questioned in some psychiatric sectors (Tosquelles, 2009; Merkling, 2018). Fransesc Tosquelles mentions in 2009 that his book "*Le travail thérapeutique en psychiatrie*" was written for psychiatric nurses, following on from its first edition in 1967, and stresses: "This is why a text on work, or rather on occupational therapy, is still welcome for those who would like to assume a caring role with the human person who suffers from his or her existence" (Tosquelles, 2009, p. 20).

Occupational therapists' involvement in out-of-hospital rehabilitation activities that focus on patients' needs and integrate cognitive functioning could tend to differentiate their roles, but this is hardly evident in many practice settings.

Also, in psychiatry, the development of art therapy aimed at developing expression in therapeutic workshops based on a psychodynamic approach has been in competition with certain practices of occupational therapists (Broustra, 1988; Oury, 1989). Here too, the boundaries are blurred, as many occupational therapists came to occupational therapy through their interest in artistic activities and psychodynamic approaches.

The decree on professional acts of November 1986 and registration in the public health code in February 1995

In the early 1980s, due to the lack of a legal definition of the profession, and the absence of regulations for the private sector, the Ministry of Health became concerned about what could be described as the "illegal practice of medicine" by occupational therapists.

Indeed, since the hospital statutes of April 80, a state Occupational Therapy diploma is required in the public sector, but in the private sector, no title is legally required for practice: a director of a private rehabilitation center can employ any professional to fill an occupational therapist post, as long as he or she is deemed competent.

The French Ministry of Health has asked occupational therapists and doctors from the CSPPM (*Conseil Supérieur des Professions Para-Médicales*: Higher Council for the Paramedical Professions) in collaboration with ANFE, to draw up a list of professional acts delegated by doctors to occupational therapists. This list is intended to be sufficiently broad for all occupational therapists to find their way around. It does not apply to commercial, consultancy or expert practice.

The occupational therapy profession welcomes the publication of Decree no. 86-1195 of **November 21, 1986,** setting out the categories of persons authorized to perform professional acts in occupational therapy. After defining the profession of occupational therapist, the decree specifies the medical acts delegated to occupational therapists, the professionals authorized to perform these acts, and the context in which occupational therapists may practice.

This decree does not list specific acts, as is the case for nurses, for example, but describes in general terms: assessments and physical conditioning, the organization of activities involving handicrafts, play, expression activities, daily life, leisure or work, with a view to specified

objectives such as "the transformation of a movement into a functional gesture" or "the expression of internal conflicts", as well as “the application of equipment and assistive devices appropriate to occupational therapy”. Since these are medical acts delegated to occupational therapists, the text is approved by the Académie Nationale de Médecine, as is the case for all paramedical professionals. In the end, this text reflects more the skills than the acts delegated by the doctor to the occupational therapist, as a precise list of acts proved impossible to draw up.

Unlike certain other paramedical professions, such as masseur-physiotherapists, occupational therapists do not have a professional monopoly, i.e. reserved acts, as the socialist Ministry of Health refuses to grant new monopolies. There are therefore acts that overlap with other paramedical fields of competence, which does not make it any easier to recognize the originality of occupational therapy, nor to defend it against other malicious professionals, but is intended to encourage interprofessional collaboration.

The Ministry of Health refused the request to work in private practice. Occupational therapists had little objection to this state of affairs, as in the early 1980s there were virtually no occupational therapists in private practice, and this was still far from the general concept of occupational therapy work.

To regularize the situation of occupational therapists working in the private sector, practice authorizations are granted to employees who have worked as occupational therapists for at least 3 years between 1976 and 1986, and who have passed a knowledge test before 1989. Licensing is granted for either re-education and functional rehabilitation, mental health or geriatrics, depending on the option requested by the candidate during the knowledge test.

Fig. 4 - Autonomy Ergotherapy ANFE

At the same time, ANFE published a booklet entitled "Autonomie Ergothérapie" (Autonomy and Occupational Therapy), describing the professional activities of occupational therapists, mainly in the various sectors of intervention: neurology, traumatology, psychiatry, visual disability, maladjusted childhood, geriatrics... but also mentioning some experiences in a homecare center for the elderly, in a local authority or in the commercial sector (ANFE, 1986).

The text of the November 1986 decree was later incorporated into the French Public Health Code in Act no. 95-116 of **February** 4**, 1995**, which included occupational therapists in the Health Code and protected their title and practice:

> *Any person who, not being a medical doctor, habitually carries out professional occupational therapy acts, as defined by decree of the Conseil d'Etat after consultation with the Académie nationale de médecine, is considered to be practicing the profession of occupational therapist*" (Article L4331-1) "*The profession of occupational therapist may be practiced by persons holding the diploma defined in article L. 4331-3, or holders of the authorization provided for in article L. 4331-4 and whose diplomas, certificates, titles or authorizations have been registered in accordance with the first paragraph of article L. 4333-1. The person concerned bears the professional title of occupational therapist, with or without a qualifier.*" (Article L4331-2) and "*The diploma referred to in article L. 4331-2 is the French state occupational therapy diploma*" (Article L4331-3).

This registration entitles them to the title of medical auxiliary, and is a necessary step towards recognition as a self-employed practitioner. Occupational therapists must register on the

ADELI file in each department with the Direction départementale des affaires sanitaires et sociales (DDASS), and later with the ARS (*Agence régionale de Santé*).

Private practice

From the late 1980s onwards, a few experiments in self-employment began in France, but remained marginal until the late 1990s. These experiments responded to a need to get out of institutions or to develop work opportunities close to home. Some were one-off projects (Mas, 1988; Castano and Rigal; 1989; Peiffert, 1989; Besson, 1990). Others were to become true liberal practices, particularly in major cities such as Lyon, Paris and Nice (Redoux, 1990; Hercberg, 1994 and 1997; Séraphin, 1996; Carlino, 1999; Couasné, 2000). In **1998**, ANFE set up a committee of self-employed occupational therapists.

5) The evolution of occupational therapy training

Ongoing training

ANFE's Continuing Education Section, set up in **1978** by Pibarot, grew steadily during this period, and was renamed the Continuing Education Service (SFC) in 1995. In addition to cooperation on certain courses offered by the University of Lyon, two training courses were offered by ANFE in 1980: "Matière et ergothérapie" and "Corps et matière" led by Pibarot (*Journal d'Ergothérapie*, 1980, Tome 2, Vol.1, p.31). In 1981, a week-long training course on "Training occupational therapists" was organized in Nancy, bringing together a group of occupational therapists, including the heads of the eight French occupational therapy schools, with the exception of Lyon, which was then run by a physiotherapist. Michèle Dubochet, a Swiss occupational therapist, spoke at the meeting, outlining current issues in occupational therapy training (Dubochet, 1982).

ANFE organizes numerous national and regional study days, particularly in the Lyon region. They are often an opportunity to raise awareness of and reflect on developments in occupational therapy practice. The SFC's training offer will increase exponentially throughout this period, allowing ANFE to gradually professionalize.

In **1988**, the Montpellier School of Occupational Therapy launched a major series of congresses dedicated to occupational therapy. The "Experiences in Occupational Therapy" days were to become a powerful national and international French-language event, each time associated with a book. These collections of texts constitute a particularly useful library for occupational therapists and occupational therapy students until 2019.

And the period ends with the European Occupational Therapy Congress in Paris in September 2000!

Management training: from occupational therapy management instructors to occupational therapy health managers

In January **1980**, occupational therapists finally saw the publication of decree no. 80-13, creating the *Certificat de moniteur cadre d'ergothérapie*. In 1982, two occupational therapy management schools were authorized to open: in Nancy and Montpellier, each with a capacity

of five students per year. The Montpellier school operated in conjunction with the physiotherapy management school, and opened in September 1982. The OT specific Nancy school opened in 1983, but only operated every other year. Between 1982 and 1995, the Montpellier instructor-manager school trained forty-four occupational therapists (Izard, 2001). Instructor-manager training is difficult because it is full-time for one year, costly for healthcare establishments and demanding for the occupational therapists entering the training program.

These two schools remained the only pathways to the *Certificat de moniteur-cadre d'ergothérapie* until **1995**, when the decree of August 18, 1995 created the Institut de Formation des Cadres de Santé (IFCS) paramédicaux, under the impetus of the Union Inter Professionnelle des Associations de Rééducateurs et Médicotechniques (UIPARM). Under the supervision of the Ministry of Health, a large number of executive training sites were opened to occupational therapists throughout France (Durand and Hernandez, 1999). In some cases, this facilitated access to training, enabling occupational therapists to become teaching managers or heads of department. The versatility of occupational therapy managers and their holistic perception of care situations are generally appreciated, but they are far fewer in number than their nursing or masseur-physiotherapy colleagues, which limits their impact on the organization of care and the development of occupational therapy in institutions.

Admission to occupational therapy schools

The September 1971 decree specified a number of criteria for admission to an occupational therapy school (such as minimum age), but made no mention of a competitive examination: each occupational therapy school organized its own admission procedures.

The decree of June 13, 1983 introduced an entrance examination for the **1984-1985** school year, organized by the DRASS (*Direction Régionale des Affaires Sanitaires et Sociales*), which lasted four years until 1988, when organization of the examination was delegated to the schools.

At the end of August 1991, the text was published authorizing admission to the PCEM 1 (First Cycle of Medical Studies) in Bordeaux and Lyon on an exceptional basis. This "experimental" dispensation, renewed every year, will last until 2021!

Occupational therapy school management

The decree of September 24, **1990**, on the operating conditions of occupational therapy schools, allows an occupational therapy supervisor to manage an occupational therapy school. Until now, this has been the exclusive role of doctors, with the exception of Paris, where François Lecomte (1984) and Nicole Sève-Ferrieu (1988) were appointed directors when ADERE OT school was set up. Each school was then run either by an occupational therapist manager as director, or by a medical director assisted by an occupational therapist manager as technical director. The latter configuration continued the existing collaboration at most schools. The decree of May 27, **1997** entrusts management to the occupational therapist health executive alone. However, at their request and as a transitional measure, the doctors at the helm of the Bordeaux, Créteil, Lyon and Montpellier occupational therapy schools will remain so until the date of cessation of their duties.

New occupational therapy training program

Now that the selection procedures have been published, the teaching commission set up by the *Conseil supérieur des professions paramédicales* (Higher Council for the Paramedical Professions) is getting down to work on a new training program. This work is being carried out in conjunction with ANFE, and in particular its Teaching Committee, made up of directors of occupational therapy schools.

In 1986, at the request of the French Ministry of Health, a working group set up by the CSPPM (*Conseil supérieur des professions paramédicales*) and including Marcelle Ridel and Marie-Chantal Morel for the occupational therapists, as well as Pr Simon (Montpellier) and Dr Vignat, a psychiatrist in Lyon, for the doctors, began work on a reform of the occupational therapy curriculum. This new program will be drawn up mainly by the ANFE Teaching Committee, with the help of doctors such as Pr Mazaux, medical director of the Bordeaux OT school.

The decree of **September** 24, **1990** on preparatory studies for the occupational therapist state diploma abrogates the previous official program and specifies that "the objectives of occupational therapy are to maintain or achieve maximum individual, social or professional autonomy for the disadapted person". Access to work is still an important objective, but its place is shrinking in favor of self-care activities when the pathology is invasive, or leisure activities which are developing in society, made possible by various financial supports such as the Allocation Adulte Handicapé (AAH) created by the 1975 Orientation Law.

The definition of occupational therapy given in the **1990** program clearly links the person, /her activities and his/her social and physical environment:

> "Occupational therapy is a discipline applied in the fields of care, re-education, rehabilitation, prevention and counseling. It is aimed at people with a declared or potential deficiency, dysfunction, incapacity or handicap of a somatic, psychic, intellectual or associated nature, creating a disadaptation or alteration of identity.
>
> The aim of occupational therapy is to help the disabled person maintain or achieve maximum individual, social or professional autonomy.
>
> This method intervenes on two levels:
>
> - at individual level: depending on the case, the aim is to improve deficient functions, promote personality restructuring, or develop residual capacities for functional or relational adaptation. To achieve this, occupational therapists use activity and work situations. They can also suggest, design or manufacture suitable equipment when necessary;
>
> - the environment: both the human environment, by taking into account what happens at relational level, and the material, architectural and urban environment, by proposing practical solutions to make it more accessible and promote better integration of the person. In this respect, industrial and commercial companies (as employers as well as producers), local authorities and associations can call on the services of occupational therapists.
>
> By understanding the individual, his or her pathology and environment, and the interrelationships between these different factors, the occupational therapist is able to

assess the loss of autonomy by understanding the person as a whole. The occupational therapist acts as an intermediary between the person's adaptation needs and the demands of daily life.”

In addition to the reorganization of teaching, the biggest changes include the introduction of methodology in the first year (methodology of learning, observation, scientific approach, professional approach), a relationship training module, the teaching of neuro-anatomy and neurophysiology earlier in the curriculum, and the extension of practical training time, with the possibility of an internship without an occupational therapist. The State Diploma will no longer include a written examination, replaced by an interview with the jury on the student's work during the course. The two practical tests are reduced to a single one, in either functional rehabilitation or psychiatry, by drawing lots.

On the whole, this new occupational therapy training program is in tune with changes in practice, developing the scientific approach and practice in rehabilitation and reintegration, and restricting the role of craft activities, but it does not revolutionize occupational therapy teaching.

Methodology appears in the program, but professional writing is hardly mentioned at all. Occupational therapists read books (psychology, personal accounts, pathologies, etc.) mainly written outside the field of occupational therapy, as these are few in number. Occupational therapists are still rarely asked to write as part of their practice. This difficulty is even more acute in psychiatry: "Occupational therapists have long been slow to take up written transmission, as if they were not legitimate to construct a discourse on their practices." (Klein and Bergès, 2014).

The decree of September 24, **1990** on preparatory studies for the state occupational therapy diploma also stipulates the need for at least one full-time occupational therapy executive instructor in addition to the director or technical director. Occupational therapy schools, which were previously managed by a single senior occupational therapist, will now be staffed by new teaching executives. “Teaching teams" finally came into being. In **1993**, student numbers at occupational therapy schools were increased at almost all training institutes in France. However, no other schools opened at that time.

In January **1997,** "occupational therapy schools" became "*Instituts de Formation en Ergothérapie* (IFE)” (occupational therapy training institutes) and "pupils" became "students".

6) Occupational therapy activities

The decree of November **1986** lists the medical procedures delegated to occupational therapists:

1) *Osteoarticular, neurological, muscular, trophic, functional, autonomy or relational assessments;*

2) *The conditioning of joints and muscles or the facilitation of a function, excluding acts mentioned in article L.487 of the Public Health Code (massage and medical gymnastics: monopoly of physiotherapists) enabling the acts defined in 3° to be performed;*

3) *By organizing crafts, games, self-expression, daily life, leisure or work activities:*

a. *transforming a movement into a functional gesture;*
b. *sensory-motor rehabilitation ;*
c. *re-education of temporo-spatial reference points;*
d. *adaptation or readaptation to professional or everyday activities;*
e. *development of adaptive or compensatory skills;*
f. *maintaining functional and relational capacities and preventing aggravation;*
g. *revalorizing and restoring interpersonal and creative skills;*
h. *maintaining or regaining personal identity and social role;*
i. *the expression of internal conflicts.*

4) *The application of equipment and assistive devices appropriate to occupational therapy.*

Fig. 5 - Photos IFE UPEC Créteil: Handicraft activities and use of a transfer frame.

Evaluation in occupational therapy: "Assessments"

In the 1980s, occupational therapists had little to say about assessment: there were, for example, only six articles in the *Journal of Occupational Therapy* between 1981 and 1990, mainly focusing on pathology. The 1990 training program mentions "assessments": articular, muscular and functional assessment in the anatomy and biomechanics module; assessment of deficiencies and incapacities in neurology (motor, sensory, memory...), assessment of disability in neurology (independence at home...).

Over the next decade, articles were to become more numerous and diversified: functional assessment (Le Blay *et al.,* 1992; Calmels, 1992; Adant, 1993; Gable, 1996; Decourcelle *et al.,* 1996; Gable *et al.,* 1997: Semard, 1998; Hodgkinson, 1998; Jacquot, 1998), systemic assessment (Castelein and Noots-Villers, 1994), cognitive function assessment (Plouhinec, 1995; Valencia *et al*, 1996; Barray *et al.,* 1996; Lacert *et al.,* 1998), computer software (Dubus, 1996 and 1997), complementary ecological assessments (Sève-Ferrieu, 1998), home assessment (Dorso-Nolet *et al.,* 1992) and psychiatry (Kolb, 1997)...

Organizing crafts, games, self-expression, daily life, leisure or work activities

C. Bourrellis (2006) has analyzed publications in the Journal d'ergothérapie and the "*Expériences en ergothérapie"* collections from 1968 to 1998, and notes a formalization of practices. She notes that craft activities are particularly present in publications from 1968 to 1977; from 1978 to 1987, play activities dominate; then from 1988 to 1997, activities linked to new technologies appear. The theoretical basis of the activities presented is increasingly described and made stronger. Finally, the term "evaluation" appeared in 1981, and more and more publications focused on patient assessments, which also demonstrated "greater precision in the intervention of occupational therapists" (Bourrellis, 2006, p.39).

In fact, in the 80s, when occupational therapists described the rehabilitation activities they proposed for different "pathologies" (burns, Volkman syndrome, hip prosthesis, amputees, geriatrics, head trauma, hemiplegia...), they commonly cite games, grasping activities, activities

of daily living, cooking, carpentry, weaving, pottery, basketry, macramé... (Moriconi, 1981; Charpentier et Le Gall *et al*., 1983; Blancher, 1984) In psychiatry, drawing, painting, modelling and pottery are used as creative and expressive activities (Suchet, 1982; Guinchard *et al.,* 1983).

These activities are aimed at a range of objectives that make occupational therapy unique. These include functional re-education and psychiatry care objectives, rehabilitation in everyday and professional activities, and prevention. The order in which the activities are listed in the November 1986 decree is representative of the importance attached to them at the time. All occupational therapists find themselves in one way or another in this very broad text. It's both open and dynamic, but not very specific, as in the case of assessments, joint and muscle conditioning and certain work objectives. This can make occupational therapy difficult to understand for colleagues and clients alike.

In the '80s, the activity was generally analyzed from a kinesiological and "ergonomic" point of view, or in a creative way to imagine possible uses. In 1981, for example, an article described the craft of macramé, as was then regularly done with students in training: presentation of the activity with the necessary equipment, gestural analysis during the various stages, working positions, details of the muscles called upon, as well as other abilities brought into play, such as spatial orientation and coordination, and a few indications of use, for example in neurology (Pottier and Maria, 1981). Activity is thus clearly positioned as a means of intervention.

The following year, Annie Bienfait suggested "Another adaptation of the cone game: Master Mind" (1982). The plan of the article is the same, and the conclusion aptly describes its spirit: "This game, easy to play, is generally well accepted by patients, since on the one hand it avoids the monotony of cone handling, and on the other, it uses the rules of a game designed for adults." (Bienfait, 1982, p. 27).

At the end of the 80s, when the 1990 training program was being drawn up, certain craft activities that required time, availability and professional skills, as well as substantial financial resources, began to disappear from occupational therapy departments: ironwork, large loom weaving, ceramics... Indeed, metalworking requires specific equipment and premises that are rarely found outside the Nancy region. In weaving, assembling a warp on a large four-shaft loom requires a full day's work for the occupational therapist, which proves difficult to manage. As for ceramics, the skills required to manage such a workshop, as well as the high cost of a pottery kiln, will limit the development of these practice areas. On the other hand, basketry, small-scale carpentry, drawing and painting, and games are still widely used. In addition, with advances in medicine, patients with more serious pathologies (such as brain damage) or long-term chronic illnesses (neurology, geriatrics) were arriving in rehabilitation departments. As a result, personal care activities (grooming, dressing, meals, mobility), like environmental design, take on even greater importance in practice (Coste, 1985; Penel-Lefevre, 1988; Bouchet *et al.,* 1988; Schabaille *et al.,* 1988), as do new information and communication technologies (Pansard, 1985; Chraibi and Condroyer, 1988).

At the end of the 1980s, some occupational therapists began to specialize, for example in neurology for people with hemiplegia, incorporating new methods such as the Perfetti method (Rabasse, 1989).

Returning to work is still one of occupational therapists' objectives, even if it is more punctual (Antoine *et al.,* 1987; Belliard *et al*., 1990; Blaise *et al.,* 1990).

The **1986** decree on professional acts lists the potential objectives of the activities used in occupational therapy. These objectives synthesize the diverse practices of occupational therapists, but the way in which activities are to be analyzed to achieve these objectives is often implicit. A few articles in the *Journal of Occupational Therapy* explain this analysis, clearly situating it in a particular pathological context. For example, the article on occupational therapy for thumb repositions in Nancy (de Barmon *et al.,* 1986) is based on pathology and surgical treatment. It is explained that activities for early reuse of the hand should be without resistance or endurance, by proposing a light bimanual tool, such as a file, a scroll saw, with adapted handles. Later, with the aim of reintegrating the thumb's mobility, stability and strength, different activities are mentioned: dexterous grasping (drawing, writing, pyrography...), strength (wood carving, metal hammering...). Activities will become more diversified as endurance develops, after-effects are assessed and vocational prospects are considered. Like most of the articles in this issue, this article has no bibliographical references, but clearly demonstrates the experiential approach of occupational therapists, based on pathology and rehabilitation needs, ergonomic and pragmatic analysis of activities, and "disability-work concordance".

The **1990 program**, in the "Technology 1: rehabilitation and care activities, intervention techniques and tools" module, proposes two "basic manual activities" (carpentry and weaving) and at least one other of the school's choice (pottery, macramé, cardboard, etc.), as well as "plastic arts, gestural expression and body activities" according to the school's choice. Micro-computing, patient handling and assistive device are mentioned in the "intervention techniques and tools" section of this same module.

If we compare the two training programs of 1971-72 and 1990, we see that in the first training program, learning manual techniques takes place mainly in the first year, but continues over the following two years, totaling almost 700 hours. In the 1990 program, manual techniques are taught solely in the first year, including micro-computing and assistive device, for a total of around 300 hours. A distinction is beginning to be drawn between the activities that occupational therapy students learn to perform with patients, and those that they will perform themselves, such as splinting (Enothe, 2004).

In their 1990 survey, Christine Orvoine and Hubert Le Montagné report that 70% of occupational therapists surveyed use manual and artistic activities, and 75% use activities of daily living (1992).

In the 90s, in psychiatry, creative and expressive activities continued, with the emergence of music, photography and video. On the other hand, in functional rehabilitation, we see an evolution or a return to professional activities, rehabilitation to activities of daily living (mobility and transfers, cooking, shopping, writing, housework...) and leisure (computers, games, painting, gardening...).

In the literature, there is less emphasis on group occupational therapy, and treatment seems to be becoming more individualized. Occupational therapy intervention is adapted to each individual: "for each person, for each pathology, we will propose a different activity" (Cheron and Soldano, 1990, p. 48), but we note that the person is not always the main actor in the decisions that concern him or her.

Occupational therapists adapt to the reality of patients' daily activities. Professionals invest in the field of leisure (the notion of work is less central) and play activities (Cheron and Soldano, 1990). With children in particular, occupational therapists use drawing, games and outings,

followed very gradually by electronics and computers (Belheur, 1986; Pawlak *et al*., 1989; Martin, 1995). Finally, there is a complementary use of activities with an analytical purpose, and adaptation of the environment to compensate for remaining difficulties (creation of assistive devices and splints, etc.).

Fig. 6 - Bois - le Roi 1989 (courtesy of C. Binther)

Activity analysis in the 1990 training program is still heavily influenced by "the kinesiological and biomechanical components of movement" and "ergonomic methodology" (Preamble to the occupational therapy curriculum). One of the objectives of the technology module is "to analyze the therapeutic components of technical gestures", but this is not explained. On the other hand, ergonomic analysis is the subject of a module section (Technology 2: Ergonomics, rehabilitation, engineering, assistive device). The relational aspect of the activity is mentioned several times. Overall, the occupational therapist is expected to have a good understanding of the pathology and the rehabilitation needs, so as to be able to propose medically relevant activities and independence in activities of daily living, in particular washing, dressing and eating.

The "ergonomic" analysis developed during OT training and the study of workstations in the field encourages many occupational therapists to continue their training in this field, leading them to positions as occupational therapist-ergonomists, and sometimes ergonomists. This vision is reflected in the analysis of workstations (Darnault, 1992).

Winnicott's theories explaining the transitional space created in occupational therapy form a theoretical basis integrated by many occupational therapists (Lecomte, 1988). The objectives of occupational therapy are sometimes "motor recovery" (Pibarot, 1981), sometimes "healing" (Pelbois-Pibarot, 1982). In other words, at the start of this period, the profession's objectives appear to be biomedical, with activity as the tool. Then, progressively, more global concepts appeared, such as "independence" (Pibarot, 1981; De Tienda, 1984), "avoiding isolation and excessive dependence of the patient" (Puharre, 1989), "[the] maintenance and [the] attainment of maximum autonomy in one's environment" (Cheron and Soldano, 1990), “autonomy" (Schwarz, 1991). The concepts of independence and autonomy seem to be gaining in importance. Both concepts were increasingly integrated into the occupational therapy literature of the time. In the titles of articles in the Journal d'Ergothérapie, the word "independence" appeared for the first time in 1975, and nine times by 1998. The word "autonomy" appeared for the first time in 1988, and fifteen times over the following ten years (Bourrellis, 2006).

Taking the environment into account began to develop in the **1990s** (Lescure *et al.,* 1987; Martin *et al*., 1988; Grisoni, 1991; Montredon, 1993; Mac Fee, 1996; Descamps, 1996). Support for the social reintegration of people with disabilities was tested and questioned, often from a systemic perspective (Rondet and Sorita, 1993; Blaise *et al*., 1991; Blaise, 1995; Dutier *et al.,* 1995)

The emergence of conceptual models in occupational therapy challenged the vision of occupational therapists and opened up the field of analysis. The first writings from North America describing guidelines, values or fundamental concepts in occupational therapy began to arrive in France, thanks to occupational therapists who had left to train in Quebec, such as Jean-Louis Ruet (Lyon) and Christine Orvoine (Rennes).

In **1993**, in Montpellier, Ruet presented the work of Gary Kielhofner (Ruet, 1993; Kielhofner, 1985), Christian Belio and Jean-Marc Destaillats (1993) and Pierre Castelein and Dominique De Crits (1990) drew on the systemic model, while B. Azéma focused on ICIDH in psychiatry

(1993). Conferences in Versailles (1996), Tours (1997) and Paris (1997) on the concepts and models bring a new perspective to occupational therapy and activities. In **1998**, Marie-Chantal Morel-Bracq presented for the first time a range of conceptual models for use in occupational therapy, with this definition: "What is a conceptual model? It is a simplified mental representation of a process that integrates theory, underlying philosophical ideas, epistemology and practice." (Morel-Bracq, 1998, p.11).

In 1996, a survey of occupational therapists who had graduated in Montpellier between 1974 and 1995 showed that two-thirds of them worked full-time, the other third part-time. Just over a third (35%) work in psychiatry, the rest in functional rehabilitation: most work with neurology patients (98%), traumatology (75%), geriatrics only half (49%), and 38% work with cerebral palsy patients (Primaut *et al.,* 1996, p.254). The techniques most frequently used are painting and drawing, basketry and carpentry, macramé and computer skills. Pottery, weaving and games are also common. Most make orthoses, assistive devices and adaptations. However, a quarter of them feel that their training is not adapted to their job (Primaut *et al.,* 1996).

Practice is still very much divided between functional rehabilitation and psychiatry. However, two areas of intervention bring these two fields closer together: geriatrics and traumatic brain injury, which will highlight the need to observe and seek to understand cognitive disorders and their impact on daily life.

This led to numerous questions being raised in the IFEs, but also at European level, about the type of activities to be taught to occupational therapy students, as well as the methods used to teach activity analysis, which no longer corresponded to the evolution of occupational therapy (ENOTHE, 2004; Morel *et al.,* 2006; ENOTHE, 2008).

Assistive devices and technology

In the *Journal d'ergothérapie*, published by Masson since **1979**, numerous short articles describe adaptations or assistive device that occupational therapists have designed and which can be manufactured on site: armrests for hemiplegics in wheelchairs (de Thesut, 1981), mouth-gripping wands for C5 tetraplegics (Tiquet *et al.*, 1984), sub-axillary bath support (Gauharou *et al.*, 1992)... In 1993, a new section entitled "Fiche technique" (Technical Data Sheet) regularly featured these "do-it-yourself" adaptations: in foam, PVC, plywood... The "Fiche technique" section continued until 2000, when the publishing contract with Masson came to an end. More developed articles also deal with adaptations and assistive device, such as in 1981: « Le jeu dans la rééducation analytique des adultes » (play in adult rehabilitation) (OT department Invalides, S. Blanc *et al*., 1981) or in 1982: « l'adaptation d'un code communication pour IMC » (adaptation of a communication code for cerebral palsy) by E. Hardy and her colleagues (1982) in St Hilaire du Harcouët.

Similarly, in the Montpellier "*Expériences en ergothérapie" (Occupational Therapy Experiments*) series, launched in **1988**, several articles each year focus on communication devices, walking aids, electronics and computing, as well as product design in occupational therapy (Caron *et al*., 1988), the occupational therapist's role in distribution and advice (Besson, 1989), and his or her approach to evaluation (D'Erceville *et al.*, 1996).

Numerous assistive devices have been developed for people suffering from rheumatic diseases, as well as for amputees and wheelchair users. Initially, the idea was to rehabilitate, but later,

the idea of reintegration, i.e. a return to an ordinary living environment, became crucial (Calmels *et al.*, 1989).

From the Garba Linguaduc communication system (Sylvestre, 1981), to the "electromechanical designator" initiated by the Saint-Maurice occupational therapy team in 1984, to the experimentation of an elevator control system in a specialized home (MAS) for severely disabled people in 1998 (Bonhomme *et al.,* 1998), technology is used for communication, mobility and environmental control.

In 1983, the Handidata database was presented by Jean-Claude Moreau of the Centre de technologie biomédicale appliquée à l'aide aux handicapés physiques et sensoriels in Saint-Maurice (Moreau and Berthier, 1983).

And yet, in **1986**, Jean-Pierre Belheur, who had developed in-depth technical skills in the development of adapted equipment, wondered about "The future of electronics and computing in occupational therapy" (Belheur, 1986). For him, electronics are a tool for rehabilitation, autonomy and independence, while computers provide access to games, music and drawing: he doesn't quite understand the reluctance of occupational therapists to use these new tools. Fortunately, not all occupational therapists are so cautious: Hélène Hernandez, in her article with Gérard Ricochon, a technical educator, on occupational therapy with myopathic adolescents and adults in 1984, combines games, various activities, assistive devices, electronics and environmental design (Hernandez and Ricochon, 1984). In practice, it is becoming clear that we need to work with competent technicians to develop adapted equipment, and that occupational therapists cannot do everything on their own. Ready-to-use computers haven't yet arrived in occupational therapy departments!

In the 1980s, occupational therapists were recognized as experts in the field of assistive device. However, they were sometimes still "forgotten", as in the presentation of the first *Entretiens de Garches* congress in 1988 : "Disability and autonomy : motor control of the environment and wheelchair", inviting doctors, physiotherapists, nurses, engineers and industrialists to exchange ideas and assess future prospects!

But the opening up of occupational therapists to the outside world was unavoidable, and their role was to consolidate. This period saw the creation of numerous initiatives involving occupational therapists, even if funding was still scarce. We can cite the Escale home help program in Lyon for children with motor disabilities (Farhat *et al*., 1987), the CICAT (information and advice centers for assistive devices), the *Papa Bouscat* home help program for the elderly (Campillo *et al,* 1987), APF's *Sites pour la vie autonome, Scaph 38* or *Service Conseil en Autonomie pour Personnes Handicapées de l'Isère* (Memin *et al.,* 1991), and "*Bretagne Mieux Vivre*": an information and documentation center (Bretagne Mieux vivre, 1990).

Finally, in **1996**, Élisabeth Ruette (occupational therapist) and T. Allas (medical doctor) in Berck wrote in their article entitled "Preparation for the return home of severely motor impaired people": "*Long gone are the days when occupational therapy was confined to a workshop reserved for handicraft activities*" (Ruette *et al.,* 1996, p. 62).

At the end of the 90s, occupational therapists were still making assistive devices, as witnessed by their latest data sheets: "*Le coussin d'abduction du membre supérieur avec repos avant-bras*" (Handicap International, 1999) and "*Réalisation d'un contacteur pneumatique*" (Handicap International, 2000). But they now have access to American catalogs, which they

discovered at the World Congress of Occupational Therapists in Montreal in **1998**, and which will soon become more accessible. The marketing of assistive devices will enable them to invest their time in a different way, and they will have a more assertive advisory role, which will require considerable professional monitoring.

The period 1980-2000 was marked by technological progress: the spread of electric wheelchairs, the development of environmental control systems, speech synthesis and voice recognition, remote controls, computers... and the advent of "a new science: home automation"! All this progress gave rise to great hopes, but funding was hardly forthcoming: this was the big problem at the beginning of the 2000s.

7) Opening towards foreign countries

Occupational therapy in developing countries

As early as the **1980s**, a number of occupational therapists embarked on more or less occasional missions in developing countries (Besson, 1983; Besson, 1985; Baudesson-Deneu, 1987; Peyrard, 1991). A little later, an experience in rural Senegal was based on a more systemic approach to occupational therapy: ″The aim here is not to strictly define a practice of 'humanitarian occupational therapy', but more to demonstrate that we have the professional sensitivity to act in this direction, because the environmental approach is one of the essences of our profession." (Bernu, 1998, p.67).

COTEC and ENOTHE

Occupational therapists organized themselves at European level, but French participation remained confidential for a long time. COTEC (Commitee of occupational therapists for the european communities) was set up in **1986** at European level to coordinate national occupational therapy associations, later renamed the Council of occupational therapists for the european countries. ANFE participates with two English-speaking delegates, which is not easy to find. The European Network of Occupational Therapy in Higher Education (ENOTHE) was set up in **1995** to coordinate OT training: several French occupational therapy training institutes joined, but participation was sporadic due to language problems. The European congress in Paris Ergo 2000 will change our perspective!

North America

Strong ties have long existed between France and Quebec. The **1998** World Congress of Occupational Therapists in Quebec attracted many French people, as French was one of the congress' languages of communication.

The Model of Human Occupation (MOHO) was published in the United States in 1980, based on Kielhofner's Master's thesis (Kielhofner and Burke, 1980). In France, this model appeared later in the 1990s (Castelein and De Crits, 1990; Ruet, 1993), but was not really used until the late 2000s (Bowyer *et al*., 2008).

The publication in French of the Canadian book "*Promouvoir l'occupation*" (ACE, 1997), which echoes the Person-Environment-Occupation model (Law *et al*., 1996), introduced us to

client-centred practice and became a reference for many French occupational therapists, especially as the occupational therapists of the time were interested in the links between the person, his/her activities and his/her environment (Cheron and Soldano, 1990; Defer *et al.,* 1994; 1990 OT program).

8) Conclusion

The period 1980-2000 saw the legal structuring of occupational therapy. Occupational therapists consolidated their place in the medical world, but the boundaries of competence were still difficult to define with many other members of the paramedical team. In functional care, occupational therapists often refocus on analytical rehabilitation activities, personal care activities and adaptations. In psychiatry, expressive and interpersonal activities remain very important. Craft activities are gradually being replaced by activities that are easier to implement, as the average length of stay in care institutions decreases.

However, professional practice has expanded and diversified. Occupational therapists are starting to work outside the institutions to help physically disabled people return to their own homes, and to support their reintegration into social life. The skills of occupational therapists are beginning to be recognized for adapting equipment, advising on assistive devices and adapting the environment to enable people to live in their own homes and enjoy a social life. The person-activity-environment link is becoming a matter of course for occupational therapists, who are seeking to get closer to the ecological environment of the people they treat. The integration of a systemic vision of disability situations by many occupational therapists enables them to develop this holistic approach of care which has always been supported.

The role of medical doctors is diminishing: on the one hand, they are beginning to play a more limited role in occupational therapy schools, and on the other, the opening up of institutions to the outside world is enabling occupational therapists to develop their autonomy.

The French National Association of Occupational Therapists (ANFE) represents occupational therapists at the French Ministry of Health, and has joined forces with other rehabilitation and medico-technical professions to found UIPARM. ANFE works to defend occupational therapy and occupational therapists with ministerial authorities, even if the road to professionalization is still difficult.

The emerging interest in research and occupational therapy outside our borders could herald changes in the years to come!

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Chapter 5 3e paradigm 2000-2020: from activity to occupation

1) Introduction

At the start of this period, the European Occupational Therapy Congress, *Ergo 2000!* in Paris, marked a major turning point for the profession. It provided a strong impetus for research and openness to *occupational science*, both of which were instrumental in changing professional training and practice. Occupational therapists are seeking to assert their identity and their place in the health and social system. The summary of the regional day organized by ANFE Rhône-Alpes in 2002 bears witness to this:

> "History, context and theories are elements that help define occupational therapy, but they are not enough on their own to define professional identity. In order to grasp the conception of this identity, we need to look at the relationship occupational therapists have with these elements." (Mehannèche, 2002).

Isabelle Pibarot provides one of the answers: "The science that underpins the professional future of occupational therapists is therefore the science of potential space at the heart of relationships with oneself, with others and with the environment. We can call it ergology, or the science of *ergon*, or the science of human activity" (2002, p. 10). Echoing this, historian Jean-Pierre Goubert evokes "a reconstruction of the relationship between environment and health through the therapeutic relationship, thanks to the use of an *ergon*, that is, a "conceptualized action*"*" (2004, p. 249). Thus, the 2000-2020 period shows the integration of concepts into professional practice structuring occupational therapy, while affirming a professional identity that tends to be shared.

As with the previous chapters, this chapter focuses on the most important societal and health-related contextual factors affecting occupational therapy training and practice in France between 2000 and 2020. It is based on highlights such as the European Congress, the 2005 Disability Act, the 2010 Activities, Skills and Training Standards for OT, and the development of prevention, scientific research and lifelong learning brought about by numerous laws and regulations. In addition, the digital revolution and the shift to ambulatory care are leading to new practices and a greater involvement of occupational therapists in the various areas of life, through rehabilitation and reintegration interventions. Ultimately, the paradigm is gradually becoming colored by occupational science, as is the case in many countries, through evidence-based practices combining specific occupational therapy research and the concept of occupation, in addition to the hitherto prevailing notion of activity: occupational therapy thus contributes to health and occupational balance in close connection with the living context.

2) A high-impact European congress for French occupational therapists

From September 27 to 29, 2000, the European occupational therapy congress *Ergo 2000! Mémoire et Devenir*, took place under the patronage of Jacques Chirac. The World Health Organization (WHO) was represented by a representative from the European national office in Copenhagen. It was an unforgettable moment of fruitful encounters and exchanges between political and institutional representatives and the many occupational therapists from Europe, Quebec, Australia and elsewhere.

Hanneke Van Bruggen (ENOTHE), François Eyraud (President ANFE), Ergo 2000 Congress

On this occasion, "*Ergothérapie : guide de pratique*" (ANFE, 2000) is published: the first book edited by ANFE twenty years after *Ergothérapie* (Pierquin *et al.,* 1980). The congress is combined with the annual Enothe conference in Paris on September 26, to which all IFE directors are invited. This was the first time *Occupational science* was presented: it was translated as "science of human activity" in an article the following year on Flow theory (Morel-Bracq, 2001). Patrick Segal, then inter-ministerial delegate for the disabled, and Michel Busnel, a doctor, director of the Kerpape mutualist rehabilitation center and ministerial advisor, also took part. It was at this time that the desire to increase the number of students in all IFEs was asserted. Together, the Enothe conference and the European Congress were key moments in the history of occupational therapy in France: they prompted IFE directors to open up to Europe, to research in occupational therapy, and to realize that English was becoming indispensable in this context. The directors, like the occupational therapists present, are aware of this necessary evolution: their vision of international occupational therapy is changing, especially as digital technology develops and provides access to data on a global scale.

3) An explosion in Internet use

From the 2000s onwards, the French have been equipping themselves with hardware beyond their desktop computers. According to statistics presented by Statista Research Department (2020), sales of laptops and cell phones began to grow in the late 1990s, followed by smartphones and iPhones in 2007, e-readers in 2008, and tablets in 2010: these devices are purchased in large numbers, for both personal and professional use. In 2020, these acquisitions will continue. Internet penetration in French households stood at 89% in 2018. It differs according to age: younger people declare themselves to be more Internet-ready than those aged 70 and over (92% vs. 56% in 2016). Similarly, the spread of smartphones in France saw a meteoric rise between 2011 and 2018, supplanting so-called "classic" cell phones and being adopted by all social categories (Statista Research Department, 2020). This digital progression is becoming part of occupational therapy practice. In addition to desktop and laptop computers, occupational therapists use smartphones and tablets for rehabilitation, disability compensation (Tosser, 2014; Durieux, 2014; Pouplin *et al*., 2018), stimulation of memory or executive functions (Ribas, 2014), as a communication medium or work support (Thévenon and Avril, 2014; Ballengheim and Sourd, 2014). Similarly, these tools are indispensable for teleworking, in times of global pandemics (Riou, 2020; ANFE, 2020a; Riou, 2021; Riou *et* al., 2021).

4) Health and social reforms: the ambulatory shift

It's a period of legislation, modifying the regulatory framework and influencing the practices of healthcare professionals, including occupational therapists. For example, practice models are evolving to adapt to the reduction in average length of stay, and the shift to ambulatory care. The latter aims to meet the needs of the population in different social and residential settings, and to control hospital costs. In addition, occupational therapy practices are responding to new societal needs: an ageing population, an increase in multi-pathologies and chronic pathologies, the fragility of certain social categories, and the demand for quality care and information. Gradually, the fight against inequalities is also being added, both in terms of healthcare provision across territories and in terms of health determinants in terms of gender and social status (INSEE, 2018; Hernandez, 2019). Finally, the Covid-19 pandemic is reshuffling some cards: requisitioning healthcare personnel and opening up to telecare.

The "patient" is gradually being placed at the heart of care, as the main actor and decision-maker (law of March 4, 2002 on patients' rights and the quality of the healthcare system). A new approach is reflected in the occupational therapy patient record published in May 2001: the record encourages the collection of the patient's project and the expectations of those around him/her (ANAES, 2001). In addition, the introduction of the patient record affirms professional writing and interprofessional transmission (Hernandez, 2013a; Brousseau and Tosser, 2015; Mignet, 2019).

With the reinforcement of regional healthcare organization plans (SROS), health and medical-social establishments are entering into a logic of productivity: fee-for-service and activity-based pricing (T2A) is developing a culture of results and evaluation (Plan Hôpital 2007). This is close to the notion of *goal-oriented* (focusing on objectives and results), present in models used by occupational therapists such as CMOP-E (Canadian Model of Occupational Performance and Engagement). The desire to cut costs by reducing the duration of full hospitalization is aimed at promoting the number of day hospital places - follow-up and rehabilitation care, mental health - (Boisguérin *et al*., 2020) while developing prevention before health problems require costly care. The increase in places is programmed according to the field of care; sometimes, notably in mental health, or during the Covid-19 pandemic, it falls short of the public health stakes (Boisguérin *et al*., 2020). This is also congruent with the desire to enable people with disabilities to participate in the mainstream environment (2005 law). Institutions and professionals are increasingly accountable for improving the quality of their services (Law of January 2, 2002), which are more formalized and evidence-based. Also, the more ambulatory practices become, the more collaboration needs to be strengthened between the various healthcare players. With Law no. 2016-41 of January 26, 2016 on the modernization of our healthcare system, four forces guiding the coming years are displayed, for which occupational therapists have a role to play: equal access to care, prevention, health promotion and health pathways.

Law no. 2005-102 of February 11, 2005 on equal rights and opportunities, participation and citizenship for people with disabilities is fundamental, as it reinforces the person-centered approach and the move away from institutions towards maximum participation in the ordinary environment. This law defines the various types of disability with reference to the model of the International Classification of Functioning, Disability and Health (WHO, 2001), and institutes, for the first time, a right to compensation (Frattini, 2013). It gives occupational therapists a major role to play in new areas of practice such as MDPHs (Maison Départementale pour les Personnes Handicapées). The law also introduced services that are closer to where people live

and where they can be integrated into the mainstream environment, such as sheltered workshops (ESATs which replaced CATs), SAVSs and SAMSAHs (services d'accompagnement à la vie sociale; services d'accompagnement médico-social pour adultes handicapés): all structures in which occupational therapists work (Truffet-Malet, 2005; Bouget *et al.*, 2013).

Similarly, the French **law no. 2009-879 of July 21, 2009** on hospital reform in relation to patients, health and territories (HPST law), with the creation of regional health agencies (ARS) in 2010, has also contributed to changes in the view, place and participation of people in care, in vulnerable or disabled situations, by organizing local health and social services as closely as possible to needs. In addition, it reinforces therapeutic patient education (ETP), which was included in the initial OT training curriculum in 2010 (Heddebaut and Denayer, 2015) and to which occupational therapists are committed (Bocaspomi, 2015). On the other hand, few occupational therapists are taking up the "cooperation" aspect: however, the project carried out by occupational therapists in the Grand Est region in 2018 (Pelé, 2018) is validated in 2019 and 2020, initiating close collaboration with Philippe Denormandie, orthopedic surgeon at Garches hospital, pilot of the mission on assistive device, as well as with Cécile Chevalier, occupational therapist in charge of the mission at the CNSA (*Caisse Nationale de Solidarité pour l'Autonomie*). In 2020, ANFE put forward several proposals, including the prescription of assistive devices by occupational therapists, the need for occupational therapists to be involved throughout the assistive device acquisition chain, and the funding of this involvement (ANFE, 2020d; Le Monde de l'Ergothérapie, 2020a and 2020b). In October 2020, the Denormandie-Chevalier report is submitted to the Minister of Solidarity and Health and the Secretary of State for the Disabled: *Des aides techniques pour l'autonomie des personnes en situation de handicap ou âgées: une réforme structurelle indispensable* (Denormandie and Chevalier, 2020).

All these changes in the hospital and medico-social sectors are modifying the work of staff, and in particular that of occupational therapists, by demanding traceability and evaluation of their practice, while complying with shortening average lengths of stay: occupational therapists must therefore organize themselves to always do better in less time, but also prepare very quickly for the discharge of people who are still fragile. In mental health, for example, practice models need to evolve in response to shorter stays: the psychodynamic model is increasingly giving way to the cognitive-behavioral model and social rehabilitation (Da Silva, 2005; Manidi, 2005; Hernandez, 2007 and 2016; Person *et al*., 2010; ANFE-GRESM, 2015). The establishment of healthcare pathways and care networks is encouraging the shift to ambulatory care, with the progression of a home-centered practice model that is well suited to occupational therapy practice (Trouvé *et al*., 2015). As for practice with young children (0-6 years, 7-12 years), an early intervention package for neurodevelopmental disorders (NDD) can be allocated to occupational therapists with the establishment of coordination and referral platforms (PCO): a real step forward for beneficiaries and their families, and also for the recognition of occupational therapy, making it possible to smooth support pathways, help make the diagnosis, and reduce the remaining charge to zero euro (Decree no. 2018-1297; Order April 16, 2019). In the presentation of the *Parcours des 1000 premiers jours de la vie*, it is envisaged to facilitate access to health services, information, childcare and parental leave (Le Monde de l'Ergothérapie, 2020a).

In June 2020, the government launched the *Ségur de la santé*, to "restore agility to the healthcare system" (Ministère des Solidarités et de la Santé, 2020). The announcement of the creation of the new Autonomie branch appears to be a strong signal of the future Aging and Autonomy Act. The focus on prevention and the ambulatory sector is confirmed: keeping as many elderly people at home as possible, for as long as possible. In France, a prevention program for aging

people inspired by *Lifestyle Redesign®* and based on occupational science is also being developed (Morel-Bracq, 2019; Soum-Pouyalet, 2019).

The most significant health and social event at the end of the period (2020-2021) is the Coronavirus pandemic. Over and above the number of deaths, particularly among the over-60s, 42,365 out of 44,594 by 12/31/2020 (Covid Ined), the Covid-19 epidemic highlights the shortcomings in the organization of the healthcare system (lack of protective equipment, vaccination doses, etc.). Some of the occupational therapists were needed to welcome patients and clean equipment; their workrooms were requisitioned for Covid care areas. Others initiate telecare according to a protocol negotiated with the Ministry of Health during confinement (Riou, 2020; Gaudin *et al*., 2021). Already in 2019, an experiment in France with a Tele-ergotherapy device is presented in Montpellier (Briquet and Ung, 2019). At the beginning of 2020, two professional recommendations (ANFE, 2021a, b) are published: "*Occupational therapy support for patients with Coronavirus 2019 (Covid-19) disease from hospital to home*" and "*Occupational therapy management of patients with Coronavirus 2019 (Covid-19) disease in intensive care units"*.

In addition, the " *Quick guide for occupational therapists: rehabilitation for people recovering from COVID-19* " has been translated from the *Royal College of Occupational Therapists*' document (ANFE, 2020c). A new professional recommendation has been issued on the sustainability of telecare in occupational therapy, depending on certain situations. A survey of occupational therapists' occupational adaptation during the spring 2020 lockdown shows that occupational therapists, like many healthcare professionals, were affected by the lockdown both in their practice and in their personal lives (Biard *et al*., 2021).

5) Work in a changing context

While health and social regulations are evolving to better meet health needs, the world of work in general, and of disabled people in particular, is changing in new ways. Prevention is beginning to be taken into account, particularly with regard to psychosocial risks. Legislation stemming from the 2005 Disability Act is revamping the mechanisms for integrating disabled people into the workforce. Telework is on the rise, particularly in the wake of the pandemic.

Prevention of psychosocial risks and teleworking

Ergonomists and occupational psychologists demonstrate through their research that ″work can influence physical and psychological health, for better but also for worse" (Coutrot, 2018, p. 5). The recognition of musculoskeletal disorders and psychosocial risks is accompanied by prevention policies in companies. Occupational therapists have a wealth of positions to develop in occupational health departments, using the OSHA Checklist or the Ergo Kit (Expert, 2019, p. 65). Thomas Coutrot points out that quality of life is defined, in the June 2013 Accord national interprofessionnel, as:

> "A feeling of well-being at work perceived collectively and individually that encompasses the atmosphere, the company culture, the interest of the work, working conditions, the feeling of involvement, the degree of autonomy and empowerment, equality, a right to make mistakes granted to everyone, recognition and appreciation of the work done" (2018, p. 5).

The survey reported by Coutrot shows that employment is conducive to the development of skills and well-being, for almost 35% of working people, while respecting the usual social gradient: the most highly qualified and skilled have a more fulfilling and satisfying job.

In addition, social entrepreneurship (SE) is emerging alongside the concepts of social economy and solidarity economy. A large number of occupational therapists not working in the public hospital or territorial sector are increasingly involved in these jobs in the social field, particularly as self-entrepreneurs or micro-entrepreneurs (Duvert, 2016). Working from home and teleworking are gradually developing, and will increase during the 2020-2021 health crisis. A proportion of occupational therapists are allowed to practice teleworking, for people for whom a contact and assessment had been carried out beforehand, including in mental health (Riou, 2020; Riou, 2021).

Job placement schemes for the disabled

Since the 2005 law, the two institutional players involved in the professional integration of people with disabilities are the MDPH (Maison départementale pour les personnes handicapées) and the *Cap Emploi* network. Cap Emploi is a network of associations accredited by Agefiph. These associations are funded by Agefiph, Fiphfp (see next box) and Pôle Emploi. Their mission is to support disabled people in their job search and put them in touch with employers. A local service, *Cap Emploi* is present in all French départements, with 107 branches. Anne-Claire d'Apolito, a hospital practitioner at Garches Hospital, provides an **overview of the players involved in job retention** in the journal *ErgOThérapies* (2019, p.7-8).

- AGEFIPH, *association de gestion des fonds pour l'insertion des personnes handicapées* created in 1987, for people recognized as disabled workers employed by private-sector companies or the self-employed;
- Centrer de réadaptation professionnelle (CRP, vocational rehabilitation center), accessible to people in need of vocational retraining on referral from the MDPH;
- *Comète France* federates 52 specialized rehabilitation SSR establishments and implements the early socio-professional integration approach for patients from the start of their treatment to one year after discharge;
- FIPHFP, *Fonds pour l'insertion des personnes handicapées de la fonction publique* ;
- LADAPT, whose slogan for 2016-2020 is "living together, equal and different**"**, brings together 117 establishments and services providing support, training, integration, education and care;
- Specialized placement organizations: SAMETH, a service to help disabled workers stay in work, one service per department; *Cap emploi*, help with defining a professional project, training, job search, existing aids and schemes;
- UEROS, units for assessment, retraining and socio-professional orientation, for people with brain damage.

Accessing and maintaining employment remains a challenge for a significant number of people with disabilities (Arnoulin, 2003; Nagel, 2005). Successive legislative and regulatory changes,

as well as the commitment of the various players involved, demonstrate the desire to improve employment conditions for people with disabilities (CNSA, 2020). To promote access to and retention in employment, immersion periods have been introduced: work experience in a work assistance establishment or service (MISPE). Another measure has been introduced: since 2018, people with disabilities have been able to benefit from a supported employment scheme, which combines medical and social support with support for the professional integration of disabled workers. This long-term support begins upstream of the job search and continues after the job has been taken up, and is provided by a supported employment advisor or *job coach*. Some occupational therapists fulfill this *job coaching* role (Gailledrat and Berthe, 2015; Dechambre, 2016; Dumay *et al*., 2019).

The practice of occupational therapists is evolving with regard to the employment of disabled people, and is recognized by the MDPH and Cap Emploi. The activities listed in the decree of July 5, 2010 stipulate:

> "The occupational therapist uses exercises, games, handicrafts, projective activities or concrete situations of daily activities, domestic tasks, professional gestures, social, cultural or sporting activities.... Throughout these concrete situations, the occupational therapist assesses the person's activity in his or her environment. Where necessary, he/she provides advice and adapts elements relating to the person, the activity or the environment, to promote safe, appropriate activity and combat disability situations" (BO Santé, p.170).

Occupational therapists continue to play a key role in the professional integration and reintegration of disabled people, as well as in keeping them in employment. The evolution of this practice can be seen in the development of Comète France and its intervention model, as well as in the integration of occupational therapists into integration or occupational health schemes: the organization of work situations outside or within the company is combined with the role of advisor, technician and coach, up to and including professional integration, whereas previously the role of technician was the only one required (Arnoulin, 2003).

Application of the 2005 law is lagging behind enormously, particularly in terms of workplace accessibility: ten years on, a third of companies have fully complied with the law, a third are preparing to do so, and the remaining third have made no commitment, but since March 31, 2019, it is no longer possible to submit a programmed accessibility agenda (Ad'AP, 2020). Likewise, leisure and transport are lagging behind. However, occupational therapists, who are involved in both employment and mobility issues, are rarely called upon to help people achieve the best possible social participation. Upstream, occupational therapists intervene within structures such as UEROS or Comète France, in order to encourage and sustain this professional (re)integration over the long term. Occupational therapists support people with disabilities in a variety of settings (rehabilitation services, the workplace, professional structures and associations such as SAMETH, Cap Emploi or AGEFIPH, etc.). For example, over 10,500 patients were supported in 2019 by the Comète France network, with 87% of these people still in employment two years after their professional project took shape (Comète France, 2020).

In 2020, occupational therapists are present in various schemes aimed at employing disabled people, sometimes working closely with ergonomists (Guegan-Forget *et al*., 2019) or as part of a multi-professional team (Guichoux *et al.*, 2010) comprising physical medicine and rehabilitation doctors, ergonomists, occupational psychologists and social workers, as at Comète France.

At a time of high unemployment, disabled people have a lower overall level of qualification than the general population, and are twice as likely to be unemployed. In the end, little has changed since the *Handicapés méchants* years, despite the 1957, 1975 and 2005 laws and all the implementing decrees following their publication. This is one of the challenges for the future that occupational therapists, together with their various partners, will have to take up, especially now that so many measures and structures have been put in place.

6) Developments in occupational therapy training that have an impact on practice

As far as training is concerned, a new page is being turned: formalization is increasingly asserted thanks to the occupational therapy patient file (2001), based on practice models, and the reengineering of initial training (2010), embodied by a job reference framework (definition, activities, skills) and a training reference framework.

Re-engineering the curriculum in 2010

The **2010 training curriculum** will lead, at the same time, to a state diploma in occupational therapy and a bachelor's degree: at last, recognition at bac + 3 level, and a salary upgrade to follow! The entire profession is mobilizing before, during and after the reengineering of training. The proposal by the Ministry of Health and the Ministry of Higher Education to apply the Bologna Accords by 2010 at the latest has accelerated the process of reflection on the issue of universitarization. As early as 2003, ANFE representatives were working within the *Union interprofessionnelle des associations de rééducateurs et médicotechniques* (UIPARM) to develop a description of the profession in terms of activities and skills (Hernandez and Pugin, 2004; Hernandez, 2006).

At the beginning of 2007, the French Ministry of Health proposed that masseur-physiotherapists, chiropodists and speech therapists reengineer their initial training courses. At the call of ANFE and UNAEE (*Union nationale des associations des étudiants en ergothérapie*, created in 2006), occupational therapists and students gathered at two demonstrations in Paris to demand that their training be placed within the university framework: on February 6 and March 16, more than 2,000 occupational therapists and students took to the streets side by side - an unprecedented number! (Trouvé, 2007; Hernandez, 2007). The Ministry of Health's immediate response was to create an internship allowance for all students.

February 6, 2007 demonstration - UNAEE and ANFE

March 16, 2007 demonstration - ANFE-SYNFEL-UNAEE

And indeed, work on reengineering the curriculum began at the end of the year (December 2007), contrary to all expectations, at the same time as that of masseur-physiotherapists and chiropodists. This work culminated in a decree on the occupational therapist state diploma, dated July 5, 2010 (Ministry of Health and Sports, 2010), while our colleagues will complete the reengineering of the chiropodist diploma in 2012 and the masseur-physiotherapists diploma in 2015.

The reengineering format is based on a professional reference framework including a definition of occupational therapy, activities and competencies, and a university-style training reference framework: teaching units and internships, organization into semesters, continuous assessment, the possibility of Erasmus (European mobility for students, teachers and professionals) and the major innovation of the competency-based approach.

The 10 skills of the occupational therapist	
1	Assess a situation and draw up an occupational therapy diagnosis
2	Design and implement an occupational therapy intervention and environmental design project
3	Implement and conduct occupational therapy care, re-education, rehabilitation, reintegration and psychosocial rehabilitation activities
4	Design, produce and adapt temporary, extemporaneous orthoses for functional purposes or as assistive devices, adapt and recommend mass-produced orthoses, technical or animal aids and technological aids.
5	Develop and implement an educational and advisory approach in occupational therapy and public health
6	Conducti a relationship in an occupational therapy intervention context
7	Assess and develop professional practice
8	Research, process and analyze professional and scientific data
9	Organize activities and cooperate with various stakeholders
10	Train and inform

Source: Order of July 5, 2010 on the occupational therapist state diploma

Teaching units include occupational therapy diagnosis (Dubois *et al*., 2017), conceptual models (Morel-Bracq, 2004, 2009, 2017), therapeutic patient education (Heddebaut and Denayer, 2015), prevention, occupational therapy research (Tétreault and Guillez, 2014) including professional English. Integration units enable students to formalize what they have learned on placement with regard to academic training (Hernandez, 2010a, b; Morel-Bracq, 2010 a, b), through reflective analysis of professional practice (ARPP) according to Kolb's model (1984). The effort of accompanying students in this analysis rests on the OT trainers and especially on the OT tutors: "Conducting a student's ARPP implies that the tutor abandons his or her status as model" (Barthélemy, 2014, p. 65). Very quickly, trainers notice an acceleration in the understanding of the core business: "Students show a broader knowledge of the profession. Students appear imbued - and for some impressed - with the breadth of the occupational therapy profession" (Hernandez *et* al., 2012, p. 115). Changes have also been observed in the field of internships: "The study reform aimed to transform the first observation internship into a skills-acquisition internship, and the gamble paid off" (Id., p. 125), even if internship tutors are having difficulty assessing the internship. In fact, the training reference framework aims to "professionalize the student's career path, who gradually builds the elements of his or her skills through the acquisition of knowledge and know-how, attitudes and behaviors in therapeutic

activity situations", in order to "become an autonomous, responsible and reflective practitioner" (Order of July 5, 2010, Appendix III).

The December 2010 issue of *ErgOThérapies* is devoted entirely to clarifying the new training text, in order to pass it on and help clinical teams grasp the spirit of the reform: how to help mobilize skills and assess them in students on placement. In addition, our teaching teams are expanding, and are keen to work together on the pedagogical arrangements between OT schools (IFE). Training days are organized for internship tutors at the initiative of the OT schools (IFE) and ANFE.

Since the Order of February 25, 2004, students have been trained in an introduction to research (the first dissertations were published in 2006). In 2010, the introduction of several teaching units dedicated to research (including English for 3 years) and to assisting students with their final dissertation helped raise scientific standards. The Jardé law, published in 2012, was amended in 2016, 2017 and 2018: it strengthens the protection of people undergoing research aimed at developing biological or medical knowledge. It specifies the cases requiring recourse to the *Comité de protection des personnes* and those accessible to occupational therapy students as part of their dissertation (Décret n° 2017-884; Arrêté du 12 avril 2018; Pouplin *et al*., 2018). This teaching helps to support certain students in pursuing an academic path.

A further step in the universalization of initial training is the recruitment of students on the *Parcoursup* platform in 2020 (https://www.parcoursup.fr/), on which applicants formulate their wishes to enter healthcare studies. In addition, experimental admissions and curricula (bachelor's, master's) are authorized by Law no. 2019-774 of July 24, 2019 on the organization and transformation of the healthcare system, and are flourishing from region to region. From now on, every high school student must be vigilant about the training offer in his or her region.

Creation of OT schools (IFEs) and an increase in the number of occupational therapists

The steps taken by Segal and Busnel with the *Syndicat des Instituts de Formation en Ergothérapie Français* (SIFEF) have led to an increase in the number of students in training. However, it is above all the 2010 training standards that are driving the explosion in the number of IFEs, just as they did in 1970, but on an unprecedented scale!

IFE directors and trainers gathered at La Grande Motte for the Expériences en Ergothérapie conference in 2016.

Eighteen IFEs have been added to the eight already in place for over thirty years. In 2009, the Berck annex on the Loos site (near Lille) and the Alençon IFE (Orne-61) were opened, followed in 2011 by the Mureaux IFE (Yveline-78); in 2012, the Marseille (Bouches-du-Rhône-13), Hyères-La Garde (Var-83), Laval (Mayenne-53), Auvergne (Puy-de-Dôme-63), Mulhouse (Haut-Rhin-68), Limoges (Haute-Vienne-87) and Saint-Denis (Réunion-97) sites; in 2013, La Musse (Eure-27) and Tours (Indre-et-Loire-37); in 2014, Rouen (Seine Maritime-76); in 2015, Poitiers (Vienne-86); in 2016, Toulouse (Haute-Garonne-31) and Amiens (Somme-80); in 2017, Nevers (Nièvre-58); in 2018, Magny-les-Hameaux (Yvelines-78), Grenoble in 2020 (Isère-38) and Besançon in 2021 (Doubs-25). A total of 27 IFEs by the start of the 2021 academic year. From now on, there will be four types of IFEs depending on their affiliation: university, hospital (CHU or CH), association or private for-profit. It's true that the 2010 training standards are a wake-up call, as it's easier to open a training center when the program has just been overhauled, but the regional councils have also assumed their responsibilities in consultation with the ARS. Indeed, in 2005, responsibility for paramedical training was

transferred to the Regional Councils (Law of August 13, 2004), which finance all or part of the training, and as a result, before arbitrating on the creation of a training center, the Regional Councils assess the training needs in the light of a regional mapping issued by each ARS, to whom this mission has been devolved since 2010, in addition to the task of supervising initial training. With the reduction in the number of regions in 2016, each region is now home to at least one IFE, and up to four IFEs in the Île-de-France region, covering the entire country and considerably increasing the number of students and, ultimately, the number of professionals.

Occupational therapy is also developing in the French overseas departments and territories. While the IFE in Bordeaux, under an agreement with the University of Bordeaux, has been welcoming students from La Réunion since 1995, Tahiti since 2004 and Antilles-Guyane since 2006, the first and still only overseas IFE opened in Saint-Denis de La Réunion in 2012. Other occupational therapists train at other French IFEs or in Belgium to take up more or less permanent positions. The number of occupational therapists is growing in La Réunion, Martinique, Guadeloupe, Guyana, Mayotte and Tahiti. Occupational therapy is adapted to the specific context of these territories.

Growth in the number of occupational therapists in France from 2001 to 2020. Source: DREES 2020

As it does every year, the DREES (*Direction de la recherche, des études, de l'évaluation et des statistiques*) publishes a report on the demographics of the healthcare professions for the previous year, based on ADELI files. This provides the profession with information on the evolution of its workforce. On January 1, 2020, there were 13,644 occupational therapists in France, of them 87% are women, and 14.39% self-employed or in mixed practice. Looking back over the last twenty years, the number of professionals has more than tripled, since in 2001 there were just 4,241 occupational therapists. Over the last ten years, it has almost doubled (DREES, 2020).

Surveys to find out more about the profession

In early 2010, the professional association commissioned two surveys to gain a better understanding of the profession. The first was commissioned from Géronto-Clef and included gerontologist Caroline Richard, INSERM research director Alain Colvez and sociologist Nathalie Blanchard. Carried out in 2009, it covers the *current state of occupational therapy and the profession of occupational therapist in France. Analyse des représentations socioprofessionnelles des ergothérapeutes et réflexions pour l'avenir du métier* (Richard *et al*., 2011). Occupational therapists find it difficult to give a precise definition of what occupational therapy is, as it is most often based on a description of practice. On the other hand, "the major concept on which occupational therapists agree is that of adaptation", constituting the founding principle and an explanation of the modalities of practice. This research also "highlights the importance of anchoring occupational therapy in a research process that would enable occupational therapists to step back from their practices and succeed in conceptualizing the profession" (Richard *et al.*, 2012, p. 37).

The other study is carried out by the Catel resource center: *Enquête nationale sur la démographie et les activités des ergothérapeutes en France* (ANFE Catel, 2015), it provides a precise picture of the practice of occupational therapists across the country. The results identify the profession's youth, sustained demographic growth, and beyond the well-known female characteristic, the very small number of occupational therapists in private practice (8%), as well

as the diversity of practice locations and therefore of professional practice modalities. Since then, private practice has grown, reaching 14.39% in 2020.

These two studies also reveal the emerging need for occupational therapists to better know the profession, in order to better grasp the future in the face of major changes in health and social legislation and regulations, but also in the light of this profound change in initial training: elements which each contribute, in interaction, to the affirmation of a professional identity (Morel-Bracq *et al.*, 2021).

PRAP 2S training

The introduction of PRAP 2S (Prevention of Physical Activity-Related Risks in the Healthcare and Social Sector) training for occupational therapy students is also undeniably a highlight. This is the recognition of a new field of professional practice for work teams and facility managers. This training meets the nine general prevention principles of the French Labor Code "Adapting work to Man, taking into account inter-individual differences, with the aim of reducing the effects of work on health" (L.4121-2 of the French Labor Code), not just adapting man to work! Since 2017, IFEs have been involved in training students at PRAP 2S so that they become PRAP 2S trainers (Jeay and Dazin, 2017; Dazin, 2018, 2019). The health and social services sector is particularly accident-prone, with a high claims rate: the rise in the frequency of workplace accidents particularly concerns activities carried out with the elderly (EHPA-EHPAD) and at home. Their number is almost 3 times higher than in all other sectors of activity, including hospitals and clinics (Ameli, 2020; Hernandez, 2018, p. 20). As a result, PRAP 2S occupational therapy trainers can work with their nursing and administrative colleagues to prevent the risk of work-related accidents.

Health service for health students

Since 2010, initial training has strengthened the preventive and educational aspect, with teaching units (UE) on public health and therapeutic education techniques and tools in occupational therapy. It is also becoming more open to interprofessionality, with two dedicated courses: “the institutional and partnership environment of the occupational therapist”, and “organization, work management and interprofessionality”. As a result, the Ministry of Health's request to introduce a health service for all health students has been met, despite the increased workload for students and teaching teams. This health service is part of the national health strategy, the first axis of which is to implement an interprofessional prevention and health promotion policy (Decree no. 2018-472). It makes it possible to disseminate student-led prevention interventions throughout the territory, under the cover of ARSs. To integrate this service into training, six weeks must be made commonplace. The health service becomes compulsory to obtain the state diploma:

> "Possible places of action include prison environments, university health centers, retirement homes, public and private companies, places where people with disabilities live, EHPADs, but also and above all colleges, high schools, schools and universities." (Trouvé, 2018, p. 20).

7) Continuous Professional Development

Another novelty in the second half of this period was the introduction of Continuing Professional Development (CPD). Since Law no. 71-575 of July 16, 1971, on the organization of continuing professional training within the framework of lifelong education, salaried employees have had access to continuing professional development. For occupational therapists, as for all healthcare professionals, the HPST law reinforces this right to training by making it compulsory. Article 59 of the HPST law stipulates that:

> "The objectives of continuing professional development are to evaluate professional practices, enhance knowledge, improve the quality and safety of care, and take into account public health priorities and the medical control of healthcare expenditure."

As a result, since 2016, all healthcare professionals have been required to update their professional knowledge and ensure professional oversight of legal and regulatory provisions, in line with best practice, in order to continuously improve the quality and safety of care. Over a period of three years, each professional must justify his or her commitment to a CPD approach involving continuous training, analysis, evaluation and improvement of his or her practices and risk management according to priority orientations proposed by the *Conseil national professionnel de l'ergothérapie* (CNPE) set up and declared on June 1rst, 2018 (Hernandez and Gogly, 2016; Hernandez, 2017a; Hernandez and Vagny, 2018).

8) The emergence of research and an increase in the number of publications

Following the *Ergo 2000!* European Congress in Paris, and meetings with occupational therapists outside France who are highly committed to research, and thanks to the numerous articles and books by Morel-Bracq (2004, 2009, 2017 and the translation of Doris Pierce's book in 2016), and to Master's degree instructors, IFEs have gradually integrated the results of research work into their courses, leading *ultimately* to end-of-studies dissertations presenting a clinical field problematic in a research initiation perspective since 2004. In this way, both courses and dissertations take *evidence-based practice* into account (Morel-Bracq, 2008; Tosser and Morel-Bracq, 2015; Mignet, 2015). Practice models are made available to students and also to occupational therapists, as they are provided in continuing education by ANFE: they help guide and argue occupational therapists' practice according to various professional contexts (Botokro, 2006). For example, specific occupational therapy models include Gary Kielhofner's Model of Human Occupation (MOHO), the Canadian Model of Occupational Performance and Engagement (MCREO), Michael Iwama's Kawa (River) Model, and Francine Ferland's Ludique Model. And more recently, the Transactional Model of Occupation (Fisher, 2019) published in *Powerful Practice, A model for Authentic Occupational Therapy*, is beginning to be taught, helping students acquire the ability to analyze occupation with a *top-down* approach. The OTIPM reasoning process also makes its appearance in courses. The growing interest in research also appears in books such as *Recherche en ergothérapie : pour une dynamique des pratiques* (Trouvé *et al*., 2011) or *Guide de recherche en réadaptation* (Tétreault and Guillez, 2014). Similarly, the *Revue francophone de recherche en ergothérapie* (RFRE) points out, "The vast majority of readers thus comes from France, which augurs well

for the future development of occupational therapy research in Europe." (Pellerin *et al*., 2020-1).

As for publications, the number has exploded since 2000: over 40 books have been published under the impetus of ANFE (TMS, Solal then de Boeck), but also by other publishers (Erès, Masson, for example); numerous articles appear in various occupational therapy journals and in other journals from other disciplines. For example, articles are published in : *ErgOThérapies ; Expériences en Ergothérapie ; Journal de réadaptation médicale ; Kinésithérapie scientifique ; La Lettre de médecine physique et de réadaptation ; Motricité cérébrale ; ANAE ; Contraste ; Développements ; Revue francophone de Gériatrie et de Gérontologie ; Soins Gérontologie ; Soins Cadres ; Soins ; Santé mentale ; Vie Sociale et Traitement ; Santé publique,* etc. Others are published on websites dedicated to occupational therapy. Others are on the websites of scientific journals such as *IRBM, Archives of Physical Medicine and Rehabilitation, Spinal Cord or Eur J Phys Rehabil Med, 12th International Society of Physical and Rehabilitation Medicine World Congress, Disability & Rehabilitation, Journal of Occupational Science (JOS), OJTR*, or in the *Revue Francophone de Recherche en Ergothérapie* (RFRE), etc.

This shows an appetite to reflect on occupational therapy practice and build up a professional identity, while at the same time demonstrating what occupational therapy brings to the health and social sector: the professional body of occupational therapists is asserting itself (Morel-Bracq *et al*., 2021). As a result, occupational therapists are publishing more and more widely beyond the profession, towards other professionals and towards disabled people and their families. A large number of occupational therapists read the professional and scientific literature to play a role in their initial training (as trainer, teacher, dissertation supervisor) and when resuming academic studies (university diploma, bachelor's degree, master's degree, doctorate), others to better assert themselves in their practice (Morel-Bracq *et al.*, 2019). In the survey conducted by ANFE's Scientific College in 2017-2018, there are still professionals who read little, expressing methodological difficulties and a lack of time for professional monitoring (Hernandez and Riou, 2019, p. 49). This is why it is necessary "to negotiate a project with the employer to set aside working time for learning about research and applying research findings" (Caire *et al.*, 2011). This is how "occupational therapy will be able to continue to develop in France and consolidate its scientific foundations" (Hernandez and Riou, 2019, p. 49). ANFE is committed to narrowing this gap in order to accompany as many occupational therapists as possible towards scientific reflection and evidence-based practices, both through training (DPC and lifelong learning) and through the publication of books (*Id.*, p. 50).

While many occupational therapists write for their peers and open themselves up to the views of others, exchanges of practice are also made possible, helping the occupational therapy profession to move towards greater reflexivity, scientific research and professional affirmation.

Premières Assises de l'Ergothérapie, Paris, 2008

On the ANFE website, a dozen brochures and fifteen assessment tools are available, as well as the *ErgOThérapies* magazine. Each year, the profession and its students benefit from a wide range of publications. In addition, the final dissertations of students who have obtained *at least* a 15/20 mark for the written document, are available on the ANFE website, since 2014 (https://www.anfe.fr/memoire-etudiants-ife) and also, for some of them, on the DUMAS website, the university repository for dissertations after defense (https://dumas.ccsd.cnrs.fr/).

Another aspect is that, as early as 2015, ANFE was looking to identify further study opportunities for occupational therapists. In 1987, a study day was held in the Rhône-Alpes region to identify the possibilities for further study: *Les formations possibles après le diplôme d'État d'ergothérapeute* (ANFE, 1987). Nearly thirty years later, the aim is to specify the commitments and successes of further study: doctorate holders, doctoral students and occupational therapists in the process of completing or having completed a Master's degree (Caire *et al*., 2017). In fact, this is the consequence of an increase, since the very beginning of the 2000s, in the number of occupational therapists holding a Master's degree and, consequently, a growing number of PhD students (around twenty, by 2020) and PhD thesis holders (also around twenty, by 2020). These doctorates are in a variety of disciplines: neuroscience, educational sciences, sociology, anthropology, psychology, social psychology, public health, movement science but also *occupational science*, etc., according to data collected by the ANFE Scientific Committee. In addition, a number of occupational therapists are successfully taking the *EuroMaster* European Occupational Therapy Master's courses and reporting on them through presentations and publications (André and George, 2017; George, 2018; Pellichero, 2018; Salomon, 2018; Luthringer, 2021): thus seven French occupational therapists have been enrolled in this European program, as of the end of 2020.

This phenomenon is combined with research conducted by occupational therapists, usually in interprofessional collaboration, as part of hospital nursing and paramedical research programs (PHRIP), and has been since 2011. For example, three projects have received financial support from the Haute Autorité de Santé (HAS) : Permadom (Mettai-Declerck *et al*., 2015), EF2E alias Cooking Task (Poncet *et al*., 2015) and the *Programme Pluridisciplinaire de prévention en phase précoce de l'épaule douloureuse post-AVC* 4P-ED (Cook *et al*., 2015).

As a result, French occupational therapists are clearly committed to research, with a twofold aim: firstly, to understand the therapeutic potential of occupational therapy and improve practice by transferring research findings into professional practice, and secondly, to infuse initial training with what is known as "*training for research through research*" (Cros, 1998; Rinck, 2011).

And there's good news coming in October 2019:

> "Insofar as the recruitment of teacher-researchers is a key issue in university integration, the public authorities have decided to open up new qualification routes for holders of a habilitation to direct research or a doctorate wishing to become university professors or university lecturers, in nursing, rehabilitation/rehabilitation and maieutics." (Richard & Le Bouler, 2019).

Chantal Chavoix, occupational therapist and neuroscience researcher at INSERM, University of Caen, has been appointed to the National Council of Universities (CNU) for medical, odontological and pharmaceutical disciplines, in the new section 91 created for the disciplines of rehabilitation and nursing sciences. The CNU, a national body, decides on individual measures relating to the qualification, recruitment and career of university professors and lecturers. Two occupational therapists are thus qualified in 2020, and two more in 2021, for the position of *maître de conférences*, in section 91 (Le Monde de l'Ergothérapie, 2020, p. 44). This represents a real opening for university positions for occupational therapy colleagues (Chavoix & Laprevotte, 2020, p. 9). We can only hope that this number will increase, further affirming the contribution of research to both training and professional practice.

9) The assistive device market takes hold

The February 11, 2005 law on equal rights and opportunities, participation and citizenship for disabled people finally enshrines real funding for assistive devices and adaptations, which has an impact on the work of occupational therapists. Indeed, MDPH teams are available to help disabled people or their representatives with any queries they may have. Instead of having to "beg" from social security services, mutual insurance companies, welfare offices or charitable organizations, people with disabilities, their families and occupational therapists from health or social care establishments now turn to a one-stop counter : the MDPH, which was strongly requested both by people with disabilities and by occupational therapists themselves (Merlin, 2005). Within the MDPH, the *Commission des droits et de l'autonomie des personnes handicapées* (CDAPH), in which occupational therapists participate, decides on the entitlement to benefits for each disabled person. This is based on the assessment carried out by the multidisciplinary team and the proposed compensation plan. From now on, funding will be provided for compensation aids (assistive device, home, vehicle and workstation adaptations, training needs, specialized care, adapted transport). For the elderly, the *Allocation personnalisée à l'autonomie* (APA) (Personalized Autonomy Allowance) can be used to finance part of the cost of a stay in an EHPAD (nursing home), care and interventions in the home - including those carried out by occupational therapists - or mobility.

At the third *Comité interministériel du handicap* (CIH), the French government pledged to implement twenty-two concrete improvements by 2020 to make everyday life easier for people with disabilities. A number of these measures concern the practice of occupational therapists, either by simplifying administrative procedures, or by opening up new opportunities for practice. For example, the implementation, from 2020, of the first "evolutive housing units, with the obligation of adaptable bathrooms (zero shower protrusion), requires SOLIHAs and therefore occupational therapists to adapt a house or apartment in the event of the onset or evolution of a disability. Or the introduction, at a pilot site in each region, of a single *Pôle emploi/Cap emploi* reception point will strengthen the offer of personalized, more effective support for disabled jobseekers (Comité interministériel du handicap, 2020).

As the years go by, a market takes hold, disability becomes more visible and the environmental approach undergoes a craze that makes citizens exchange among themselves, and create too, like those who use 3D printers more and more. The new possibilities offered by the 3D printer make it possible to adjust assistive devices to the disability (Ehretsmann, 2015 and 2016; Bodin, 2016; Hernandez, 2016; Allègre *et al*., 2017). The occupational therapist determines, modifies and sometimes designs these objects capable of smoothing out a complicated daily routine. This complex and particular activity is part of the arsenal of possibilities to be offered to the beneficiary excluded from *design for all*, as recommended by the Council of Europe n° R (98) 9:

> "All people who are or may become dependent (...) must have the right to the assistance and help they need to lead a life in keeping with their actual and potential abilities, at the highest possible level. Consequently, they must have access to high-quality services and the most appropriate technologies (1998)."

Occupational therapists have the skills to carry out assessments and provide support for the person in his or her environment, in line with lifestyle habits, and to recommend the assistive device best suited to his or her needs, as well as to train and coach the person and those around him or her in the handling and proper use of these aids, so that autonomy is established over

time (Denormandie and Chevalier, 2020). However, when recommending the many and varied technical and technological aids available, occupational therapists need to develop and maintain a level of knowledge about innovative materials and their recycling, in order to make the most environmentally-friendly choice possible by avoiding harmful products. Furthermore, occupational therapists' awareness of ecological challenges positions them towards "an adaptive balance between ecosystems, people and their occupations, by joining a Network for Sustainable Development in Occupational Therapy, R2DE" (Thiébaut-Samson, 2018, p. 289).

Connected and unconnected aids aim to maintain the social participation of people with disabilities, by enabling them to compensate for their limitations and making it easier for them to carry out everyday tasks. This concerns at least 2.5 million people in France, representing a major economic market (PHEDRE survey, conducted by DREES and IRDES). For the numerous and highly complex connected technological aids, they require monitoring of both the legal aspects - General Data Protection Regulation (GDPR), informed consent, *hacking* risks - and the technological aspects (short or long transmission frequencies, GSM, WIFI, RFID...). This connected technology is used for telemedicine, for remote medical monitoring or preventive self-monitoring in e-health (Pradier, 2015 a, 2015b), for supporting autonomy at home, reducing isolation, distance learning for the most disabled. Anti-wandering systems for an institution (EHPAD), connected floors and various robots are examples of possible aids at both personal and institutional levels (Pradier and Lévêque, 2016; Hudson Pradier, 2018). In this specific disability sector, while many assistive devices are or have been developed collaboratively between creators, and future users, many products on the market are not the subject of specific study.

The environmental approach is now firmly anchored in people's minds (Trouvé, 2016). The natural environment is the focus of much attention. Disability is increasingly taken into account in the city and the territory, much more so than in the past, but well below the reality of the Nordic and Anglo-Saxon countries (CNSA, 2019), more inclined to an ethic of autonomy and responsibility, whereas France still remains too much in an ethic of assistance (Rameix, 2002). After the introduction of accessibility audits, cities are becoming more accessible, but there is still a great deal of progress to be made to make universal accessibility a reality and not an utopia (Ménard, 2020).

On August 7, 2020, organic laws no. 2020-991 and 992 on social debt and autonomy were promulgated. This new branch of the Social Security system relating to autonomy, also known as the Fifth Risk, was created because of the need to rescue the social protection system. This new strategy follows on from the November 2020 recruitment campaign for the professions of the elderly, in which the question of creating diplomas and certifications to improve bridges and make the professions more attractive was raised. One of the challenges of dealing with loss of occupation is to manage established situations of high dependency, both in institutions and at home, since hospitalization places are decreasing, and to prevent their morbid consequences, a mission devolved, among others, to occupational therapists.

10) The evolution of occupational therapy activities

In 2000, the list of medical procedures delegated to occupational therapists, published in 1986, is still in force. Vocabulary and concepts have evolved, but the scope of the text still covers the essentials of occupational therapy practice.

The term "assessment" is beginning to be replaced by "evaluation" (Guihard, 2000; Bally-Sevestre *et al*., 2003; Caire *et al*., 2004; Paban, 2004). In fact, evaluation allows us to take into account observation, tools for collecting qualitative data during interviews and those giving quantitative results, such as scales or scores. Assessments, on the other hand, are established between two data-gathering periods. Occupational therapy assessment has come a long way since 1986, with tools becoming increasingly standardized. The **occupational therapy patient file** published in **2001** by the *Agence nationale d'accréditation et d'évaluation en Santé* (ANAES) is a useful guide for occupational therapists (Jugan, 2003). It clearly states that ″activity is the end and the means of occupational therapy" (ANAES, 2001, p. 27). According to these recommendations, the occupational therapist begins by mentioning in his or her file the patient's "clinical presentation on arrival", his or her "previous living habits", the patient's "project" and the "expectations of those around him or her" (ANAES, 2001, p. 49). The summary of assessments is based on the Disability Creation Process (PPH) model, and describes personal factors, environmental factors and disability situations (ANAES, 2001). The PPH permeates our publications: the *Journal d'ergothérapie* uses this model, and it is also present in the *Bulletin de liaison* through the various writings of the General Secretary, or relating to regional training days. This model is also gradually making its way into practice, with the use of the LIFE-H and the MQE. University writings such as Jean-François Bodin's Bachelor's thesis (2000) and Rozen Botokro's Master's thesis (2002) bear witness to this.

As for the articles published during this period, they are very diverse. A few mention craft and expressive activities (Nadau and Mas, 2002; Donaz and Reboul, 2003; Clouet, 2004; Dupuy, 2004), play and leisure activities (Casanovas *et al*., 2003; Poulat *et al*., 2005; Darsy, 2004), work (Lourdais, 2004; Guichoux *et al.*, 2005; Criquillon *et al.*, 2004), activities of daily living (Chauderon, M., 2000; Leval *et al*, 2003), but the vast majority of articles deal with issues other than the therapeutic activities offered to patients: home design, family involvement, teamwork, new rehabilitation techniques, models, pathology and cognitive disorders in particular, equipment and assistive device, new areas of intervention, methodology and evaluation... We can see in this a change of perspective on the part of occupational therapists: the vision centered on the activity proposed to the patient to meet a need for re-education or rehabilitation is opening up towards a systemic approach to disability situations and the life project (Destaillats and Sorita, 2001; Pechoux and Bretaudeau, 2016; Poriel, 2016).

Learning to transfer from wheelchair to car, Raymond Poincaré Hospital, Garches.

Shopping. Photo IFE UPEC Créteil

However, this shift in perspective is only gradually taking place in practice and training. In 2004, for example, a survey was carried out in Bordeaux to identify the activities used by occupational therapists, with a view to adjusting training (Morel, 2004). It revealed differences between the practice areas of psychiatry, pediatric functional rehabilitation and adult rehabilitation. In fact, the activities most frequently used are computing, drawing and painting, small-scale carpentry, cooking, games, as well as grooming and dressing. The objectives proposed in the survey are taken from the ICF. The survey shows that the priority objectives in psychiatry are to establish a relationship, motivate and provide psychic stability, facilitate communication and interact with others. In functional rehabilitation, in addition to establishing a relationship, observing and assessing the person, activities are proposed mainly to work on cognitive and movement-related functions, as well as fine motor skills and personal maintenance. With children, activities aim to develop perceptual, higher-level cognitive and movement-related functions, as well as the application of knowledge and daily routines. The development of skills and performance in community, social and civic life is still little considered, as it will be in a dossier in the journal *ErgOThérapies* in October 2020.

Photos IFE UPEC Créteil: cooking and using a bank machine

Until 2010, with the 1990 training program still in force, students perceive a discrepancy between the craft activities taught in training and the practice of occupational therapists during internships. Weaving, carpentry and pottery are taught but little used, while personal care activities, games, computers and cooking are supposed to be familiar to everyone and are less present in occupational therapy training, which is becoming problematic (Leval *et al*., 2003).

What kind of practical training should be envisaged for occupational therapists? This question occupied a European research group within the ENOTHE network between 2000 and 2004. A distinction was made between activities proposed to patients with a therapeutic objective, and those that the occupational therapist herself/himself will be required to carry out, such as assessments and splinting. As any activity can become therapeutic, the emphasis was placed on the students' skills in observing, analyzing and adapting activities that would be meaningful for the people receiving occupational therapy (ENOTHE, 2004).

The development of the 2010 training standards has changed the approach to rehabilitation and care activities, both in terms of learning methods and choice of activities. In 2010, the activities used and taught have become much more diversified. The occupational therapist's activity reference manual states: "The occupational therapist uses exercises, games, handicrafts, projective activities or simulations of daily activities, domestic tasks, professional gestures, social, cultural or sporting activities..." (Appendix I, p. 170).

As a result, there is no longer a module or teaching unit specifically dedicated to the teaching of craft or artistic activities: theoretical and practical courses are combined to encourage reflection and *ultimately* give meaning to all teaching. As a result, experimentation with handicrafts, art and daily life activities, either individually or in groups, takes place through the exploration of teaching unit content such as occupational therapy and the science of human activity (now called occupational science), introduction to the foundations of occupational therapy practice, models of activity analysis, mediation, relationships and the therapeutic framework... Each semester, according to the Order of July 5, 2010, the integration units "correspond to tutorial teaching aimed at integrating the knowledge acquired - theoretical knowledge, practical knowledge and relational knowledge - to develop the skills targeted by the occupational therapist competency framework" (Hernandez, 2010, p. 22).

Photo IFE UPEC Créteil: getting back into the swing of things

“Human, technical, animal aids and mobility" constitutes a teaching unit. It is becoming clear that occupational therapy now focuses more on "participation" in the ICF sense, adapting to the meaningful and significant activities of the people who come to them. Craft activities that are costly in terms of technical training, completion time and adapted equipment are virtually disappearing from occupational therapy services in favor of everyday activities such as cooking, shopping in a supermarket, IT, DIY, access to adapted sport or physical activity (Bolcato *et al*., 2016). The assessment and adaptation of the home, after hospitalization or for the elderly, has taken on such importance that many French people only know the profession from this aspect, which is quite reductive. We are also seeing the development of virtual reality activities, mentioned for example at the IFPEK's 3rd Scientific Day (Guillaume *et al*., 2012) or in the innovative practices section of the journal *ErgOThérapies* (Marais, 2017; Sorita *et al.*, 2017), and those carried out with the Armeo robot© (Meimoun, 2013) or In Motion© (Renaudin *et al.*, 2015).

In addition, the 2010 training standards have been drawn up in line with developments in occupational therapy at European level, taking into account the complexity of disability situations, and the interaction between the individual, his or her activities or occupations, and his or her physical and social environment. The links between activity and health are understood in a different way than in previous periods, as occupational therapists now have access to the latest developments in occupational science. "*Occupational science*", translated as "science of human activity" in the training program and then as " occupational science " when Doris Pierce's book was translated in 2016, is now the scientific foundation of occupational therapy training. Interestingly, the translation of *occupational science* by "science de l'occupation" was unimaginable in 2000. It took over fifteen years to move from the concept of activity to that of occupation. The first French-language colloquium of the "*Occupations humaines et santé*" network in Lausanne on May 19, 2017 attracted many French participants.

In the "Terminology" project developed by the European Network of Occupational Therapy Schools (ENOTHE) during the years 2005-2008, Sylvie Meyer reports the following definition for occupation: "*a culturally denominated group of activities that has personal and socio-cultural value and supports participation in society. Occupations can be classified into personal care, productivity and leisure*" (2013, p. 59), with activity being "*a structured sequence of actions or tasks that contribute to occupations*" (2013, p. 59).

As for Doris Pierce, she proposes two levels of definition: "*a definition of occupation at the level of individual, richly contextualized experience, and a definition of activity at the level of culturally bound ideas*" (2016, p. 25). Thus:

> "An occupation is a specific, individual's personally constructed, nonrepeatable experience. That is, an occupation is a subjective event in perceived temporal, spatial and socio-cultural conditions that are unique to that one-time occurrence. An occupation has a shape, a pace, a beginning and an ending, a shared or solitary aspect, a cultural meaning to the person, and an infinite number of other perceived contextual qualities" (2016, p.25).

In addition, research into the links between activity/occupation and health is increasing the wealth of knowledge that occupational therapists can use to advise on and facilitate health-promoting activities, particularly with a view to prevention. Drawing on the science of occupation, the "*Do-Live-Well*" (Moll *et al.*, 2015) or "*Vivez bien votre vie*" (Bourque, 2017) highlights eight dimensions of activity in relation to research work: 1/activating one's body, mind and senses; 2/ creating connections with others; 3/ contributing to community and society; 4/ taking care of oneself; 5/ building prosperity; 6/ developing and expressing one's personal identity; 7/ developing one's abilities and potential; 8/ experiencing pleasure and joy (Moll *et al.*, 2015). These dimensions relate to the use of time described according to the following elements: commitment; personal meaning; balance; choice and control; routines (Moll et al., 2015). These elements are all based on research providing evidence of links with health (Moll *et al.*, 2015, p.15). This new way of analyzing human activity, or more precisely, occupation, is based entirely on research developed in occupational science.

Activity analysis shifts the focus away from underlying elements (muscular, articular, etc.) to consider a more global mapping that takes into account occupational balance and the links between occupation and health (Morel-Bracq, 2018). In this way, occupational therapy in France joins the scientific conception long championed by our colleagues in the English-speaking sphere such as Ann Wilcock (Hitch *et al.*, 2014).

11) Conclusion

The evolution of knowledge, of the social world and of occupational therapy has completely overturned the vision of the early days, which to this day seems quite mechanical, of the order of a direct cause-and-effect model as orthopedics conceives it. Even if the rehabilitation perspective is still of some importance, occupational science is bringing to the fore knowledge of fundamental meaningful and significant activities, and emphasizing, in a different way, the links between occupation and health, leading to an important evolution in the analysis of activity (Morel *et al*., 2006). This extends to other models such as the model of human occupation with the concepts of volition and habituation (Mignet, 2016; Ducousso-Lacaze *et al*., 2016). Occupational performance analysis takes into account the choice, organization and performance of an activity in its environment, and not just in the care structure (Marchalot, 2016; Sorita, 2016). The concept of occupational balance is becoming essential in the practice of occupational therapists, as it is hardly a question of repairing but rather of discovering another way of living differently (sometimes "with" one's disability) in a satisfying way (Ung, 2018). When work is carried out with one or more people around the life project, the consideration of multiple dynamic and subjective elements constitutes what the ENOTHE project group calls "*occupational mapping*" and which is translated into French as "*cartographie de l'occupation*" (ENOTHE, 2008; Meyer, 2013).

In a nod to *Ergo 2000!* the European Congress of Occupational Therapists which opened the period 2000-2020, the *18th WFOT Congress Occupational R-Evolution* will also be held in Paris, and is being actively prepared as the decade draws to a close.

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Conclusion

In the course of writing this book, a number of lessons have emerged, shedding light on both the past and the present, with a view to the future of occupational therapy in France. Paradigms have been identified that are specific to the development of our profession in France. Occupational therapy has its roots in the socio-political and cultural events of previous centuries, and the profession has evolved since the 1950s, always in tune with and shaped by its context. This development, which we address here with the evolution of occupational therapists' vocabulary, invites us to take a look at the future prospects for occupational therapy and the occupational science, and to identify the particularities of occupational therapy in France. This is what our intergenerational group of occupational therapists set out to do, drawing on available documents and direct testimonials to sketch out a history of French occupational therapy.

In the introduction, we set ourselves the goal of shedding light on the dynamics that have marked the fields of health, disability and French society, in order to pinpoint how the idea of occupational therapy took root in France in its singularity. This book was intended not only as a work of memory and transmission, but also as a basis for reflection on the construction of the professional identity of French occupational therapists (Morel-Bracq *et al.*, 2021). What constitutes the core of occupational therapists' practice in the various fields in which they practice? How has the idea of considering activity in its various forms as an angle of approach developed to promote health and quality of life in an inclusive and accessible society?

The meaning of the activity proposed by occupational therapists needs to be contextualized, since, as a healthcare actor, they interact with society's perceptions and representations of health and disability. Over the years, the particularities of occupational therapy in France have emerged, and the role of occupational therapists has evolved to best meet the needs of beneficiaries in each period.

1) Identifying three paradigms

Occupational therapy has evolved in terms of its representations and fundamental values, enabling us to envisage different periods, each with its own characteristics. The chapter entitled "The roots of occupational therapy in French history" looks at the practices that preceded occupational therapy and occupational therapists, concerning those whom illness or accident had deprived of their role in society. We have identified three paradigms based on the reflexive dynamics and practices that have run through occupational therapy: each, in its own way, carries important and significant facts for the development of the profession and ongoing professionalization. In the first paradigm, occupational therapy focused on "The benefits of craft activities". This chapter deals with the beginning of the occupational therapy profession in France, with the creation of two, then six more occupational therapy schools, the establishment of the first national training curriculum and the national association. In the chapter on the second paradigm, "Towards more context-adapted activities, to live in one's environment", we were able to show that occupational therapy practices have become more diversified, opening up to the outside world of institutions and thus focusing on the interaction between the person, the activity and the environment. Finally, in the third paradigm, presented

in the chapter "From activity to occupation", we have seen the appropriation of concepts, models and tools, developed for and by occupational therapists guiding occupational therapy practice. Scientific research is on the increase, particularly in occupational science, and is becoming an integral part of both the training and practice of occupational therapists in France.

2) The evolution of professional vocabulary and concepts

Over time, the vocabulary used changes. The ideas conveyed by society and the professional body of occupational therapists evolve in line with the paradigms identified. For example, the notion of "global approach" and the very idea of "environment" have evolved. For some occupational therapists, the "holistic approach" involved looking at both physical and mental health, to welcome the person in his or her "globality". For others, it meant taking into account the person's environment. In one of Pibarot's first articles, the environment included the occupational therapist, her/his workshop and the materials used within the institution (Pibarot, 1978; "*Dynamique de l'ergothérapie*". . A little later, other authors considered the person's daily living environment, whether physical (e.g. home, assistive device) or social (e.g. family) (Desplanches, 1977; Dorso-Nolet, Jamin, and Tortel, 1992; "EVADOM. Evaluation horaire des besoins du patient à domicile"). . In the second paradigm, bio-psycho-social models of disability call on occupational therapists to take the environment into account as a major element in people's disability situations (Castelein and De Crits, 1990; Belio and Destaillats, 1993; Ruet, 1993; Destaillats and Sorita, 2001; Blaise, 2002). This contextualized approach to disability becomes essential in the third paradigm.

If the concepts of independence and autonomy were very prominent in the second paradigm (Cheron and Soldano, 1990, "*L'ergothérapie*"; De Tienda, 1984, "*L'indépendance*"; Le Gall and Ruet, 1996, "*Evaluation et analyse de l'autonomie*"; Pelbois-Pibarot, 1981, "*Structures de l'activité humaine Réflexions à partir de l'acte de JOUER Des fondements de l'activité ergothérapique*"; Schwarz, 1991, "Autonomie : Therapeutic, professional, personal goals"; Turlan, 1997,"Autonomy: a key concept for occupational therapy? "Turlan, 1998a, "In search of autonomy"; Turlan, 1998b, "Autonomy: a conceptual approach for better practice"; Sève-Ferrieu, 1998), they then fit into different occupational therapy models that link up with other concepts, such as social participation or prevention, which include the previous concepts and go beyond them. As another example, in the early days of occupational therapy, craft activities were proposed as a means of biomedical recovery of a particular function, impairment or disability. The extension of the means beyond craft activities is aimed at meaning and coherence with patients' daily lives: play, sports, computer, communication and leisure activities, as well as personal care, appearance and productive activities (work, training). This demonstrates the contextualization of what is proposed, but also a less biomedical approach, while maintaining a *bottom-up* approach. This contextualization comes in response to the evolution of disability models towards bio-psycho-social models, as mentioned above. New terminology and concepts such as "lifestyle habits" or "quality of life" are also appearing in the literature, and therapeutic, preventive or support proposals are based not only on assessments and ecological scenarios, but increasingly on assessment tools developed by occupational therapists. The results of assessments are leading to even more personalized proposals, freeing us from the prescriptive approach, and combining *bottom-up* and *top-down* approaches for an occupation-centered approach.

Today, occupational therapists and occupational scientists are being encouraged to go beyond "taking the environment into account" and adopt a transactional approach. This approach,

developed over the last twenty years from the thinking of John Dewey, "involves deconstructing the separation between the concepts of Person (P), Environment (E) and Occupation (O)". (Margot-Cattin, 2018, "*La perspective transactionnelle de l'occupation racontée pas à pas*", p.30). and invites to consider the continuity between the person and the environmentaswell as to situate occupations “at the level of the situation of which the individual is an integral part” (Cutchin, "Using Deweyan Philosophy to Rename and Reframe Adaptation-to-Environment"; Cutchin and Dickie, *Transactional Perspectives on Occupation*; Dickie, Cutchin, and Humphry, "Occupation as Transactional Experience", 2006, p. 91).

One of the most significant changes has been the development of the concept of "occupation", gradually replacing what French occupational therapists used to call "*activité*". Indeed, for a long time, the term "*occupation*" was rejected as a synonym for "distraction" or "pastime", with a pejorative connotation during the Second World War. The French term "*occupation*" did not seem sufficiently relevant to a profession in the French medical environment. From the 2000s onwards, activity was defined as "meaningful and significant activity" to reflect what occupation represents. But with access to occupational science and occupation-centered models (MOHO, CMOP-E, etc.), the concept has become more widespread and developed. For example, in occupational science ("the study of human beings as occupational beings" Yerxa et al, "An Introduction to Occupational Science, A Foundation for Occupational Therapy in the 21st Century", 1990, p.6.), the concept of occupation includes more than "doing", but also "being", "becoming" and "belonging" (Hitch, Pépin, and Stagnitti,2014a, 2014b; Wilcock, 1998; 2006). extending what Pibarot had developed between "being and doing: two forms of acting" (Pibarot, 2013). "Studies of human occupation have expanded beyond simply understanding the "doing" of occupation to also examine how engagement in the various activities of daily living contributes to a sense of being, becoming and belonging" (Huot, 2016, p.2). Occupational therapists' vocabulary has thus been enriched with concepts developed in occupational science such as "occupational engagement", "occupational balance", "occupational justice" (Durocher, Gibson, and Rappolt, 2014; Wagman, Håkansson, and Björklund, 2012; Whiteford et al., 2018; Wilcock and Townsend, 2000) . Today, occupational science produces knowledge that is useful to occupational therapists, both for theorizing and for extending their practices in society.

Another change has occurred in the way we talk about supported people: in the 19th, terms were first constructed around deficiencies, such as amputees or insane, blind or deaf; then some doctors gave their names to forms of pathology, such as Duchêne de Boulogne's disease, Broca's aphasia or Alzheimer's disease. In the early days of occupational therapy in France, in the first training programs, conditions, pathologies and impairments in the field of neurology, rheumatology, psychiatry or pediatrics were specified, for the "patients" to be treated. The 2010 program no longer lists pathologies: the teaching units focus on dysfunction, evolution and aging processes. Occupational therapists no longer deal with "patients" or "disabled people", but with people at some point in their lives. This opens up the field of occupational therapy both to prevention and support for people, whatever their age or risk of dysfunction, and to social intervention for vulnerable people or those losing their social ties, taking into account the links between occupation and health, with a systemic perspective.

3) The particularities of occupational therapy in France

It is important, in France, to emphasize the status of medical auxiliary, which hampers the process of professionalizing occupational therapy: indeed, doctors' supervision of medical

auxiliaries remains strong, especially in a biomedical conception of health, even if the texts have evolved and now specify that occupational therapists "act on medical prescription when the nature of the activities they carry out so requires" (Arrêté du 5 juillet 2010, Annexe 1, p. 170). In 2010, occupational therapy diagnosis emerged in the training referential and was the subject of a reference work (Dubois *et al.*, 2017). For a long time, only doctors were allowed to run occupational therapy schools. It wasn't until 1997 that the management of IFEs was fully entrusted to occupational therapist health managers.

The historical approach shows that, with the introduction of Social Security, the return to employment of disabled workers was then offered by establishments run by doctors, which left a biomedical imprint. As for the social dimension, entrusted to associations with a view to social and professional integration, this has yet to be further asserted, in response to the principles of national solidarity, non-discrimination and participation (Ville *et al*., 2014).

It is also doctors, via the *Académie de Médecine*, who validate the creation of diplomas and decrees governing the practice of paramedical professions, and thus their inclusion in the Public Health Code to protect their title. In Europe, the landscape of paramedical professions (medical auxiliaries) varies from one country to another (COTEC, 2021). In France, the existence of psychomotricians and the importance of psychiatric nurses have a particularly strong influence on the number of occupational therapists, unlike in other countries.

In terms of both academic development and research, occupational therapists in France have been slow to distance themselves from the medical profession.

4) The beginnings of a new paradigm

Beyond the three paradigms on which we have based our writing, the year 2020 today appears to be a pivotal one. The health crisis has shaken up the habits, behaviours, relationships and occupational equilibrium of the entire population, with a significant impact on occupational therapists and occupational therapy. Professional practice is now inspired by occupational science, drawing on conceptual models, programs and assessment tools adapted to occupational therapy. New approaches are emerging in practice, such as the sensory integration approach (Lefévère -Renard and Vauvillé Chagnard, 2016) and the CO-OP (Cognitive orientation to daily occupational performance) approach (Martini and Téchené, 2018), or the OTIPM (Occupational therapy intervention process model) with its AMPS (Assessment of motor and process skills) assessment tool (Saget and Montardon, 2018). Programs are being implemented such as COTID (Community occupational therapy in dementia) (Graff, 2013) or the *Programme de renforcement de l'autonomie et des capacités sociales* (PRACS) (Hervieux *et al.*, 2007). Mental health is also concerned, with the psycho-social rehabilitation approach (de Lussac, 2016) or the Eladeb-R assessment scales (Pomini *et al*., 2008; Koch, 2016). Occupational therapists are also involved in prevention, health education, therapeutic patient education and health promotion, as part of public health initiatives. Teams are adapting the occupational therapy intervention of *Lifestyle Redesign*® based on occupational science into a French version to promote the development of a healthy and personally meaningful lifestyle with the elderly (Morel-Bracq, 2019; Soum-Pouyalet, 2019; Levasseur and Levêque, 2019; Soum-Pouyalet *et al*., 2021). Occupational therapy is developing as a practice based on the links between occupation and health and well-being, which underpins the social aspect of intervention. As a result, occupational therapists are becoming more involved in social practices. The National Occupational Therapy Day in Toulouse, "Engagement, Occupation and

Health: an approach focused on supporting people's activity in their life context" (2018), and the *Quatrièmes Assises nationales de l'ergothérapie, "Participation, occupation et pouvoir d'agir: plaidoyer pour une ergothérapie inclusive"* (2019), bear witness to this social orientation of practice. In 2020, the journal *ErgOThérapies* (No. 79, October 2020) on "social and community occupational therapy" received numerous articles, showing the enthusiasm of occupational therapists for this theme.

As a result, new target groups are benefiting from the services of occupational therapists: children with neurodevelopmental or autistic spectrum disorders at a very early age, people living in social isolation, those who are advancing in age but not already in a vulnerable situation, those who will be able to benefit from prescriptions for assistive devices directly from the occupational therapist, those who are supported in employment, in the home, in the city or in rural areas, but also work colleagues in healthcare establishments thanks to the PRAP-2S program. The opening up to the social and ambulatory field appears to be less medicalized and closer to the needs of the population. It provides a direct link between the activity proposed by the occupational therapist and health. Over the last twenty years, the profession of occupational therapy has expanded beyond health and medical-social establishments, in a systemic approach, based on a methodology that is becoming increasingly established.

In addition, new practice modalities emerged during the Coronavirus pandemic (Biard *et al*., 2021; Gaudin Adam and Perrein, 2021; Bidabe-Allais *et al.,* 2021): telecare was opened up to occupational therapists in April 2020 (Order of April 14, 2020) in the remote support and monitoring of a person undergoing care; videoconferencing teaching was widely developed, as well as for professional or inter-professional meetings. Occupational therapists have taken a proactive approach, and ANFE has succeeded in negotiating texts enabling occupational therapy to be carried out in complete safety. These procedures will renew the practice and eventually open it up to new procedures. Following on from the Libault report (2019), occupational therapists are also ready to support the transition from dependency management to autonomy support for the elderly population, including within *Maisons des aînés et des aidants*, as was the case within MDPHs.

In addition, at the end of 2019, a new section 91 was created within the *Conseil national des universités* for the disciplines of re-education and rehabilitation sciences and nursing sciences. As of 2020, two occupational therapists have been qualified as *maîtres de conférences*, followed by two more in 2021. The university route is gradually opening up for the profession in France, and has been brought up to date with the opening of the first master's degree in occupational therapy at the University of Créteil.

As for the year 2022, French occupational therapists, together with ANFE, are proud to be hosting, in Paris, the World Congress of Occupational Therapists: *18th WFOT Congress Occupational R-Evolution*, from August 28 to 31: an international scientific congress promoting "*high standards of occupational therapy practice, research and education worldwide*" (WFOT, 2020). A new page, which could open up a new paradigm, to be written in the history of occupational therapy in France!

Over these decades, occupational therapists have gained experience, developed their maturity and built their professional identity, enabling occupational therapy to evolve from a trade into a profession that is beginning to be recognized.

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https://www.legifrance.gouv.fr/eli/decret/2016/7/8/AFSH1608338D/jo/texte

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Order of January 17, **2020** relating to admission to institutes preparing for the State diplomas of chiropodist, occupational therapist, psychomotrician, medical electroradiology manipulator and medical laboratory technician and bearing miscellaneous provisions.

https://www.legifrance.gouv.fr/eli/arrete/2020/1/17/SSAH1934299A/jo/texte

Direction de la recherche, des études, de l'évaluation et des statistiques (**2020**) Demography of healthcare professionals, occupational therapists. https://drees.shinyapps.io/demographie-ps/

Order of March 25, 2020 supplementing the order of March 23**, 2020** prescribing measures for the organization and operation of the healthcare system required to deal with the COVID-19 epidemic as part of the health emergency.

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Arrêté du 5 février **2021** portant diverses modifications concernant l'admission dans les instituts de formation de certaines professions non médicales.

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Order of June 10, **2021** concerning provisions relating to the authorization of paramedical training institutes and schools and the approval of their directors in application of articles R. 4383-2 and R. 4383-4 of the public health code.

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2) Key events relating to occupational therapy in France

Year	Events and public health policies	Developments in occupational therapy (legislation and training)	Organization and professional development ANFE, congresses and publications in French	Occupational therapy definitions
1950	Polio epidemic in France 1940- 1960			
1952			**WFOT creation**	
1953		September 29 order opening a functional rehabilitation center: "One occupational therapist for twenty patients".		
1954		**Creation of the first two occupational therapy schools: Nancy and Paris**		
1956		Decree 56-284: 1 occupational therapist per 20 patients in the private functional rehabilitation sector		
1957	Law no. 57-1223 of November 23, 1957 on the reclassification of disabled workers			
1959				
1960	Circulaire mars sectorisation de la psychiatrie	Interregional congress on occupational therapy at the Centre psychothérapique de Mayenne (doctors, nurses and occupational therapy instructors)		
1961			**ANFE founded Publication of first association newsletter**	
1963				
1964			**ANFE joins WFOT**	Pierquin & Roche *Journal d'ergothérapie*: "Occupational therapy is a genuine form of therapy, prescribed by the doctor and carried out by the disabled person under the guidance and supervision of the medical assistant. It is designed to correct motor handicaps and gradually train the mind and body to perform practical tasks. Through its action on the body and mind, it is the first stage in retraining for work
1965		**Creation of the Lyon School of Occupational Therapy**		
1966				
1967		Decree 67-43 Approval of private establishments for children with cerebral palsy: one occupational therapist for every 8 minors with cerebral palsy. If there are 3 or more groups of 8 minors, one of them will assume the role of head occupational therapist (art. 30)	Dumoulin, J. Précis d'ergothérapie Paris: Maloine (Belgian work, one of the first in French)	
1968	The social movement and demonstrations of May 68		**First publication of the Journal français d'ergothérapie**	
1970		**November 1970 decree: creation of the occupational therapist diploma (DE d'ergothérapeute)** Decree 70-1332: gestural stimulation through occupational therapy for blind children and teenagers		

1971		**Order of September 1971 concerning operating conditions and official program (1st year of training)** **Creation of Montpellier School**	1	September Order "Occupational therapy is a method of rehabilitating the motor and mental handicapped using work in the most general sense of the word: transformation of matter, making an object, various occupations.
1972		**Official program (2nd and 3rd year of training) Creation of two occupational therapy schools: Berck and Rennes**		Barcelona Congress Pierquin, Roux-Lejeune & Farcy: "In the course of their studies, occupational therapists have learned the therapeutic value of work, its 'specific' effectiveness in correcting this or that pathological disorder." (p.6)
1973	1st oil crisis	**Creation of the Conseil Supérieur des Professions paramédicales (CSPPM)** **Creation of the Créteil School of Occupational Therapy**		
1974		**Creation of the Bordeaux School of Occupational Therapy**	Bedos, F., Moinard, S., Plaire, L., Garrabé, J. (1974) Marionnettes et marottes, méthode d'ergothérapie projective de groupe. Coll. Sciences humaines appliquées. Paris: Ed. ESF.	Rapport Donnadieu *Journal d'ergothérapie* "In all these cases, occupational therapy aims to restore patients' independence by adapting some to their deficits, curing others, and preparing them all for professional and social reintegration. Its great originality, compared with physiotherapy, is that it treats through work.
1975	**Loi n° 75-534 du 30 juin 1975 d'orientation en faveur des personnes handicapées Loi n° 75-535 du 30 juin 1975 relative aux institutions sociales et médico-sociales**			
1976				
1977				
1978			Creation of ANFE's Continuing Education Section	Pibarot *Journal d'ergothérapie*: "It's therapy through activity..... Occupational therapy or ergon therapy is therefore therapy through action, i.e. through work considered as action on and with matter, symbolizing the environment.... So now we understand that the essence of occupational therapy lies in the transition to action, in the movement to transform matter.
1979	2nd oil crisis			
1980	Publication in English of the ICH	January 1980: Creation of the Certificat de Moniteur-Cadre d'Ergothérapie April 1980: Hospital statutes (recognition of the Diploma in hospitals and equivalence for psychiatric nurses ff occupational therapists)	Masson (Abrégés): "Ergothérapie" by Pierquin, André and Farcy	Pierquin, André, Farcy Abrégés Masson : "Occupational therapy is part of functional medicine, which aims to reduce the consequences of illness. In particular, it corrects motor function at its most elaborate, utilitarian and expressive. It has the advantage of pointing out that real work is the most significant and probably the most effective of all activities, the one that leads to social reintegration.
1981	1981-1996: AIDS epidemic			
1982	39-hour working week with 5th week of paid vacation	**Occupational therapy management school opens in Montpellier**	**November: 1st ANFE national symposium in Lyon: L'activité et la personne âgée + book published by Chroniques sociales de Lyon**	
1983		**Opening of an occupational therapy management school in Nancy Decree of June 13, 1983: competitive entrance examination organized by DRASS for seven paramedical training courses.**		C. Chardron *Faire de l'ergothérapie en psychiatrie*: "Occupational therapy in the strict sense of the term, the most medicalized form where the activity remains above all a support for rehabilitative or re-educative action, is not subject to the imperatives of productivity and profitability. (p. 11).
1984				

1985	Law of December 31, 1985: sectorization of psychiatry			
1986		**COTEC** (Committee of Occupational Therapists in the European Communities - Council of Occupational Therapists for European Countries) **founded in Strasbourg**. **Law no. 86-33 on statutory provisions relating to the hospital civil service: like other professionals, hospital occupational therapists become civil servants.** **Decree no. 86-1195 of Nov. 21, 1986 on professional acts (definition, equivalences: authorizations, etc.).**	Ergothérapie et environnement" Masson coordinated by Pr Simon & Pr Pélissier	Decree no. 86-1195 Professional acts: "to contribute to the treatment of deficiencies, dysfunctions, incapacities or handicaps of a somatic, psychic or intellectual nature, with a view to soliciting, in an activity and work situation, the deficient functions and residual capacities for functional and relational adaptation of the persons treated, to enable them to maintain, recover or acquire individual, social or professional autonomy
1987	Law n° 87-517 in favor of the employment of disabled workers			
1988	French translation of the ICH	Decree December 23, 1987: competitive entrance exam run by schools (tests and written exam)	**1st "Experiences in occupational therapy" conference in Montpellier (organized by IFE)**	
1989	Decree of October 1989: creation of special education and home care services (SESSAD).	**Decree no. 89-609: Status of rehabilitation staff in the hospital civil service**		
1990		Order of September 24, 1990 concerning preparatory studies for the DE d'ergothérapeute (occupational therapist diploma) Decree of September 24, 1990 on the operating conditions of schools preparing for the occupational therapist diploma (management by a doctor assisted by an occupational therapist instructor or by an occupational therapist instructor; in addition, at least one full-time occupational therapist instructor).		Definition in the official program: The objectives of occupational therapy are to maintain or achieve maximum individual, social or professional autonomy for the disabled person. It is a method that intervenes at two levels: the individual and the environment
1991		**August decrees on admission to occupational therapy schools (Lyon and Bordeaux): on an experimental basis, admission via PCEM1.**		
1992	Creation COMETE France	**Creation of the SNDEE (Syndicat national des directeurs d'écoles d'ergothérapie - national union of occupational therapy school principals): previously, principals made up the ANFE Teaching Committee.**	**Creation of UIPARM: ANFE co-founder**	
1993		Overall increase in student numbers at French schools (30%: from around 250 students admitted in 1st year to 320)	First occupational therapists in private practice	
1994				
1995		**Law no. 95-116 of February 4, 1995: Registration of occupational therapists in the Public Health Code Obligation to register in the ADELI file August: Instituts de Formation des Cadres de Santé (IFCS)**	Publication by Nicole Sève-Ferrieu: Body, visual and gestural neuropsychology	

		open to various paramedical professionals **Creation of ENOTHE - European Network of Occupational Therapy in Higher Education**		
1996	Creation of UEROS	**December: Name: "Institut de Formation en Ergothérapie" (no longer "école d'ergothérapie"), "étudiants" (no longer "élèves")**		
1997	Creation of the Agence Nationale d'Accréditation et de l'Évaluation de la Santé (ANAES - National Agency for Accreditation and Health Evaluation)	**May decree: the IFEs are managed by an occupational therapist health executive**		
1998	**Publication of PPH**	Decree of June 29, 1998: "As a transitional measure, director approvals issued to physicians are extended until the date of cessation of their functions	Creation of the Instance des ergothérapeutes en libéral within ANFE World Congress of Occupational Therapists in Quebec City	
1999				
2000			**COTEC European Congress in Paris: ERGO 2000 ENOTHE Annual Conference in Paris Theme: Occupational Science 1st ANFE publication (TMS): "Ergotherapy: a guide to practice**	Occupational therapy is an activity-based therapy. ...Occupational therapy is aimed at people with somatic, psychological or intellectual illnesses or deficiencies, people with disabilities, or people with temporary or permanent disabilities. The aim of occupational therapy is to enable these people to maintain or develop their potential for independence and personal, social, educational or professional autonomy." (p.25)
2001	**ICF publication**		**ANAES: publication Dossier du patient en ergothérapie (Occupational therapy patient file)**	
2002	Law on patients' rights and the quality of the healthcare system		Creation of AFEG and SYNFEL	
2003				
2004		**Order of February 25, 2004: The DE exam is modified: the TES is replaced by an introductory research dissertation.**	SNDEE becomes SIFEF Publication ANFE (TMS): "Approche des modèles conceptuels en ergothérapieApproaching conceptual models in occupational therapy)	
2005	**law of February 11, 2005 for equal rights and opportunities, participation and citizenship for disabled people Regional Council competence for training**		First study of occupational therapists in France (sociology thesis 2004) Publication L'Harmattan: "Profession ergothérapeute" C. Wagner (2005)	
2006			Creation of UNAEE, ARFEHGA and Cap-Ergo	
2007		Creation of the Haut Conseil des Professions Paramédicales (HCPP) to replace the CSPPM Order of April 21: Governance of paramedical training institutes May 15 decree: internship allowances December: Beginning of occupational therapy training	ANFE-Solal publications: New collection inaugurated by *Ergothérapie en psychiatrie* March 16: joint demonstration in Paris by 1100 occupational therapists and students for the reengineering of studies and internship allowances	

		reengineering at the Ministry of Health		
2008			**April: 1st Assises Nationales de l'ergothérapie ANFE: *Occupational therapy and health policy***	
2009	**Law no. 2009 - 879 on hospital reform and patients, health and territory (HPST Law)**	**Creation of IFE Alençon**	ANFE- Solal publications: (number and collection) 1st National Occupational Therapy Week	
2010	Creation of regional health agencies (ARS)	**Order of January 20: Authorization commissions for the practice in France of professions including occupational therapy (persons trained in the EU coming to work in France)** **Arrêté du 5 juillet 2010 relatif au Diplôme d'état d'ergothérapeute : Définition, activités, compétences, Arrêté du 18 août : Validation des Acquis de l'Expérience (VAE) for the occupational therapist DE diploma** **Decree no.° 2010 - 979 of August 26: commissioning the admission of top athletes to IFEs**		Definition: "Occupational therapists are health professionals whose practice is based on the link between human activity and health. He/she works on behalf of a person or group of people in a medical, professional, educational and social environment. They assess a person's integrity, injuries and abilities, as well as their motor, sensory, cognitive and psychological performance. He analyzes needs, lifestyle habits, environmental factors and disability situations, and makes an occupational therapy diagnosis
2011		Order of May 31, 2011 (in force from June 3, 2011 to September 1, 2012): abandonment of the practical work placement test for the DE **Creation of the IFE de Meulan-les-Mureaux**	**November: 2nd Assises nationales de l'ergothérapie ANFE: *Occupational therapy research: a dynamic approach to practice***	
2012		**Decree no. 2012-907 on the award of the Licence degree Creation of 7 IFEs: Aix-Marseille, Hyères, Clermont-Ferrand, Limoges, Mulhouse, Tours and Saint-Denis de La Réunion**		
2013		**Creation of 2 IFEs: Évreux and Laval**	ANFE-De Boeck-Solal publications: "Occupational therapy in the home for elderly people suffering from dementia and their carers: the COTID program"; "From activity to participation"; "An ergology of the subjective dimension of human activity	
2014			ANFE-De Boeck-Solal publications: "Guide pratique de recherche en réadaptationPractical guide to rehabilitation research)	
2015		**Order of August 12, 2015: modification of the portfolio (HCPP July 2014) Creation of IFE Poitiers**	**April: 3rd Assises nationales de l'ergothérapie ANFE: *L'activité humaine: un potentiel pour la santé?***	
2016		**Creation of 2 hospital-based IFEs: Toulouse and Amiens**	ANFE-De Boeck publications: "Agir sur l'environnement pour	

			permettre les activités"; "La science de l'occupation pour l'ergothérapie	
2017		**Creation of IFE Nevers**	Publication ANFE-De Boeck: "Les modèles conceptuels en ergothérapie : introduction aux concepts fondamentaux" (2nd ed.); "Guide du diagnostic en ergothérapie" " Publication ANFE- De Boeck: "Les modèles conceptuels en ergothérapie : introduction aux concepts fondamentaux" (2nd ed.); "MOHOST: outil d'évaluation de la participation occupationnelle" May: 1st French-speaking occupational science symposium in Lausanne: Occupation humaine et santé (OHS): Occupational sciences: at the heart of everyday life and health.	
2018		**IFE Assas creation**	ANFE publication: "Engagement, occupation and health" ANFE joins GIFFOCH	
2019		**Creation of IFE Grenoble**	**April: 4th Assises nationales de l'ergothérapie ANFE: *Participation, occupation et pouvoir d'agir: plaidoyer pour une ergothérapie inclusive.***	
2020			International network of French-speaking occupational therapy associations	
2021		**Creation of IFE Besançon**	ANFE publication: "Occupational therapy research: understanding and improving practice	
2022			**WFOT Congress in Paris**	

3) Training occupational therapists in France

Eight occupational therapy schools opened in France between **1954** and **1974**. These first schools in France were all set up on the initiative of doctors. With the exception of Créteil which gave it a certain originality, they were attached to physiotherapy schools. The approval of these eight occupational therapy schools, with their total number of students, was granted at a meeting of the occupational therapists' commission of the *Conseil supérieur des professions paramédicales* on June 25, 1975.

The **ninth OT school (IFE)** will not open until **2009**, thirty-five years later.

Nancy:

In **1954**, Prof. Pierquin, Director General of the *Institut Régional de Réadaptation*, strongly defended occupational therapy and supported the project to open an occupational therapy school, despite opposition from masseur-physiotherapists, who did not want the two professions to be differentiated. In the end, the Ministry of Health agreed to the dissociation of the two training courses, but in the absence of an official occupational therapy program, accreditation could only be granted to masseur-physiotherapist training. A private non-profit association (1901) was set up to manage the two schools, in association with the Faculty of Medicine, the *Caisse Régionale de Sécurité Sociale* and the regional hospital, which was the only body authorized to manage a school (André *et al*., 2004, p.120). The "Nancy School of Physiotherapy and Occupational Therapy" was founded in October 1954. Professor Pierquin was its director. The teaching, inspired by WFOT principles, was organized by occupational therapists from Great Britain, who were also developing occupational therapy in neighboring departments. In 1955, A. Roche, who had graduated in England, became the first director. Paul Farcy, an emblem of occupational therapy in the years of the profession's emergence in France, graduated in 1958 and took over as director in 1963 until 1990. He was succeeded by Gabriel Gable, who was replaced in 2013 by Olivier Dossmann. The teaching team gradually expands to 5 instructors by 2021. The first classes began with 4 graduates per year until 1964. In 1975, a total of 52 students were enrolled in the three cohorts. Since then, the number has risen steadily, reaching 54 per graduating class in 2012.

From 1983 to 1995, it was associated with a school for managers, and since 1987 has been organizing Practical Occupational Therapy Days (*Journées Ergothérapies Pratiques*). The IFE has changed address three times, moving to *rue de Nabécor* in 1978 and then to *rue des Sables* in Nancy in 2006. An agreement was signed with *Université de Lorraine* and *Université Champagne-Ardenne* in 2012.

André, J. M., Xénard, J. and Meyer, C. (2004). *Institut de réhabilitation des Diminués physiques à l'Institut Régional de réadaptation - Nancy 50 ans de médecine physique et réadaptation 1954 - 2004*. Institut Régional de Réadaptation and UGECAM du Nord-Est. Available at: http://www.professeurs-medecine-nancy.fr/IRR_50.pdf

Paris:

The same year, **1954**, an "occupational therapy section" was also set up in Paris at *Hôpital Necker Enfants Malades*, on the initiative of Pr Fèvre, Vice-Dean of the CHU at *Hôpital Necker Enfants Malades*, and Pr Hindermeyer, a specialist in children with physical deformities. The "Medical Gymnastics and Functional Rehabilitation Courses" are organized jointly with the

physiotherapists. Pr Pellerin is general manager. Geneviève Rémond, a former ambulance driver and military nurse, already in place as technical director for physiotherapists, also takes over the reins of occupational therapy training. She was replaced by Rosine Cazenave and then François Lecomte in 1980. At this point, Professor Pellerin decided to close the occupational therapy department. The school separated from the masso-kinésithérapie course, moved to *23bis quai d'Austerlitz* (Paris, 13th arrondissement) and, under the initiative of François Lecomte (president), Nicole Sève-Ferrieu (treasurer), Marguerite Lemarchand (secretary) and Benoit Chené (vice-president) became the *Association pour le Développement, la Recherche et l'Enseignement en Ergothérapie* (ADERE). Nicole Sève-Ferrieu became director in 1986. During this period, the school hosted meetings of the ANFE and the Teaching Committee. In 1994, the school moved to *rue Vitruve* (Paris, 20th). In 2012, Sylvie Freulon became Director, followed by Yolaine Zamora in 2020. The teaching team gradually expanded to include 5 people (4.8 full-time equivalents).

Initially, the first classes at Necker Enfants Malades consisted of 10-15 students. In 1975, the school was accredited to admit 40 students in the first year. In 2006-2007, approval was increased to 60.

In 2000, the IFE was asked to organize the ENOTHE conference in conjunction with the *ERGO 2000!* European OT congress, and remains involved in this network to this day. The Department for Research and Continuing Education, created in 2004, organizes the European and Francophone Days in 2007, 2009, 2011 and 2013. An agreement was signed with *Université Pierre et Marie Curie* (now Sorbonne University) in 2015.

Lyon:

In **1965**, under the impetus of Prof. Bourret, Prof. Garin, then Prof. Cier and Mr. Prouvost, respectively Dean and General Secretary of the Faculty of Medicine, the Ministry of Education signed the decree transforming the physiotherapy establishment into the *École de Kinésithérapie et d'Ergothérapie* within the Claude Bernard University in Lyon. Classes of 15 occupational therapy students are combined with physiotherapy students. P. Schmitt, a physiotherapist, had been director of the occupational therapy school since 1966, and did not wish to take part in the ANFE teaching committee. The appointment of Louis Soudy, occupational therapist, Technical Director from 1988 to 2004, enabled the Lyon school to take part. Pascal Beynette took over until 2010, then Bernard Devin until 2022.

Occupational therapists in the Lyon region are heavily involved in ANFE, its journal and the organization of numerous regional and national days.

On an experimental basis since 1991, trainees have been admitted exclusively from the Faculty of Medicine. Classes have been gradually expanded since 1994. Today there are 45 students per cohort, supervised by a team of 5 occupational therapy instructors (4 full-time equivalents).

When the text **establishing the DE d'ergothérapeute** was published in **November 1970**, there were three occupational therapy schools in France: Paris, Nancy and Lyon. Five new schools were created when the texts setting out the official curriculum were published in 1971 (1st year) and 1972 (2nd and 3rd years).

Montpellier:

In **1971,** the first school to open was in Montpellier. Pr Simon, a functional rehabilitation physician, created an occupational therapy section attached to the physiotherapy school. At the time, six occupational therapists were working in the Hérault department, including Gunvor Houlez, a Swedish occupational therapist trained in Germany, who opened the rheumatology occupational therapy department and assumed technical responsibility for the occupational therapy school.

The first class welcomed 10 students, then two years later 20. In 1975, approval was granted for 45 students in first year. The private school was located in the Clinique Saint-Eloi at the Montpellier Regional Hospital, where Pr Simon and G. Houlez worked. A few years later, the school moved to new premises. Marie-Hélène Izard headed the school from 1983 to 2020. Since then, Audrey Vallat has been appointed Director. Today, there are 80 students in each cohort in the school's new premises on rue de Saint-Priest, with a team of six occupational therapy instructors.

From 1988 to 2019, occupational therapy conferences have been held every year: *Expériences en Ergothérapie*, organized by M.-H. Izard, all of which have resulted in publications.

An agreement has been signed with the Faculty of Medicine at the University of Montpellier.

Documentation IFE de Montpellier :

Izard, M. H. (2001) *L'institut de formation en ergothérapie de Montpellier*. Sauramps médical

Izard, M. H. (2011) *L'institut de formation en ergothérapie de Montpellier*. *1971-2011, 40th anniversary.* Sauramps médical

Izard, M. H. (2017) *The Montpellier occupational therapy training institute. 44th graduating class, 30(th) anniversary of Experiences in Occupational Therapy.* Sauramps médical

Rennes:

In Rennes, Pr Leroy, a functional re-education physician, assisted by Michèle Murie, assistant director, trained in Paris and occupational therapist at the Rennes Regional Hospital, opened the school in **1972**. The classes consisted of 20 students. The two schools, physiotherapy and occupational therapy, were housed in the Pontchaillou hospital at the Rennes Regional Hospital. The occupational therapy school split off a few years later, to have its own premises and separate teaching. Subsequently, the OT school (IFE) moved into new shared premises on *rue Jean Louis Bertrand,* Rennes, with the masso-kinésithérapie and pédicurie-podologie (IFPEK) training courses. Jean-Yves Bausson took over from Michèle Murie in 1993 until 2004, followed by Christine Orvoine until 2017. Since 2021, Servane Boujard has been educational manager.

The occupational therapy school's influence has spread throughout Brittany, with a continuing education service since 1994 and numerous study days. The IFE was awarded quality certification in 2006. The IFE currently accepts 75 students per year, with a team of seven occupational therapy instructors.

An agreement was signed with the universities of Rennes 1 and Rennes 2 in 2012.

Berck:

In **1972**, the Berck school opened under the impetus of Pr Laude, director of the *École de Masso-Kinésithérapie*, and Dr Malgouzou, mayor of the town of Berck-sur-Mer and president of the *Association pour la Promotion des Professions Para-Médicales*. Marcelle Ridel, occupational therapist trained in Nancy, was director until 2004. On her departure, management was entrusted to Michel Gedda, masseur-kinésithérapeute, assisted by a pedagogical director, Pascal Guillez until 2012, then Pascale Stefaniak for one year and Stéphanie Heddebaut until 2018. From that date onwards, Denis Waroquet becomes Pedagogical Director in Berck and S. Heddebaut in Lille-Loos.

In 1975, approval was granted for a total of 45 students. Classes increased to 60 students per year in Berck. In 2009, the IFE opened a branch in Lille-Loos with a capacity of 30 students per class, for a total of 90 students per year. Today, the teaching team at both sites is made up of eight occupational therapists.

An agreement has been signed with the University of Lille.

Créteil:

In **1973,** the Créteil school was created on the initiative of Pr Hamonet, with the support of Marie-Madeleine Champion, occupational therapist, who had trained in Paris. The Créteil OT school (IFE) was first attached to a CIS department (*Communication et Insertion dans la société*), then to the University's central services from 1997 to 2015, and finally to the *Pôle Santé* of the *Université Paris-Est-Créteil (UPEC)*.

Initially approved for 32 students in first year, it reached 80 in 2011. The number of staff on the teaching team gradually increased from 0.5 to 6 full-time equivalents. From 1993 to 1996, Michel Le Gall was in charge. He was succeeded by Pierrette Meunier until 1999. Hélène Hernandez was then appointed Technical Director, then Director in 2007 until 2017. Arnaud Le Labourier has been Pedagogical Director since that date.

Pr Hamonet, author of "*Les personnes en situation de handicap, Que sais-je?*", is a strong supporter of training and occupational therapists, who he involves in various projects such as the Spartacus project in the 1980s (Manus upper limb assistance robot) and projects to set up occupational therapy schools abroad (Algeria, Lebanon and Tunisia).

In 2002, IFE set up Continuing Education in Occupational Therapy and Rehabilitation. An agreement was signed with *Université Paris-Est* in 2013. In 2021, for the first time in France, IFE is offering a Master Santé course in Research, Project Management and Professional Practice in Occupational Therapy (RG3PE), coordinated by Cynthia Engels, Senior Lecturer in Occupational Therapy.

Bordeaux:

In **1974,** the last OT school to open during this period was at Bordeaux University Hospital. This was the result of a meeting between Jacqueline Roux and Jacques Chaban-Delmas, Prime Minister from 1969 to 1972. Chaban-Delmas, who was also Mayor of Bordeaux and Chairman of the CHU's Board of Directors, supported Professor Arné's request. The first class of 12 students was managed until 1977 by Anne-Marie Steininger, an occupational therapist trained in Nancy.

It was the only free public hospital OT school in France. Authorized for 12 students, the school took in only seven at the start of the 1977 school year, as the occupational therapist manager's post was vacant and the school operated with only a secretary, a workshop instructor and support from the physiotherapy school. This situation lasted for two years. Prof. Mazaux was appointed Medical Director, taking over from Prof. Arné. From 1979 to 2015, Marie-Chantal Morel was in charge of teaching and administration management. Virginie Bonnici was appointed Pedagogical Director in 2016, with Valérie Lozano, Director of Care, taking over as Head.

On an experimental basis since 1991, students have been admitted exclusively from the Bordeaux medical school, including students from the universities of Réunion, Antilles-Guyane and Tahiti.

From 1996 to 2014, the IFE was a partner of the ISEK School of Occupational Therapy in Brussels, and a member of the ENOTHE European network of occupational therapy schools. Numerous study days are organized in conjunction with ANFE, ISEK and the *Consultation Handicap et Famille*.

There are currently 45 students in each class, supervised by a team of 6 occupational therapist trainers (5.3 full-time equivalents).

Of these first eight occupational therapy schools, seven were attached to existing physiotherapy schools. Many courses (anatomy, kinesiology, physiology, pathology) were taught in common, particularly in the first and second years of study. Practical work was separate, as were courses in psychology and psychiatry given only in occupational therapy. The Créteil school is an exception, as it was set up without the involvement of physiotherapists, in a university setting and with a larger number of students (35 per cohort).

Between 1974 and 2009, no new schools will be created.

At the ENOTHE annual conference in Paris in **2000**, the Ministry of Health was asked to increase the number of occupational therapists in France. The result was an overall increase in student numbers at existing IFEs of around 30% in 2003. These figures proved insufficient, however, prompting ANFE and SIFEF (*Syndicat des Instituts de Formation en Ergothérapie Français*) to join forces to consider a plan to increase the number of IFEs. A thirty-page document entitled "*Étude des besoins en ergothérapie pour la création de nouveaux instituts de formation en France*" (Study of occupational therapy needs for the creation of new training institutes in France) was jointly drawn up and submitted at an initial meeting with the IFMK (physiotherapists school) in Alençon on July 3, 2006.

In **2009**, the IFE will open in Alençon (Orne-61), as well as the Berck annex on the Loos site (near Lille). This was followed **in 2011** by Les Mureaux (Yveline-78); in **2012** by Marseille (Bouches-du-Rhône-13), Hyères-La Garde (Var-83), Laval (Mayenne-53), Auvergne (Puy-de-Dôme-63), Mulhouse (Haut-Rhin-68), Limoges (Haute-Vienne-87) and Saint-Denis (Réunion-97); in **2013**, La Musse (Eure-27) and Tours (Indre-et-Loire-37); in **2014**, Rouen (Seine Maritime-76); in **2015**, Poitiers (Vienne-86); in **2016**, Toulouse (Haute-Garonne-31) and Amiens (Somme-80); in **2017**, Nevers (Nièvre-58); in **2018**, Assas in Magny-les-Hameaux (Yvelines-78), and Grenoble in **2020** (Isère-38) Besançon **in 2021** (Doubs-25). A total of 27 IFEs by the start of the 2021 academic year.

From now on, there will be four types of IFE support: university, hospital (CHU or CH), association or private for-profit.

Changes in admission procedures for occupational therapy training in France

From the outset, it was necessary to draw up admission procedures for occupational therapy schools, in view of the intake capacity set by the Ministry of Health. These procedures have varied, involving interviews, written tests, practical exercises, psycho-technical tests, sometimes the order in which applications are submitted, etc., but have always required the baccalaureate level. These procedures were specific to each school, and were not regulated until 1983.

Depending on the tests and the criteria sought, the profile of pupils, then students (as they were called after 1997), varied considerably. While in the early years, creativity, interpersonal skills and manual dexterity were sought after, by the time occupational therapy schools had to align themselves with official texts from 1983 onwards, it was more a question of knowledge, logic and reflection. Selection by *Parcoursup* since the start of the 2020 academic year has further altered the profile of students admitted.

According to a pioneering teacher in the occupational therapy department at the *Hôpital Necker-Enfants Malades* in Paris as early as **1956**, to enter the said "department", you had to hold the baccalauréat (1re partie) or, failing that, have passed an entrance examination comprising a French composition on a subject of general culture, with spelling marked, and a composition on natural history. In addition, all candidates had to pass a two-hour written psychology test. In 1962, the conditions were similar, although the candidate had to be at least 19 years old.

Order of September 1, 1971 concerning the operating conditions of schools preparing for the occupational therapist state diploma.

This decree specified a number of criteria for admission to an occupational therapy school: minimum age 18 in the year of admission, fitness certified by a doctor, baccalaureate or equivalent. But there was no mention of a competitive examination: each occupational therapy school was free to admit its candidates as it saw fit. The eight occupational therapy schools set up their own procedures, which varied over time and from region to region.

Decree of June 13, 1983 on admission to schools preparing for the State diplomas of occupational therapist, nurse, laboratory technician, medical electroradiology manipulator, masseur-kinésithérapeute and chiropodist: DRASS involvement.

The decree (JORF, July 10 1983) overturned the organization that had been satisfactory to occupational therapists. For the start of the 1984 academic year, it introduced an entrance examination organized jointly by the DRASS (*Direction Régionale des Affaires Sanitaires et Sociales*) for the various schools covered by the decree. Two tests in French and biology are common to all. An additional, differentiated test has been introduced: for occupational therapist candidates, these are psycho-technical tests shared with nurses and chiropodists. Candidates for masseur-physiotherapists, electroradiology manipulators and laboratory assistants have a physics and chemistry test. Candidates must be at least 17 years old on December 31 of the admission year.

Arrêté du 23 décembre 1987 relatif à l'admission dans les écoles préparant aux diplômes d'État d'ergothérapeute, de laborantin d'analyses médicales, de manipulateur d'électroradiologie médicale, de pédicure-podologue et de psychomotricien : retour aux écoles en 1988

The selection system introduced in 1983 lasted four years, until 1988, when the organization of the competitive examination was delegated to the schools concerned by the decree of December 23, 1987 (JORF, December 27, 1987). In occupational therapy, the psycho-technical tests were retained, along with a text contraction or biology-physics test (based on the curriculum of the Première S and Terminale D classes), at the candidate's choice. Thereafter, the three tests will be compulsory for all candidates by the decree of December 21, 1992 (JORF, January 5, 1993) until 2020.

Decrees of August 20, 1991 on admission to schools preparing for the state occupational therapy diploma: experimental access via the PCEM (first year for medical students) in Bordeaux and Lyon

This "experimental" exemption (JORF, August 31, 1991) for the IFEs in Bordeaux and Lyon has been renewed every year, and will last until 2021.

Order of April 28, 2009 concerning admission to schools preparing for the diplomas of occupational therapist, biomedical analysis technician, medical electroradiology manipulator, masseur-physiotherapist, chiropodist and psychomotrician: experiment open to all IFEs.

This decree (JORF, May 6, 2009) opens up the possibility of selecting candidates for admission either from ranking lists drawn up by medical training units, or on the basis of results obtained in the first two semesters of the bachelor's degree in sciences and techniques of physical and sports activities (STAPS), or in life and earth sciences (SVT), in accordance with procedures set out in an agreement with one or more universities. The program has been renewed from year to year.

Order of July 5, 2010 on the occupational therapist state diploma (BO Santé-Protection sociale-Solidarité no. 2010/7 of August 15, 2010)

The selection procedures remain the same as before, with the addition of two articles concerning certain candidates.

Article 31

Holders of a state nursing diploma obtained before 2012, one of the diplomas mentioned in Titles II to VII of Book III of Part IV of the Public Health Code, a state midwifery diploma, a bachelor's degree, and people who have completed and validated the first cycle of medical studies may be exempted from the admission tests and validation of part of the first year's teaching units by the director of the institute, on the advice of the pedagogical council, after comparing the training they have followed with the teaching units making up the occupational therapist State diploma program.

Article 32

Holders of a diploma in occupational therapy or another qualification or certificate entitling them to practice the profession of occupational therapist obtained outside a Member State of

the European Union or another State party to the Agreement on the European Economic Area, the Principality of Andorra or the Swiss Confederation may, subject to passing selection tests, benefit from an exemption from schooling to obtain the State diploma in occupational therapy.

Order of January 17, 2020 on admission to institutes preparing for the State diplomas of chiropodist, occupational therapist, psychomotrician, manipulator of medical electroradiology and medical laboratory technician: *Parcoursup*

This decree (JORF, January 24, 2020) modifies admission: it will be carried out via *Parcoursup* from the start of the 2020 academic year. A wish examination committee is set up for each course within each establishment, and examines the application files according to the timetable of the national pre-registration procedure. Five criteria are defined for admission to occupational therapy: interpersonal skills; interest in health and social issues; analytical skills; ability to organize one's work; mastery of written and oral expression.

Arrêté du 5 février 2021 portant diverses modifications concernant l'admission dans les instituts de formation de certaines professions non médicales : mesures transitoires

The decree (JORF, February 8, 2021) specifies that, in accordance with a university agreement, students selected on the basis of results obtained during validation of teaching units in the training delivered during the first year common to health studies, for the 2020 and 2021 start dates; and students selected on the basis of results obtained during validation of teaching units during the first two semesters of the bachelor's degree in sciences and techniques of physical and sports activities, or the bachelor's degree in the sciences, technologies, health field, for the 2020 start date only, may be admitted.

Decree of June 10, 2021 on training leading to the state diploma in nursing assistance and various provisions relating to the operating procedures of paramedical training institutes: development of apprenticeships

This decree (JORF, June 12, 2021) adds apprenticeship training to the initial training missions of training institutes.

Development of occupational therapy training programs in France

The school of occupational therapy, which in 1997 became the *Institut de formation en ergothérapie* (IFE), the cradle of professional identity (Morel *et al*., 2021), trains students in contemporary practices and "produces" professionals capable of meeting the expectations of the field, the professional body and the qualifications set by government bodies.

Occupational therapists' practices are evolving with society, particularly with healthcare policies moving from a hospital-centric model to the domicilo-centric model (Trouvé, Offenstein and Agati, 2015). Training is interdependent with professional practices. The IFE, considered as a place in professional watch, must therefore be able to anticipate progress in the field of occupational therapy, in order to propose the most appropriate study program at a given time.

In France, a single occupational therapy training curriculum has existed since 1971-1972, following the introduction of the state diploma. Prior to this period, the three existing schools each ran their own programs, based on identified regional needs (André *et al.*, 2004).

At the very beginning, training was built around a triptych of theory, manual techniques and practice. The number of hours spent on practical work and internships exceeded the number of hours taught in the basic sciences, which corresponded to what was expected of occupational therapists at the time: solid knowledge of manual techniques. While the duration of studies has remained at 3 years since the first national program in 1972, there have been changes in the curriculum. The hours of theoretical instruction increased, and gradually more specific content was added. The format has also changed. In the 1990 program, students first learn about the functioning of the "healthy man" in the first cycle, before acquiring knowledge about pathologies. This program is much more substantial than the 1972 one, and it seems that the IFEs have had difficulty keeping up with the number of hours. Indeed, when the 2010 program was designed, a lower volume of teaching hours was proposed, but with a volume of personal work hours integrated into the model. The program is now organized in semesters, following integration into the university LMD model. In addition, there are courses in methodology, introduction to research and occupational sciences, with the occupational therapy diagnosis confirming a higher level of autonomy through knowledge specific to the profession. On the other hand, there are fewer and fewer courses in manual activities.

However, even if the IFEs are based on the same national program, there is still a certain amount of diversity, depending in particular on the regional authorities and the status of the IFE. This diversity can be seen right from the admission stage, with tuition fees depending on the status of the IFE. It can be found in the way the program is interpreted and implemented, and in the teaching methods used. Last but not least, the people who work there, such as the teachers, the management and the team of trainers, also bear a stamp. However, the state diploma remains national, and no distinction is made between IFEs in terms of diploma recognition.

1956: Paris School program, "*Cours de gymnastique médicale et de Rééducation Fonctionnelle*", Ergotherapy Section (school program given by a pioneering teacher at the time).	
Duration	**19 Months** First year 10 months, second year 9 months, with the possibility of continuing internships during the vacations.
Teaching hours	No precise indication of the number of teaching hours **1rst year**: Theoretical courses include the study of anatomy, physiology, kinesiology, psychology, psycho-pedagogy, morphology, first aid, hebertism. Handicraft sessions (basketry, weaving, modeling, drawing, cutting, sewing, pyrography, bookbinding, embossed pewter and leather, molding, sculpture, porcelain, ceramics, etc.). **2nd year**: Second-year courses include a study of the various illnesses requiring occupational therapy treatment, the application of these treatments, pathological psychology and orthopedagogy.
Courses	**1rst year**: 26 mornings of nursing training to introduce you to hospital life **2nd year**: Internships in specialized departments, but no indication of duration.
Special features of schooling	Compulsory attendance every day from 9 a.m. to 12 .m. and from 2 p.m. to 6 p.m. No boarding school. We're talking about pupils.

1962: Paris school program, "*Cours de gymnastique médicale et de Rééducation Fonctionnelle*", Occupational Therapy Section (school program given by a pioneering teacher at the time).	
Duration	**26 months**
Teaching hours	**1rst/2nd year: 1462 hours:** 617 hours of basic science, 845 hours of technology **3rd year**: Internships only, for 4 months.
Technical training hours	**845 hours of technology**, including 700 hours of manual techniques and 145 hours of theoretical instruction **1rst year**: 715 hours of practical work **2nd year**: 130 hours in technology, including 40 hours in rehabilitation techniques and their application and 40 hours in psychiatry.
Placements	**1140 hours of clinical internships**, including at least 480 hours in psychiatry in the 2nd cycle + **4 months of** internship with dissertation preparation in the 3rd cycle. **1rst year**: One month of introductory training, 2 months of full-time training. **2nd year**: Eight months part-time and three months full-time. **3rd year**: Four-month internship in a facility with preparation of a dissertation. Supervised by a qualified occupational therapist.
Special features of schooling	**1rst year**: Technical courses in the morning and theoretical courses in the afternoon. **2nd year**: Internship in the morning and theory classes in the afternoon

National program 1971-1972	
Duration	**3 years**
Teaching hours	**3352 h:** 1912 hours of theoretical instruction and 1440 hours of clinical internships **1 rst year**: 842 hours: 432 hours including 200 hours in anatomy, morphology and physiology and 410 hours in basic manual techniques **2nd year**: 640 hours mainly devoted to the study of pathology **3rd year**: 430 hours including 117 hours of surgical and medical pathologies and 120 hours of activities and techniques
Technical training hours	**610 hours** : **1rst year**: Drawing 40 h, pottery 50 h, basketry 30 h, weaving 50 h, wood 115 h, metal 115 h **2nd year**: Complementary techniques 70 h **3rd year**: Expressive activities 30 h, animated activities 10 h, recreational activities 5 h, rehabilitation techniques 35 h, assistive devices 20 h, group work 40 h.

Courses	**1rst year**: 1-month introductory internship in psychiatry, if possible **2nd year**: Part-time internships equivalent to 3 full months **3rd year**: Part-time internships: equivalent to 2 full months. 1 full-time internship of 3 months. Desired balance between psychiatry and motor rehabilitation. Validation of internships based on two criteria: work done during the internship ("good", "fair", "bad" from department heads) and an end-of-internship test conducted in front of the department head and an occupational therapist. The internship is unpaid. 1 month's internship corresponds to 160 hours = 40 hours/week
Special features of schooling	80 hours of sports included in the program during studies

National program 1990	
Duration	**3 years**
Teaching hours	**3,650 hours:** 1,870 hours of theoretical instruction, 1,560 hours of internship and 220 hours of supervised and personal work. **1st cycle**: **rst yearA**: 880 hours of teaching, including 280 hours of anatomy, biomechanics and kinesiology, 80 hours of relationship training and 160 hours of supervised and personal work. **2nd cycle**: **2/3A**: 990 hours, including 180 h in neurological disorders, 180 h in osteoarticular and muscular pathologies 140 h in psychiatry and 60 hours for supervised and personal work
Technical training hours	**1A**: 310 hours of technology **2nd and 3rd year**: 170 hrs in technology (ergonomics, rehabilitation and assistive devices) and 60 hrs in fittings
Courses	**1rst year**: 156-hour introductory course not subject to validation. **2nd and 3rd year**: 2 internships in 2nd year and 2 internships in 3rd year (1,092 hours), i.e. 624 hours in functional rehabilitation in at least two different departments and 468 hours in psychiatry in at least two different departments. 1 optional internship (312 hours) in July or August between 2nd and 3rd year, either in psychiatry, rehabilitation or new practices. Internships in health and medico-social facilities are validated by the department's head physician after consulting the occupational therapist who supervised them, while introductory and optional internships are validated by the facility manager after consulting the occupational therapist. Field placements are validated on the basis of 3 criteria (ability to establish a treatment plan, relationship established with the patient, and a practical test at the end of the placement in front of a doctor, a health executive and an occupational therapist). Evaluation is carried out using a grid at mid-course and at the end of the course. The internship is unpaid. Internships are based on 39 hours per week.
Special features of schooling	Students must attend all courses. Program in modules and cycles. 2 hours of sport per week in cycle 1 and 1 hour of sport per week in cycle 2 Pupils became students in 1997, and the schools became *Institut de Formation en Ergothérapie*.

2010 national program	
Duration	**3 years (L1, L2, L3)**
Teaching hours	**5148 hours:** 2000 hours of theoretical training, 1260 hours of clinical and situational training and 1888 hours of personal work. **L1:** 891 hours, including 127 hours in human sciences, 288 hours in medical sciences, 136 hours in occupational therapy foundations and processes, 91 hours in working methods, and 38 hours in integrating knowledge and the occupational therapist's professional posture. **L2**: 650 hours, including 28 h in human sciences, 118 h in medical sciences, 88 h in occupational therapy foundations and processes, 78 h in working methods and 110 h in the integration of knowledge and the occupational therapist's professional posture. **L3**: 459 hours, including 110 hours in human sciences, 124 hours in work methods and 140 hours in the integration of knowledge and the occupational therapist's professional posture.
Technical training hours	**L1**: 254 h in occupational therapy methods, techniques and tools, **L2**: 228 h in occupational therapy methods, techniques and tools, **L3**: 85 in occupational therapy intervention methods, techniques and tools
Courses	**L1**: 4 weeks internship in semester 2 **L2 and L3**: 8-week internship per semester 3 compulsory internship areas: follow-up and rehabilitation care, mental health care, intervention in living environments. Acquisition of skills through assessment of situations chosen by the student and tutor. Assessment by the internship tutor. Validation of the internship is not given by the field, but by the ECTS credit allocation commission. Compensation for internships and reimbursement of transport costs: €36 per week for L1, €46 for L2 and €60 for L3 in 2020 Internships are based on 35 hours per week.
Special features of schooling	Techniques for manual and artistic activities are no longer called by their name. Instead, we refer to intervention methods, techniques and tools. IFEs are attached to universities, and programs are organized into semester courses. Each semester comprises 30 ECTS Attendance is compulsory for all tutorials, and by way of derogation certain lectures become compulsory depending on the IFE's pedagogical project.

Evolution of the occupational therapy diploma in France

Training leads to the occupational therapist diploma: initially a school diploma in Paris, Nancy and Lyon, then from 1974 onwards to the State Occupational Therapist Diploma (*Diplôme*

d'Etat d'ergothérapeute). The *Diplôme* was awarded to "pupils", then "students" from 1997 onwards, who had passed specific tests. It was not until **2013** that these end-of-studies diploma **tests** were abolished (cf. 2010 program): the diploma is now awarded to students who have passed all the teaching units, including the dissertation and internships. Although the dissertation is no longer considered a "State Diploma test", it remains a rite of passage for many students.

In **1962**, the syllabus for the occupational therapy section at *Hôpital Necker-Enfants Malades* in Paris included a number of practical tests: "Case study of an occupational therapy department project, together with a collection of notes on practical work"; "a practical occupational therapy examination in two different departments, before a jury consisting of a doctor, a psychologist and the head occupational therapist"; "a practical test of upper limb testing".

"Finally, to obtain the Certificate of Completion of Occupational Therapy Studies, the student must, after four months of internships, present a Dissertation which will be read before a jury presided over by the School Director, the Director of Studies and the General Secretary."

Arrêté du 1er septembre 1971 : Chapter III (p. 9150-9151) *Diplôme d'État* examination

After training and validation of internships:

1° anonymous eligibility test "This consists of a presentation on an occupational therapy treatment in functional rehabilitation or psychiatry. This presentation will include a reminder of the subjects taught throughout the course of study, as well as a description of the techniques used. (duration 3 h) "Correction by a doctor and an occupational therapist acting as monitor".

2° admission tests: - an oral test on legislation; - two practical tests: "implementation of occupational therapy techniques and their indications in motor rehabilitation on a patient unknown to the candidate (adult or child)"; "study of a file on a mental patient unknown to the candidate and on the application of appropriate occupational therapy techniques in psychiatry"; - "a mark of 0 to 20 points for the totality of the training courses.

Decree of September 24, 1990 Article 28:

After validation of all modules and internships, two tests (Jury: one doctor and two occupational therapists):

1° An oral test covering the entire curriculum. The jury chooses a written work from among those produced by the candidate during his or her training, and asks questions based on it.

2° A practical test involving working with a person unknown to the candidate. The location of the examination is determined by the regional health inspector: it is chosen at random from among the various clinical training sites approved for the school. If the test takes place in psychiatry, it may take the form of an oral test based on a file, the location of which is determined by the regional health inspector.

Adjusted in 1994: 2 written works **instead of the 3 originally planned.**

Order of February 25, 2004: **Introduction of the research dissertation**

Same tests, but the **dissertation** replaces the two written works (*Travaux Ecrits de Synthèse)*.

Order of May 31, 2011 (in effect from June 3, 2011 to September 1(st), 2012)

Abandonment of the practical test:

"The State Diploma in Occupational Therapy includes :
An oral examination to defend the dissertation mentioned in article 17. This test, lasting a maximum of 45 minutes, includes a 15 minutes presentation by the student and a 30 minutes discussion with the jury. Students may use any teaching aids and materials of their choice. The jury awards a mark out of 20, taking into account the quality of the written work and the candidate's performance. The jury is made up of a doctor and two occupational therapists, at least one of whom holds a health manager diploma.
The dissertation referred to in article 17 must be sent to the members of the jury by the director of the occupational therapy training institute 15 days before the date of the oral test.
For candidates who are totally exempt from schooling, this test consists of an oral examination lasting one hour, including 30 minutes preparation time, covering the entire training program.

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Trouvé, É., Offenstein, A., Agati, N. (2015), The occupational therapist of tomorrow in France. *ErgOThérapies*, *59*, 5-12.

4) Articles published in *Le Monde de l'ergothérapie* to mark ANFE's 60th anniversary:

3 articles will be published in 2021 tracing the history of the French national association of occupational therapists:

- The pioneering era, from 1961 to 1980.

- Opening up to the environment, from 1980 to 2000.

- From activity to occupation, 2001 to 2021.

Presentation of the authors and members of the reading committee

Authors :

Anne-Cécile Delaisse

DE Occupational Therapist (IFE Rennes 2017). She spent a semester as an exchange student at *Nazareth College* in Rochester, New York, in 2016. Her interest in history emerged during a visit to Consolation house in Clifton Springs, site of the founding meeting of the first association of American occupational therapists (NSPOT) a hundred years earlier. Her dissertation research focused on the legacy of occupational therapy history in current practice in France and the United States. After graduating, she moved to Hô Chi Minh-Ville in Vietnam, where she volunteered for a year. She then joined the *University of British Columbia* in Vancouver, Canada, and obtained her Master's degree in Occupational Science in 2020. She began her PhD the same year. Her research uses qualitative methods and examines occupations in the context of immigration, with a critical approach. Her work is published in journals such as the *Journal of Occupational Science* and *OTJR: Occupation, Participation and Health*. She remains involved in the world of French occupational therapy as a speaker at various IFEs and through the writing of this book.

Jean-François Bodin

DE Occupational therapist, Bordeaux graduating class of 1991 under the direction of M.-C. Morel-Bracq. He soon joined ANFE and the editorial board of the *Journal d'ergothérapie* in 1994, which introduced him to key players in the history of occupational therapy, such as P. Vaur and I. Pibarot who introduced him to epistemological reflection on the profession. Co-creator of the journal l'*Ergonaute*, he continued to write and participate in a number of ANFE committees, to which he remains attached through the reading committee of the journal *ErgOThérapies.* His studies in educational science at the University of Lyon 2 have nurtured his comings and goings between clinical practice and theorizing on the history of occupational therapy, the origins of which he seeks to elucidate, as well as its links with the disciplines of the social and medical sciences in its French particularities. He is currently a member of the management team at the IFE in Lyon, while maintaining a clinical practice at the *Hospices Civils de Lyon,* to forge links between care, training and innovation. He aspires to see the emergence of a French model of occupational therapy based on a systems approach borrowed from P. Fougeyrollas and E. Morin, of which this book is a first step.

Lisbeth Charret

Occupational therapist trained at the Næstved School of Occupational Therapy in Denmark in 1990. After completing her studies, she moved to France, where she worked in psychiatry for thirteen years, first at the Institut Marcel Rivière in La Verrière, then at the Gonesse hospital in a day hospital. In 2004, she joined the teaching team at IFE ADERE in Paris as coordinator of clinical internships, notably within the framework of the Erasmus program. Her contribution to ANFE, as COTEC delegate from 1994 to 2000 and co-chair of the 6th European occupational therapy congress, *Ergo2000* in Paris, as well as her participation in COTEC congresses since

1992 and annual ENOTHE congresses since 2004, have nurtured her interest in the diversity of occupational therapy in Europe. Interested in the cultural and sociological aspects that influence occupational therapy throughout its history, her dissertation in educational science in 2012 focused on the emergence of occupational therapy in France and Denmark, and addresses the history of the occupational therapy profession from a sociology of professions perspective.

Hélène Hernandez

DE Occupational therapist (3rd class of IFE Université de Créteil, 1975-1978), Health manager (1998), MSc. Educ. (2002), *Chevalière Palmes académiques* (2017). Occupational therapist working with children from 1978 to 1998, teacher at IFE UPEC from 1981, then director from 1999 to 2017. Participated in the development of the 2010 occupational therapy training program. Member of ANFE since 1978, member of the ANFE Board of Directors from 1998 to 2016, then of the *Collège Édition* from 2016 to 2021. Represented ANFE on the Board of Directors of the *Union Inter Professionnelle des Associations de Rééducateurs et Médicotechniques* from 1998 to 2019, was its President from 2002 to 2005, and has represented ANFE on the *Haut Conseil des Professions Paramédicales* since 2000.

Over the course of her career, she has developed an ethical approach to occupational therapy and disability, as well as an interest in writing as a means of transmitting knowledge for the present and the future

Marie-Chantal Morel-Bracq

DE Occupational therapist (1rst class of the OT school de Rennes, 1972-1975), MSc Educ in 2006, Honorary Director of Care. She was Director of IFE Bordeaux from 1979 to 2015, and was involved in drawing up the 1990 and 2010 occupational therapy training programs. She was an active member of the ENOTHE European network of occupational therapy schools from 1997 to 2014. After discovering Rosemary Hagedorn's book on conceptual models at the World Congress of Occupational Therapists in London in 1994, she published with ANFE the first book in French "*Approche des modèles conceptuels en ergothérapie*" in 2004. In 2016, she edited the translation of Doris Pierce's "*Occupational Science for Occupational Therapy"*.

Appointed ANFE regional delegate in 1977, she later joined the Teaching Committee and is now a member of the ANFE Publishing College and Scientific Committee, as well as member of the Editorial board of *ErgOThérapies* journal.

Having participated in the development of occupational therapy in France, she is particularly interested in the history of the profession in our country.

<u>Reading committee:</u>

Laurent Bergès

Graduating as an occupational therapist in 1989, he has always practiced adult psychiatry in a Paris suburb described as "difficult", where his conviction in the political nature of *ergon* was forged. He referred to a psychodynamic approach that was preponderant at the time, and was also initiated into systemic thinking, which constituted the clinical orientation of his first place of practice. He began teaching in 1993 in Rennes, his original school, then in other training institutes, mainly the University of Créteil and Paris. His relationship with writing grew

stronger over time, notably through a long foray into the written press, before making a full return to public psychiatry. In recent years, he has taken the path of consistent philosophical training and ethical questioning, whose contemporary infatuation he grasps as a sensitive reflection of the harshness of our world - something from which the field of care is no exception.

Catherine Bourrellis

After graduating in occupational therapy in 1984 in Créteil, she worked as an occupational therapist at Garches hospital (Raymond Poincaré, APHP), first with children in child neurology, then with adults in neurology. These years as an occupational therapist were exciting ones in terms of developing diagnostic and therapeutic activities for her and her colleagues.

For her health manager thesis in 1999, she chose to explore the theme of the evolution of occupational therapy. There was already a lot to say!

After managing teams of occupational therapists and multidisciplinary teams in a number of geriatric facilities, she now works as a senior health executive in a cross-functional hospital environment, focusing on quality of care.

Having always followed the development of occupational therapy with interest, it was only natural that she agreed to take part in the re-reading of this seminal work.

Mathilda Charret

Occupational therapist graduating in 2021 from IFE Créteil. Practicing since September 2021 in a psychiatric hospital ward. Interested in the foundations of occupational therapy and how practice has evolved, reading this book has enriched her knowledge of the history of the profession from its roots. The book provides an insight into the evolution of occupational therapy, and will serve as a basis for reflection on the development of practices and the profession as a whole.

Noémie Kauffmann-Luthringer

Occupational therapist graduated from IFE Lyon in 2006. European Master of Science in Occupational Therapy, University of Applied Sciences, Amsterdam in 2019. Currently in private practice at the Cabinet d'Ergothérapie in Cernay (France).

Noémie Kauffmann works with children with neurodevelopmental disorders and adults with disabilities. She is interested in the development of occupational sciences and occupational therapy research in France. To this end, she is a member of the Editorial Board of the journal *ErgOThérapies*. She also teaches at various IFEs on the subject of occupation-centered practice in occupational therapy and concepts in occupational sciences.

Éric Sorita

After graduating from the *Institut d'Ergothérapie de Bordeaux* in 1984, Éric Sorita began his career in various institutions, including the *Centre de Rééducation Fonctionnelle* and the *Institut d'Education Motrice*, before joining the *Groupement pour l'Insertion des Handicapés Physiques* (GIHP Aquitaine) in 1989, where he worked for over ten years in an ordinary living environment. It was in this context that work on lifestyle habits and re-engaging people in the activities of daily living became apparent to him as a concern that should be and remain central to the occupational therapist's work. The integration of an assessment unit for brain-damaged

patients at Bordeaux University Hospital in the early 2000s led him to take a University diploma (DU) in neuropsychology, in order to gain a better understanding of the impact of cognitive disorders on daily functioning. In parallel with his clinical practice, he completed a Master's degree in cognitive science, followed by a PhD in 2013 on the use of virtual reality simulated activities of daily living in cognitive rehabilitation. Eric Sorita is a trainer at the *Institut de Formation en Ergothérapie du CHU de Bordeaux*, Associate lecturer at the *Institut Universitaire des Sciences de la Réadaptation* at the Université de Bordeaux and Associate researcher with the *Handicap Activité Cognition Santé* team.