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1981 Eleanor Clarke Slagle Lecture

Occupational Therapy Revisited: A *Paraphrastic Journey*

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I wish to dedicate the 1981 Eleanor Clarke Slagle Lectureship:

To my parents, who provided me with those cumulative experiences and values that inevitably led me to the decision to become an occupational therapist;

To a very great woman, Beatrice D. Wade, OTR, FAOTA, who has been my valued teacher and beloved mentor for more than 30 years;

To my cherished colleagues, Lillian Hoyle Parent and Jay Cantwell, both occupational therapists, who constantly stimulate me and insist on a high level of constructive activity;

To Charles H. Christiansen, OTR, whose personal and professional qualities and insistence on excellence from himself and others assure me of the future of occupational therapy.

Without the examples, teachings, guidance, counseling, and friendship of these individuals, I could never have achieved this exalted opportunity. Try as one might, it is impossible to recount the evolution of occupational therapy so that it resembles the cliff-hanging biographies of Butch Cassidy and the Sundance Kid. Masters and Johnson, as well as Kinsey, who took years to amass their stories, had something going for them that does not exist for us. Somewhat puckishly I was tempted to entitle this paper, *Everything You've Ever Wanted to Know About Occupational Therapy, But Were Afraid to Ask*. That would not have been altogether misleading. Because of my part German heritage, and true to that cultural bias and tendency, I thought I should take us back to the Thirty Years' War and bring everyone up to date. After all, it is important territory occupational therapy has won and lost.

The title, *Occupational Therapy Revisited: A Paraphrastic Journey,* prevailed because this paper is a tour to what should be familiar historical landmarks and progenitors. For some of us, it will renew old friendships and acquaintances. For others, it will be a second-hand account of certain ancestors, not unlike those stories that emanate from grandmothers. For some, it will only be like an endurance of those pictures that inevitably get projected on the screen by vacationers returning home.

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Because of the relative youthfulness of those of us in practice (most have entered within the past decade), now seems the time to critically examine our ancestral roots and subsequent grafts to determine the nature of the present and to offer some speculations about why we (and the profession) developed as we did through several generations. This is not *the* history of occupational therapy nor of the Association that supports our endeavors. Nor is it *a* history like someone else might well find it. It is *not* a detailed, definitive account of how we multiplied, divided, and invaded several areas of medicine and health care. It is *one person's* way of telling the story of who we are and citing some lessons to be learned. That is important! After several months of submergence just off the coast of Texas (as my colleagues in Galveston will attest), I have at long last come up for air and am ready to declare my findings.

This is a statement of how an idea, born in a philosophical movement, became activated through *the good works of men and women* who inalterably believed in the ideal that those who are sick and handicapped can regain, retain, and attain some semblance of function within the fundamental limitations of the human organism and the expectations of the society in which all must exist: that this may occur through the most obvious means of all—*one's reorganization through occupation, through activity, through leisure, and through rest.*

This journey about occupational therapy, its evolution and development, presents vexation: one must accept a fair number of ambiguities, something some today consider a fundamental problem in occupational therapy; a more than reasonable amount of astonishment; and a certain degree of messiness, closely akin to what is created by the beginner in finger-painting. What can it all mean? What was taking place at the time? Will the patient recover? Most significantly, does it make any difference? To answer these and related questions I wanted to conduct some scholarly research that could be equally interesting, helpful, and valuable to students, occupational therapy assistants, occupational therapists, and others who are interested in our profession. This is how I interpret the intent of the originators of the Eleanor Clarke Slagle Lectureship.

Such an historical presentation should be long enough to say something, yet short enough to be tolerated.

To give you some idea of the continuing dilemma I encountered these past several months in preparing the lecture and in limiting its scope and length, I wrote:

There once was an historian named Dan,
Whose prose no one could scan,
When, once, asked about it,
He said, "I don't doubt it,
Because I try to cram as many facts and dates into each sentence as I possibly can.

Significant Landmarks

Let us start this paraphrastic journey and take note of some significant landmarks along the way—those recurring patterns and themes of the past 200 years that give us today's relevance:

1. There is an inextricable union of the mind and the body; the employment of activity or occupation must be based on this precept, which is unique to occupational therapy.

2. Activity, inherently, contains modes the patient may employ to gain understanding of and ascendancy over one's feelings, actions, and thoughts: these modes include the habits of attention and interest; the perceived usefulness of occupation; creative expression; the processes of learning; the acquisition of skill; and evidence of accomplishment.
3. Activity provides a balance between the practical and intellectual components of experience; therefore, a wide variety of activities must be accessible to meet human objectives for work, leisure, and rest.
4. One's approach to the patient is as significant to treatment and rehabilitation as is the selection and utilization of an activity.
5. Essential elements of occupational therapy practice are continuous observation, experimentation, empiricism, and analysis.
6. An appreciation of the pain that accompanies any illness or disability; a strong desire to reduce or remove it; a gentle firmness; and a knowledge of the patient's needs are fundamental characteristics of the provider of therapeutic occupations.
7. Therapeutic processes and modes of treatment are synonymous with the processes of learning and methods of education.
8. The patient is the product of his or her own efforts, not the article made nor the activity accomplished.

A Theory of Experience

We could go back to the Garden of Eden to begin this story, if time permitted, since occupational therapy could well have started in that idyllic spot. Dr. Dunton, one of the founders of the 20th century movement, insisted that those fig leaves had to have been crocheted by Eve, who was trying to get over her troubles. They had something to do with her being beholden to Adam and his rib. We will unfortunately pass over all of that and begin the modern epoch with a brief description of what was taking place in Europe approximately 200 years ago.

It was the *Age of Enlightenment,* or, as some prefer, the *Age of Reason.* The roots of 20th century occupational therapy are visible in the empiricism of John Locke, an English philosopher and physician, who fostered confidence in human reason and human freedom; in Etienne de Condillac, a French philosopher, who advanced the dualism of body and mind; and in Pierre Cabanis, a French physician and theorist, who offered an explanation of the importance of the moral and social sciences in perfecting the art of medicine. These three, together with others, popularized the new ideas. Indeed, it was the *best of times,* a clear demarcation in the emergence of the modern world.

If one were to combine the thoughts of these three, one would arrive at a *theory of experience.* John Locke, in his famous *Essay Concerning Human Understanding,* published in 1690 (1), examines the nature of the human mind and the processes by which it learns about and comes to know the world. When born, the human is a blank tablet (tabula rasa). Because of an innate ability to receive sensations from the outside world, the human can assimilate and organize impressions. As contact with the environment stimulates the senses and causes

impressions, the mind receives and organizes these into ideas and concepts. Since the human mind does not already contain innate ideas, all must come from without (2, p. 287).

There is a second source for the accumulation of experience, according to Locke. It is the mind itself: ". . . the perception of the operations of our own mind, . . . (such as) thinking, doubting, believing, reasoning, knowing, . . . this source of ideas every man has wholly within himself." (see 3, p. 74) Locke strongly held that the body and mind exist as real entities and they interact. He spent a great deal of time developing his perspective. He spoke of the aim of education as the process of knowing and learning through experience and in striving toward happiness. Ideally, he contended, one should work toward a sound mind in a healthy body. To achieve this ideal, Locke advocated physical exercise as a hardening process, and an exposure to a wide variety of sensations from the physical and social worlds.

Condillac was Locke's apologist. He tried to simplify Locke's fundamental theory by arguing that all conscious experiences are the result of passive sensations; these sensations are the raw materials from which one forms complex and interrelated ideas. Learning is the noting of incomplete ideas, considering each separately, combining them into relationships, and ordering them. This process results in retaining the strongest degrees of association. Condillac asserted: "Then we shall grasp (ideas) easily and clearly and shall understand their origins entirely." (see 3, p. 7)

Elsewhere in his writings Condillac presented his thoughts on analysis. One cannot have the proper conception of a thing until one is in a position to analyze it. "To analyze," claimed Condillac, "is nothing more than to observe in successive order the qualities of an object, . . . the simultaneous order in which they exist." (4, p. 17)

The third philosopher, Pierre Cabanis, tended to apply medicine to philosophy and philosophy to medicine. Cabanis considered illness and its impact upon the formulation of values and ideas. Through the social sciences, which emerged in the *Age of Enlightenment,* he explained *moral* as a psychological phenomenon on a physiological base. He concluded that moral impressions can have both physiological and pathological results. At last, there was a rational explanation for the psychological production of disease in which the so-called moral (emotional) passions play a significant part (see 5, pp. 37–38). Cabanis contributed a socially based theoretical explanation of human experience that became the cornerstone for the moral management of the insane.

Age of Enlightenment and Moral Treatment

Moral treatment of the insane was one result of the *Age of Enlightenment.* It sprang from the fundamental attitudes of the day: a set of principles that govern humanity and society; faith in the ability of the human to reason; and the supreme belief in the individual. The rapid changes caused by this new philosophy advanced the disappearance of the notion that the insane were possessed of the devil. Mental diseases became legitimate concerns of humanitarians and physicians. The discontinuance of the idea that crime, sin, and vice were at the core of insanity brought forth humane treatment. Up to this time the insane had been housed and handled no differently than were criminals or paupers—often in chains.

Two men of the 18th century working in different countries, and unknown to each other, initiated the moral treatment movement. "No two men could possibly have been chosen out of all Europe at that time of whom it could be said more truly that they were cradled, and nursed, and educated among widely differing social, political, religious influences. . . ." (6, pp. 24–25) Philippe Pinel was a child of the French Revolution, a physician, a scholar, and a philosopher. He is described as ". . . far exceeding the bounds of pure humanitarianism . . . to encompass the goals of a naturalist, . . . a reformer, a clinician, . . . and, above all, a philosopher." (7, *Intro*) William Tuke was a devout member of the Society of Friends (Quakers).

Philippe Pinel: Physician–Reformer

Whenever Philippe Pinel's name comes up in a conversation among health professionals, he is immediately mentioned as the *striker of the chains* at two French hospitals. His efforts and contributions go way beyond that reformational act. As a physician, he began his most serious work in 1792 as superintendent of Bicêtre, the asylum for incurable males in Paris.

As a natural scientist, Pinel achieved exceptional skill in the observation of human behavior and the bringing of ". . . some order into the chaos of . . . treatment methods by means of critical and objective investigations." (5, p. 42) Pinel says this about himself: *Desirous of better information, I resolved for myself the facts that were presented to my attention; and forgetting the empty honours of my titular distinction as a physician, I viewed the scene that was opened to me with the eye of common sense and unprejudiced observation.* (8, p. 109) From his own experience, he urged that observations ". . . be the basis upon which (one) should decide what opinions to believe." (see 9, pp. 74–75) Throughout his work, he held constantly before him his own motto of independent thought: "Chercher à èviter toute illusion, toute prèvention, toute opinion adoptèe sur parole" (to seek to avoid all illusion, all prejudice, all opinion taken on authority; see 10, pp. 8–9).

Pinel's descriptions of the mentally deranged provide insight into his own compassionate nature. For him, the loss of reason was the most calamitous of human afflictions. The ability to reason principally separates the human from other living forms. Because of mental illness, the human's ". . . character is always perverted, sometimes annihilated. His thoughts and actions are diverted. . . . His personal liberty is at length taken from him. . . . To this melancholy train of symptoms, if not early and judiciously treated . . . a state of the most abject degradation sooner or later succeeds." (8, pp. xv–xvii)

What Pinel entitled *revolution morale,* or moral revolution, is the ultimate insight of the insane into the delusional and absurd nature of their experiences (7, p. 256). This, to him, was the basis for treatment. Some historians believe that he was stating that moral treatment is synonymous with the humane approach. His own writings do not bear this out. Pinel believed that each patient must be critically observed and analyzed; then treatment should commence. "To apply the principles of moral treatment, with undiscriminating uniformity, would be . . . ridiculous and unadviseable." (8, p. 66) The moral method is well reasoned and carefully planned for the individual patient.

According to Pinel, moral management is a maintained continuity of approach; a predictable routine, infused with vigor by personnel who inspire confidence. Moreover, moral treatment calls for a constant, observed study of patient behavior and performance. It includes a gentle, but firm approach. Each patient is given as much liberty within the institution as he or she can tolerate. The approach is designed to give the patient a feeling of security as well as a respect for authority. Pinel asserted: "The atmosphere should be the same as in a family where the parents are quite strict. To establish this relationship, the doctor must convince the patient that he wishes to help him and that recovery is a real possibility." (see 9, p. 76)

Occupations figured prominently in Pinel's conception of moral treatment. He used activities to take the patients' thoughts away from their emotional problems and to develop their abilities. He considered literature and music as effective in altering patients' emotions. Physical exercise and work should be part of every institution's fundamental program and be employed in accord with individual tastes. He concluded: "The (occupations) method is primarily designed and intended to reach man at his best which . . . means human understanding, intelligence, and insight." (see 3, pp. 63–64)

The concept of *moral treatment* belongs solely to Philippe Pinel. His fundamental belief was that its purpose is to restore the patient to himself, ". . . to use the patient's own emotions to balance his emotional excesses." (see 9, p. 76) Truly, Pinel and his efforts, rooted in the *Age of Enlightenment,* mark the beginning of the modern epoch in the care of the mentally ill.

William Tuke: Philanthropist–Humanitarian

Across the channel, in England, things were astir at the same time. King George III, who was giving the American colonies fits, was himself in similar trouble. In 1788 it became public knowledge that the King was seized with mania. Questions arose about his fitness to continue ruling. Nevertheless, public sentiment was on his side. For the first time, insanity and its treatment formed a topic of public discussion: "The subject had been brought out of concealment in a way which defeated the conspiracy of silence." (see 11, p. 42) This being the *Age of Enlightenment,* the public openly sympathized with the sufferer; there was no condemnation. No one suggested that the King was being visited by the Devil, or that he was being punished for his sins.

The Society of Friends, derisively called *Quakers,* originated in 17th century England and became one of the most distinctive movements of Puritanism: "They arose out of the religious unrest of England . . . and stood for a radical kind of reform within Christendom which contrasted sharply with Protestant, Anglican and Roman patterns alike." (12, p. 118) George Fox, founder of the Society, discovered ". . . the spirit of the living Christ and knew that it was an experience open to all men. 'This was the true light that lighteth every man that cometh into the world!' " (13, p. 1)

William Tuke, a devout Quaker, wealthy merchant, and renowned philanthropist, was made aware of the deplorable conditions in the insane asylum in York, England. There

were tales of extreme neglect and possible cruelty. He was an unusual man, not given to listening to sensational reports and acting rashly (14, p. 12). In true Quaker fashion Tuke presented a concern at a Friend's Quarterly Meeting in the spring of 1792—that an institution for the insane be established in York under the direction of the Society. At first, he was met with considerable resistance by those who believed that there were too few mentally ill Quakers, and that no one would want them concentrated in such a lovely, quiet locale (15, p. 58).

The York Retreat

Initially, Tuke was disheartened; yet, he pressed on, and within 6 months *The Retreat for Persons* afflicted with *Disorders of the Mind,* or simply, *The Retreat* came into being. Up until then the term *Retreat* had never been applied to an asylum. Tuke's daughter-in-law suggested the term to convey the Quaker belief that such an institution may be ". . . a place in which the unhappy might obtain refuge; a quiet haven in which (one) . . . might find a means of reparation or of safety." (16, p. 20) The cornerstone simply stated the purpose of the institution: "The charity or love of friends executed this work in the cause of humanity." (15, p. 19)

William Tuke became the superintendent. Thomas Fowler, an unusually open-minded man, was appointed visiting physician. After a trial-and-error period, they came to believe that moral treatment methods were preferable to those involving restraint and use of harsh drugs. The new approach was a product of Tuke's humanitarianism and Fowler's empiricism.

Several fundamental principles became evident within a short time. The approach was primarily one of kindness and consideration. The patients were not thought to be devoid of reason, feeling, and honor. The social environment was to be as nearly like that of a family as possible, with an atmosphere of religious sentiment and moral feeling (16, p. 35).

Tuke and Fowler strongly believed that most insane people retain a considerable amount of self-command. Upon admission, the patient was informed that treatment depended largely upon one's own conduct. Employment in various occupations was expected as a way for the patient to maintain control over his or her disorder. As Tuke reported: ". . . regular employment is perhaps the most efficacious; and those kinds of employment . . . to be preferred . . . are accompanied by considerable bodily action." (16, p. 156) The staff endeavored to gain the patient's confidence and esteem, to arrest the attention and fix it upon objects opposite to any illusion the patient might have. The fundamental purpose of employment and recreation was to facilitate the regaining of the *habit of attention,* as Tuke called it. Various learning exercises were used, such as mathematical problems, to help the patient gain ascendancy over faulty habits of attention.

Tuke and Fowler determined that "indolence has a natural tendency to weaken the mind, and to induce ennui and discontent. . . ." (16, pp. 180–181) A wide range of occupations and amusements was available. Patients not engaged in useful occupations were allowed to read, draw, or play various games. Tea parties, walks, and visitations away from the institution were planned regularly in preparation for the patients' returning home. All activities were closely analyzed through observation in order to individualize patients' needs.

The pioneer work of William Tuke and his son, Samuel, who wrote the definitive treatise on *The Retreat,* opened a new chapter in the history of the care of the insane in England. Mild management methods, infused with kindness, and building self-esteem through the judicious use of occupations, resulted in the excitation and elicitation of superior, human motives. Patients recovered, left *The Retreat,* and rarely needed to return for further care. The entire regimen was carefully patterned ". . . to accord (patients) the dignity and status of sick human beings." (17, p. 687)

Moral Treatment Expansion

As soon as Pinel's major work on moral treatment (1801) and Samuel Tuke's description of *The Retreat* were published (1813), there was a rush toward implementing many reforms in other hospitals, particularly in England and the United States. In both countries occupations were introduced as an integral part of moral treatment (18, pp. 83–84). Some unusual experiments were undertaken by Sir William Charles Ellis, a physician, who became the superintendent of a pauper lunatic asylum. The mainstay of his asylum management was useful occupations. He moved well ahead of mere amusements and "introduced a gainful employment of patients on a large scale and even had them taught a trade." (19, p. 62) Ellis and his wife undertook other reforms. She organized the women patients into groups under the supervision of a *workwoman* to make useful and fancy articles.

Another Ellis innovation was the development of what would eventually be called *halfway houses*. Keenly aware of environmental and social influences on insanity, Ellis suggested ". . . after-care houses and night hospitals as a stepping stone from the asylum to the world by which . . . the length of patients' stay would be reduced and in many cases the cure completed. . . ." (17, p. 871) He insisted that convalescing patients should go out and mix with the world before discharge. His proposals were made in the 1830s!

In the United States, few public and private asylums existed in the post-Revolutionary era; however, institutional reforms were needed. Any recounting of this period must include two very important individuals and their work: Benjamin Rush and Dorothea Lynde Dix. Their efforts did not overlap; they did not know one another; nor was one influenced by the other. Just as in the cases of Pinel and Tuke, no two individuals this side of the Atlantic could have been more unlike one another in background, education, or experience. Nevertheless, each recognized the hapless plights of the institutionalized insane and set out to alleviate dire conditions and the inauguration of moral treatment, including occupations and exercise.

Benjamin Rush: Father of American Psychiatry

Benjamin Rush, often referred to as the *father of American psychiatry,* was a Philadelphia physician in the latter half of the 1700s. Through his training in Europe and several visits there, he adopted many of Pinel's practices; however, Rush did not adopt moral principles until later. As a member of the staff of Pennsylvania Hospital, he was placed in charge of a separate section set aside for the insane, the first hospital in America to reserve such a section. He was

appalled by the conditions and he appealed to the staff and the public for change. Change did come and humane treatment was instituted. Rush saw to it that "certain employments be devised for such of the deranged people as are capable of working. . . ." (see 20, p. 257) This approach was based upon his philosophical stance that man, by his very nature, is meant to be active; "Even in paradise (Garden of Eden) he was employed in the health and pleasant exercises of cultivating a garden. Happiness, consisting in folded arms, and in pensive contemplation . . . by the side of brooks, never had any existence, except in the brains of mad poets, and love-sick girls and boys." (21, pp. 115–116)

In his major writing, *Medical Inquiries and Observations Upon the Diseases of the Mind,* Rush clearly differentiates between goal-directed activity and aimless exercise: "Labour has several advantages over exercise, in being not only more stimulating, but more endurable in its effects; . . . it is calculated to arrest wrong habits of action, and to restore such as regular and natural. . . ." (21, pp. 224–225)

Dorothea Lynde Dix: Humanitarian–Reformer

Dorothea Lynde Dix, a reform-minded humanitarian during the middle 1800s, vehemently pressed for improved conditions of the insane who were incarcerated in jails and almshouses. She presented a number of *Memorials* to state legislatures, believing that the public had an obligation to care for such individuals. By 1848 numerous states had responded to her efforts, and she decided to tackle a more formidable object—the Federal government. Dix envisioned the sale of public lands to finance the building of a federal system of hospitals for the indigent blind, deaf and mute, as well as the insane. For 6 years she wheedled and cajoled members of the Congress. Finally, in 1854, the bill was ready for President Franklin Pierce's signature. He was a close friend of Miss Dix and she felt highly confident of the outcome. The President vetoed the bill claiming unconstitutionality: ". . . every human weakness or sorrow would take advantage of this bill if it became law. . . . It endangers states' rights." (see 22, p. 20) Through her contacts with physicians in several states, Miss Dix embraced moral treatment as the most humane method. She strongly advocated ". . . decent care, quiet, affection and normal activity (as) the only medicine for the insane." (see 22, p. 11)

United States: Individual Treatment, Occupations, Education

The Quakers brought moral treatment to the United States as part of their intellectual and religious luggage. Through published accounts about *The Retreat* in York, some private asylums were established in which moral principles were practiced. A number of public institutions altered their programs to include individualized treatment, occupations, and education. Those patients who had remained for years unimproved and listless, even on the verge of apathy ". . . are seen in encouraging instances, when transferred to attendants who have more disposition to attend to them, . . . to waken (them) from their torpor, to become animated, active and even industrious. . . ." (23, pp. 487–488)

Moral management also was taking on a new facet: the influence of a sane mind upon the insane mind. Those who daily attended the sick were to impress upon the insane the influences of their own character, designed to specifically improve the patients' behavior. Personnel must possess a number of traits: observational skills to see the ". . . actual condition of the patient's mind . . . and a faculty of clear insight. . . ." (23, p. 489) Other traits: ". . . seeing that which is passing in the minds of (patients). . . . Add to this a firm will, the faculty of self-control, a sympathizing distress at moral pain, a strong desire to remove it. . . ." (23, p. 489)

Arguments appeared in the literature relative to the moral use of firmness and gentleness. Strong cases were made for both extremes; however, it took two alienists (the precursor to psychiatrist), John Bucknill and D. Hack Tuke, grandson of Samuel Tuke, in 1858 to settle the dispute: "The truth, as usual, lies between; and the (individual) who aims at success in the moral treatment of the insane must be ready to be all things to all men, if by any means he might save some" (23, p. 500). They elaborate on their thesis by stating: "With self-reliance, . . . it requires widely different manifestations, to repress excitement, to stimulate inertia, to check the vicious, to comfort the depressed, to direct the erring, to support the weak, to supplant every variety of erroneous opinion, to resist every kind of perverted feeling, and to check every form of pernicious conduct." (23, p. 500)

Bucknill and Tuke also wrote that moral treatment included the gaining of the patient's confidence, fixing his or her attention on interesting and wholesome objects of thought, diverting the mind from introspection, and loosening the hold on concentrated emotion. They explain: "For (these) purposes useful occupation is far superior to any form of amusement. The higher the purpose, and the more appellant the nature of the occupation . . . the more likely it is to draw him from the contemplation of self-wretchedness, and effect the triumph of moral influences." (23, p. 493)

The next step in institutional occupations emphasized education. Those occupations that require a process of learning and thought were determined far preferable, from a curative point of view, than those that require none. "Moral treatment is as wide as that of education; . . . it is education applied to the field of mental phenomena. . . ." (23, p. 501) Therefore, it was not unusual to find specific mental activities included with occupations. The purpose was to educate the individual in order to provide him or her with "the power of controlling his feelings, and his thoughts, and his actions." (24, pp. 166–167)

With continued experience, a number of alienists decided that occupations and amusements also could serve as a prophylactic against insanity. One interesting prescription for the return and maintenance of sanity was: ". . . rest in bed, occupation, exercise and amusements." (25, p. 14) D. Hack Tuke declared: "If idleness is a curse to the sane, it is the parent of mischief and ennui to the insane, especially to the pubescent and adolescent." (26, p. 1315) He urges that the same approach be taken with the sane and the insane: "Employment, Nature's universal law of health, alike for body and mind, is specially beneficial, . . . seeing that it displaces ideas by new and healthy thoughts, revives familiar habits of daily activity, restores (and maintains) self-respect while it promotes the general bodily health." (26, p. 1315)

Decline of Moral Treatment

Moral management and treatment by occupations reached its zenith in the United States just before the outbreak of the War Between the States (Civil War). Corporate, private asylums continued to expand their efforts. State- and public-supported institutions withdrew their programs, so that by the last quarter of the 19th century, virtually no moral treatment was taking place.

Several reasons for this decline and eventual disappearance can be identified, including a nation at war with itself. Bockhoven cites others: 1. the founders of the U.S. movement retired and died, leaving no disciples or successors; 2. the rapidly increasing influx of foreign-born and poor patients greatly overtaxed existing facilities and required more institutions to be built with diminished tax support; 3. racial and religious prejudices on the part of the alienists, beginning to be called psychiatrists, reduced interest in treatment and cure; and 4. state legislatures became increasingly more interested in less costly custodial care (27, pp. 20–25).

Essentially, there was no place in the public institutions for moral treatment. "The inferior physical plants and facilities, poorly trained and insufficient staff, . . . and, worst of all, overcrowding, prohibited any attempts to practice moral management." (28, p. 128) A belief emerged that many insane were incurable. One eminent psychiatrist stated: "I have come to the conclusion that when a man becomes insane, he is about used up for this world." (29, p. 155) Such pessimism was predominant for a century in this country. Custodial care had come to stay for a very long time.

As we shall see next, moral principles and practices emerged in the early years of the 20th century through the efforts of individuals, then by a group who founded an organization dedicated to those principles. This group, in collaboration with others, established a definition and fundamental principles that have carried over through several generations of specifically educated practitioners of occupational therapy.

Once again, as with Pinel and Tuke, Rush and Dix, the individuals who founded and pioneered the 20th century occupational therapy movement could not have been more diverse in their backgrounds, experience, and education. They included a nurse, two architects, a physician, a social worker, and a teacher.

Susan Tracy: Occupational Nurse

Susan Tracy was this century's first proponent of occupations for invalids. A trained nurse, she initiated instruction in activities to student nurses as early as 1905 as part of their expanding responsibilities. She also developed the term *occupational nurses* to signify specialization (30, p. 401). By 1912 she decided to devote all her energies to patient activities and she distinguished herself by applying moral treatment principles to acute conditions. As Tracy stated, "The application of this most rational remedy to ordinary, everyday sick people, as found in the general hospital, is almost unknown." (31, p. 386) She strongly claimed that remedial treatments "are classified according to their physiological effects as

stimulants, sedatives, anesthetics . . . , etc. Certain occupations possess like properties." (31, p. 386) The physician may select stimulating occupations, such as watercoloring and paper folding; or sedative occupations such as knitting, weaving, basketry.

Throughout Tracy's many years of work she employed experimentation and observation to enhance her practice. Her carefully worded writings provide ample evidence of her intense desire to bring scientific principles to the application of invalid occupations. In 1918 she published a remarkable research paper on 25 mental tests derived from occupations; for example, by instructing the patient in using a piece of leather and a pencil, "require him to make a line of dots at equal distances around the margin and at uniform distances from the edge. This constitutes a test of *Judgment* in estimating distances." (32, p. 15) Continuing with the same piece of leather, the patient is instructed to punch a hole at each dot. "In order to do this he must consider the two sides of leather, the two parts of his tool and bring these together thus making a *Simple Coordination* test." (32, p. 16) Other tests in the fabrication of the leather purse include *Aesthetic Coordination and Rhythm, Differentiation of Form and Size, Purposeful Relation.* In all 25 tests, she stressed a completed, useful and "not unbeautiful" object.

Tracy's other writings state the value and usefulness of discarded materials to successful ward work (33, p. 62). She also emphasized high quality workmanship: "It is now believed that what is worth doing at all is worth doing well, and that practical, well-made articles have a greater therapeutic value than a useless, poorly made article." (34, p. 198) A premium is placed upon originality and the ". . . adoption of the occupation to the condition and natural tastes of the patient." (35, p. 63) Further, she believes that ". . . the patient is the product, not the article that he makes." (see 33, p. 59)

Tracy's major work, *Studies in Invalid Occupation,* published in 1918 (36), is a revealing compendium of her observations and experiences with different kinds of patients, for instance: "the child of poverty and the child of wealth, the impatient boy, grandmother, the business man."

By 1921, Susan Tracy had adopted the term *occupation therapy* originally coined by William Rush Dunton, Jr., and defined it and differentiated it from vocational training. She felt this was necessary because of the arising confusion between the two concepts following World War I. She wrote: "What is occupation? The treatment of disease by occupation. . . . The aim of occupation is to get the man well; that of vocational training is to provide him with a job. Any well man will look for a job, but the sick man is looking for health." (37, p. 120)

Throughout all of her writings she stated that nothing is ". . . too small to be pressed into the service of resourceful mind and trained hands toward . . . the establishment of a healthy mind in a healthy body." (33, p. 57)

George Barton: Re-education of Convalescents

George Edward Barton, by profession an architect, contracted tuberculosis in his adult life. This plagued him for the remainder of his years. His constant struggle led him into a life of service to the physically handicapped. Out of his own personal concerns came the establish-

ment of Consolation House, an early prototype of a rehabilitation center. He was an effective speaker and writer, often given to hyperbole; he gained his point with the listening or reading public.

Barton's central themes were hospitals and their responsibility to the discharged patient; the conditions the discharged patient faces; the need to return to employment; occupations and re-education of convalescents. These were intense concerns to him because of his own health problems.

His first published article, derived from a speech given to a group of nurses, points out a weakness he perceived in hospitals: "We discharge from them not efficients, but inefficients. An individual leaves almost any of our institutions only to become a burden upon his family, his friends, the associated charities, or upon another institution." (38, p. 328) In the same article, he warms to his subject: "I say to discharge a patient from the hospital, with his fracture healed, to be sure, but to a devastated home, to an empty desk and to no obvious sustaining employment, is to send him out to a world cold and bleak. . . ." (38, p. 329) His solution: ". . . occupation would shorten convalescence and improve the condition of many patients." (38, p. 329) He ended his oration with a rallying cry: ". . . it is time for humanity to cease regarding the hospital as a door closing upon a life which is past and to regard it henceforth as a door opening upon a life which is to come." (38, p. 330)

Barton established Consolation House in Clifton Springs, New York. Those referred to his institution underwent a thorough review, including a social and medical history, and a consideration of one's education, training, experience, successes, and failures. Barton believed that "By considering these in relation to the condition (the patient) must presumably or inevitably be in for the remainder of his life, we can find some form of occupation for which he will be fitted. . . ." (39, p. 336) He claimed that Consolation House was "getting down to our social difficulties." (39, p. 337)

By 1915, Barton had adopted Dunton's term, *occupation therapy,* but preferred the adjectival form: occupational therapy. He declared: "If there is an occupational disease, why not an occupational therapy?" (40, p. 139) He expansively stated: "The first thing to be done . . . is for occupational therapy to provide an occupation which will produce *a similar therapeutic effect to that of every drug in materia medica.* An exercise for each separate organ, joint, and muscle of the human body. An exercise? An occupation! An occupation? A useful occupation! Then (occupational therapy) can fill the doctor's prescriptions . . . written in the terms of materia medica." (40, p. 139) He even advocated a laxative by *occupation.*

Re-education entered Barton's terminology with the aftermath of World War I. He viewed hospitals as taking on a mission different from that previously adopted. A hospital should become ". . . a re-educational institution through which to put the waste products of society *back and into the right place.*" (40, p. 139) Using alliteration, he declared: ". . . by a catalystic concatenation of contiguous circumstances we were forced to realize that when all is said and done, what the sick man really needed and wanted most was the restoration of his ability to work, to live independently and to make money." (41, p. 320)

Barton's major contribution to the re-emergence of moral treatment was the awakening of physical re-construction and re-education through the employment of occupations.

Convalescence, to him, was a critical time for the inclusion of something to do. Activity ". . . clarifies and strengthens the mind by increasing and maintaining interest in wholesome thought to the exclusion of morbid thought . . . and a proper occupation . . . during convalescence may be made the basis of the corollary of a new life upon recovery. . . . I mean *a job, a better job, or a job done better* than it was before." (42, p. 309) With Susan Tracy, Barton held that the major consideration of occupations ". . . should be devoted to the therapeutic and education effects, not to the value of the possible product." (43, p. 36)

William Rush Dunton, Jr.: Judicious Regimen of Activity

Of the founders of the 20th century movement, William Rush Dunton, Jr., was the most prolific writer and the most influential. He published in excess of 120 books and articles related to occupational therapy and rehabilitation; served as president of the National Society for the Promotion of Occupational Therapy; and, for 21 years, was editor of the official journal. As a physician, he spent his professional career treating psychiatric patients in an institutional setting. Key to his treatment methods is occupational therapy, a term he coined to differentiate aimless amusements from those occupations definitely prescribed for their therapeutic benefits. Before embarking on what he called *a judicious regimen of activity,* he read the works of Tuke and Pinel, as well as the efforts of significant alienists of the 19th century.

From his readings and from observations of patients in Sheppard Asylum, a Quaker institution in Towson, Maryland, Dunton concluded that the acutely ill are generally not amenable to occupations or recreation. The acutely ill exhibit a weakened power of attention. Occupations at this time would be fatiguing and harmful. The prevailing prescription is ". . . to let the patient alone, meanwhile improve (his) condition, restore and revivify exhausted mental and physical forces. . . ." (44, p. 19) Later, activities should be selected that use energies not needed for physical restoration. Stimulating attention and directing the thoughts of the patient in regular and healthful paths would ensure an early release from the hospital. Dunton developed a wide variety of activities from knitting and crocheting to printing and the repair of dynamos, in order to gain the attention and interest, as well as to meet the needs, of all patients.

Dunton's proclivities for history and research led him to extensive readings and experimentations—all related to the human, his need for work, leisure, rest, and sleep; the causal factors of mental aberrations; various cures of mental illness. Each excursion brought him back to *a judicious regimen of activity* as the treatment of choice, regardless of whether the patient was mentally or physically ill. He became more and more convinced that attention and interest in one's work and play are as efficacious, if not more so, than the many and varied other medications available. He stated it this way: "It has been found that a patient makes more rapid progress if his attention is concentrated upon what he is making and he derives stimulating pleasure in its performance." (45, p. 19)

At the second annual meeting of the National Society for the Promotion of Occupational Therapy (AOTA) in 1918, Dunton unveiled his nine cardinal rules to guide the emerging practice of occupational therapy, and to ensure that the new discipline would gain acceptance as

a medical entity: 1. Any activity in which the patient engages should have as its objective a cure. 2. It should be interesting; 3. have a useful purpose other than merely to gain the patient's attention and interest; and 4. preferably lead to an increase in knowledge on the patient's part. 5. Curative activity should preferably be carried on with others, such as in a group. 6. The occupational therapist should make a careful study of the patient in order to know his or her needs and attempt to meet as many as possible through activity. 7. The therapist should stop the patient in his or her work before reaching a point of fatigue; and 8. encouragement should be genuinely given whenever indicated. Finally, 9. work is much to be preferred over idleness, even when the end product of the patient's labor is of a poor quality or is useless (46, pp. 26–27).

The major purposes of occupation in the case of the mentally ill were outlined in Dunton's first book (47, pp. 24–26). The primary objective is to divert the attention either from unpleasant subjects, as is true with the depressed patient; or from day-dreaming or mental ruminations, as in the case of the patient suffering from dementia praecox (schizophrenia)—that is, to divert the attention to one main subject.

Another purpose of occupation is to re-educate—to train the patient in developing mental processes through ". . . educating the hands, eyes, muscles, just as is done in the developing child." (47, p. 25) Fostering an interest in hobbies is a third purpose. Hobbies serve as present, as well as future, safety valves and render a recurrence of mental illness less likely. A final purpose may be to instruct the patient in a craft until he or she has enough proficiency to take pride in his or her work. However, Dunton did note that "While this is proper, I fear . . . specialism is apt to cause a narrowing of one's mental outlook. . . . The individual with a knowledge of many things has more interest in the world in general." (47, p. 26)

Dunton continued to write and publish his observations, each one elaborating on a previous one. His texts became required reading for students preparing for practice. Even in his 90s, well beyond retirement from practice, he maintained an interest in our profession and continued to offer counsel.

Eleanor Clarke Slagle: Founder–Pioneer

Eleanor Clarke Slagle qualifies as both a founder and a pioneer. She was at the birth of the Association in 1917. Before that time she had received part of her education in social work and had completed one of the early Special Courses in Curative Occupations and Recreation at the Chicago School of Civics and Philanthropy. Following this, she taught in two courses for attendants of the insane; directed the occupations program at Henry Phipps Clinic, Johns Hopkins Hospital, Baltimore, under Dr. Adolf Meyer; returned to Chicago to become the Superintendent of Occupational Therapy at Hull House. Later, Mrs. Slagle moved to New York where she pioneered in developing occupational therapy in the State Department of Mental Hygiene. In addition, she served with high distinction in every elective office of the American Occupational Therapy Association, including President (1919–1920) and as a paid Executive Secretary for 14 years (see 48, pp. 122–125); (see 49, pp. 473–474); (50, p. 18); (see 51).

She found occupational therapy to be ". . . an awkward term . . ." but felt ". . . it has been well defined as a form of remedial treatment consisting of various types of activities . . . which either contribute to or hasten recovery from disease or injury . . . carried on under medical supervision and that it be *consciously* motivated." Further, she emphasized that occupational therapy must be "a *consciously* planned progressive program of *rest, play, occupation and exercise. . . .*" (52, p. 289) In addition, she explained it is ". . . an effort toward normalizing the lives of countless thousands who are mentally ill, . . . the normal mechanism of a fairly well balanced day." (53, p. 14) She enjoyed quoting C. Charles Burlingame, a prominent psychiatrist of her day: " 'What is an occupational therapist? She is that newer medical specialist who takes the joy out of invalidism. She is the medical specialist who carries us over the dangerous period between acute illness and return to the world of men and women as a useful member of society.' " (52, pp. 290–291)

Slagle placed considerable emphasis upon the personality factor of the therapist: ". . . the proper balance of qualities, proper physical expression, a kindly voice, gentleness, patience, ability and seeming vision, adaptability . . . to meet the particular needs of the individual patient in all things. . . . Personality plus character also covers an ability to be honest and firm, with infinite kindness. . . ." (54, p. 13)

The issue would constantly arise about the use of handicrafts as a therapeutic measure in the machine age. Her response is a classic: ". . . handicrafts are so generally used, not only because they are so diverse, covering a field from the most elementary to the highest grade of ability; but also, and greatly to the point, because their development is based on primitive impulses. They offer the means of contact with the patient that no other medium does or can offer. Encouragement of creative impulses also may lead to the development of large interests outside oneself and certainly leads to social contact, an important consideration with any sick or convalescent patient." (52, pp. 292–293)

Habit training was first attempted at Rochester (New York) State Hospital in 1901. Slagle adopted the basic principles and developed a far greater perspective and use among mental patients who had been hospitalized from 5 to 20 years and who had steadily regressed. The fundamental plan was ". . . to arrange a twenty four hour schedule . . . in which physicians, nurses, attendants and occupational therapeutists play a part. . . ." (54, p. 13) It was a reeducation program designed to overcome some disorganized habits, to modify others and construct new ones, with the goal that habit reaction will lead toward the restoration and maintenance of health. "In habit training, we show clearly an academic philosophy factor . . . that is, the necessity of requiring attention, of building on the habit of attention—attention thus becomes application, voluntary and, in time, agreeable." (54, p. 14)

The purposes of habit training were two-fold: the reclamation and rehabilitation of the patient, with the eventual goal of discharge or parole; and, if this was not reasonable, to assist the patient in becoming less of an institutional problem, that is, less destructive and untidy.

A typical habit training schedule called for the patients to arise in the morning at 6:00, wash, toilet, brush teeth, and air beds; then breakfast; return to ward and make beds, sweep; then classwork for 2 hours, which consisted of a variety of simple crafts and marching exercises. After lunch, there was a rest period; continued classwork and outdoor exercises, folk

dancing, and lawn games. Following supper, there was music and dancing on the ward, followed by toileting, washing, brushing the teeth, and preparing for bed (55, p. 29).

Once the patient had received maximum benefit from habit training, he or she was ready to progress through three phases of occupational therapy. The first was what Slagle called *the kindergarten group*. "We must show the ways and means of stimulating the special senses. The employment of color, music, simple exercises, games and storytelling along with occupations, the gentle ways and means . . . (used) in educating the child are equally important in reeducating the adult. . . ." (54, p. 14) Occupations were graded from the simple to the complex.

The next phase was *ward classes in occupational therapy* ". . . graded to the limit of accomplishment of individual patients." (56, p. 100) When able to tolerate it, the patient joined in group activities. The third and final phase was the *occupational center*. "This promotes opportunities for the more advanced projects . . . (a) complete change in environment; . . . comparative freedom; . . . actual responsibilities placed upon patients; the stimulation of seeing work produced; . . . all these carry forward the readjustment of patients." (56, p. 102)

This founder, this pioneer, this distinguished member of our profession provided a summary of her own accomplishments and philosophy by stating: "Of the highest value to patients is the psychological fact that the patient is working for himself. . . . Occupational Therapy recognizes the significance of the mental attitude which the sick person takes toward his illness and attempts to make that attitude more wholesome by providing activities adapted to the capacity of the individual patient and calculated to divert his attention from his own problems." (54, p. 290) Further, she declared: "It is directed activity, and differs from all other forms of treatment in that it is given in increasing doses as the patient improves." (see 57, p. 3)

Adolph Meyer: Philosophy of Occupation Therapy

Dr. Adolph Meyer is cited in this account of the evolution of occupational therapy because of his outstanding support and because his approach to clinical psychiatry was entirely consistent with the emerging occupational therapy movement.

Adolph Meyer, a Swiss physician, immigrated to the United States in 1892 and accepted a position initially as pathologist at the Eastern Illinois Hospital for the Insane in Kankakee. Over the next 14 years he held various positions in the United States and became professor of psychiatry at Johns Hopkins University in 1910. Throughout this period he developed the fundamentals of what was to become the psychobiological approach to psychiatry, a term he coined to indicate that the human is an indivisible unit of study, rather than a composite of symptoms. "Psychobiology starts not from a mind and a body or from elements, but from the fact that we deal with biologically organized units and groups and their functioning . . . the 'he's' and 'she's' of our experience—the bodies we find in action. . . ." (58, p. 263) Meyer took strong issue with those in medicine: ". . . who wish to reduce everything to physics and chemistry, or to anatomy, or to physiology, and within that to neurology. . . ." (58, p. 262) His enlightened point of view is that one can only be studied as a total being in action and

that this ". . . whole person represents an integrate of hierarchically arranged functions." (see 59, p. 1317)

His common sense approach to the problems of psychiatry was his keynote: "The main thing is that your point of reference should always be life itself. . . . I put my emphasis upon specificity. . . . As long as there is life there are positive assets—action, choice, hope, not in the imagination but in a clear understanding of the situation, goals and possibilities. . . . To see life as it is, to tend toward objectivity is one of the fundamentals of my philosophy, my attitude, my preference. It is something that I would recommend if it can be kept free of making itself a pest to self and to others." (see 60, pp. vi–xi)

From the very beginning of his work in Illinois, he was concerned with meaningful activity. In time, it became the fundamental issue in treatment. "I thought primarily of occupation therapy," he stated, "of getting the patient to do things and getting things going which did not work but which could work with proper straightening out." (see 60, p. 45) In a report to the Governor of the State of Illinois in 1895, Meyer wrote: "Occupation is, with good right, the most essential side of hygienic treatment of most insane patients." (see 60, p. 59)

By 1921, Meyer had become Professor of Psychiatry at Johns Hopkins University in Baltimore, and had had extensive experiences with others, such as William Rush Dunton, Jr., Eleanor Clarke Slagle, and Henrietta Price, leaders in the occupational therapy movement. At the Fifth Annual Meeting of the National Society for the Promotion of Occupational Therapy in Baltimore, October 1921, Meyer brought together his fundamental concepts of psychobiology to produce his paper, *The Philosophy of Occupation Therapy*. Through time, this has become a classic in the occupational therapy literature. It bears study by all of us.

Psychobiology is clearly visible in his statement that ". . . the newer conceptions of *mental problems* (are) *problems of living,* and not merely diseases of a structural and toxic nature. . . ." (61, p. 4) The indivisibility and integration of the human are cited in this manner: "Our conception of man is that of an organism that maintains and balances itself in the world of reality and actuality by being in active life and active use. . . ." (61, p. 5)

Because of the nature of his paper, *The Philosophy of Occupational Therapy,* Meyer emphasized occupation, time, and the productive use of energy. Interwoven are the elements of psychobiology. He stated: "The whole of human organization has its shape in a kind of rhythm. . . . There are many . . . rhythms which we must be attuned to: the larger rhythms of night and day, of sleep and waking hours . . . and finally the big four—work and play and rest and sleep, which our organism must be able to balance even under difficulty. The only way to attain balance in all this is actual doing, actual practice, a program of wholesome living is the basis of wholesome feeling and thinking and fancy and interests." (61, p. 6)

According to Meyer, a fundamental issue in the treatment of the mentally ill is ". . . the proper use of time in some helpful and gratifying activity. . . ." (61, p. 1) He expands on this precept by stating: "There is in all this a development of the *valuation of time and work,* which is not accidental. It is part of the great espousal of the *values of reality and actuality* rather than of mere thinking and reasoning. . . ." (61, p. 4) The introduction of activity is ". . . in giving opportunities rather than prescriptions. There must be opportunities to work, opportunities to do and to plan and create, and to learn to use material. . . . It is not a question of specific

prescriptions, but of opportunities . . . to adapt opportunities." (61, p. 7) He concluded his philosophic essay by returning once again to time and occupations: "The great feature of man is his new sense of time, with foresight built on a sound view of the past and present. Man learns to organize time and he does it in terms of doing things, and one of the many things he does between eating, drinking and . . . the flights fancy and aspiration, we call work and occupation." (61, pp. 9–10)

Near the end of his working life, Meyer summed up his major efforts. He wrote of dealing with individuals and groups from the viewpoints of *good sense;* of *science,* ". . . with the smallest numbers of assumptions for search and research. . . ."; of *philosophy;* and of *religion,* ". . . as a way of trust and dependabilities in life." (see 62, p. 100)

Occupational Therapy Definitions and Principles

As the founders and pioneers were experimenting with and writing their concepts, a definition of occupational therapy was emerging. It is remarkable that so early in the formation of the 20th century movement, a definition could be developed and stand for several decades and several generations of occupational therapists. Many of us were required in school to immortalize it through needlepoint, embroidery, and even printing.

H. A. Pattison, M.D., medical officer of the National Tuberculous Association, advanced his view at the annual conference of the National Society for the Promotion of Occupational Therapy in Chicago, September 1919. It was also adopted by the Federal Board of Vocational Education: "Occupational Therapy may be defined as any activity, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to and hastening recovery from disease or injury." (63, p. 21) Twenty-two years later, in 1931, John S. Coulter, M.D., and Henrietta McNary, OTR, added one phrase: ". . . and assisting the social and institutional adjustment of individuals requiring long and indefinite periods of hospitalization." (see 64, p. 19) This was inserted in order to recognize occupational therapy's involvement in chronicity.

By 1925, a committee, made up of four physicians including William Rush Dunton, compiled an outline for lectures to medical students and physicians (65, pp. 277–292). Though their document never received the official imprimature of the AOTA, it nevertheless served for several years as a guide for practice (see 66, p. 347). Fifteen principles were enunciated: "Occupational therapy is a method of training the sick or injured by means of instruction and employment in productive occupation; . . . to arouse interest, courage, confidence; to exercise mind and body in . . . activity; to overcome disability; and to re-establish capacity for industrial and social usefulness." (65, p. 280) Application called for as much system and precision as other forms of treatment; activity was to be prescribed, administered, and supervised under constant medical advice. Individual patient needs were paramount.

The outline stressed that "employment in groups is . . . advisable because it provides exercise in social adaptation and stimulating influence of example and comment. . . ." (65, p. 280) In selecting an activity, the patient's interests and capabilities were to be considered and as strength and capability increased, the occupation was to be altered, regulated, and graded

accordingly because "The only reliable measure of the treatment is the effect on the patient." (65, p. 280)

Inferior workmanship could be tolerated, depending upon the patient's condition, but there should be consideration of ". . . standards worthy of entirely normal persons . . . for proper mental stimulation." (65, p. 281) Articles made were to be useful and attractive, and meaningful tasks requiring healthful exercise of mind and body provided the greatest satisfaction. "Novelty, variety, individuality, and utility of the products enhance the value of an occupation as a treatment measure." (65, p. 281) While quality, quantity, and the salability of articles made could be of benefit, these should not take precedence over the treatment objectives. As adjuncts to occupations, physical exercise, games, and music were considered beneficial and fell into two main categories: gymnastics and calisthenics, recreation and play.

One last principle spoke of the qualities of the occupational therapist: ". . . good craftsmanship, and ability to instruct are essential qualifications; . . . understanding, sincere interest in the patient, and an optimistic, cheerful outlook and manner are equally essential." (65, p. 281)

Occupational Therapy's Second Generation

The die was cast. Practice rapidly expanded in a phenomenal number of settings following the establishment of the founders' principles and definition. A *second generation* of therapists emerged during the late 1920s and the 1930s. They were the practitioners and educators who elaborated, codified, and applied the initial theory upon which present-day practice is based. A chronicle of their efforts would offer a highly valuable and valued study in itself. The names of Louis Haas, Mary Alice Coombs, Winifred Kahmann, Henrietta McNary, Harriet Robeson, Marjorie Taylor, and Helen Willard would figure prominently in such an account.

For the purpose of *this history,* a composite of these and others is drawn into one individual who exemplifies the spirit and deeds of the *second generation* of occupational therapists—those whose efforts are lasting and ensure our present and future education and practice.

Understandably, it would be a woman. She would devote her professional career to either teaching, practicing, or administering. Quite possibly she would combine two or more of these. She would acquire an expertise in one area of practice, such as the mentally ill.

Her belief in the treatment of the total patient would guide her thoughts and actions. Occupational therapy, she would declare, "since its founding has concerned itself with the basic tenet—the treatment of the total patient. This approach is unique to occupational therapy among the . . . health disciplines. . . . There has always existed a strong component concerned with the behavior of the physically ill or disabled, as well as the mentally sick; with the entirety of man and his functioning as a patient. This occupational therapy concept," she would continue, "prevented (as has occurred in medical practice) an undesired separation of the psychiatric therapist from those who develop knowledge and skills centered in the treatment of the physically disabled." (67, p. 1) Stated another way, "The major emphasis in occupational therapy is not the body *as such* but the individual *as such*. The therapist's background is strongly weighted in an understanding of personality adjustment and reactions to social

situations; . . . and in the patients' attitudes toward an adjustment to acute and chronic disabilities." (68, p. 9)

At some point in her work, she would be asked to serve as a consultant to one or more medical facilities, possibly a state hospital system. In time, she would produce a report and re-state her definition of occupational therapy. It might well go this way: "The goal of all treatment in a modern mental hospital is the physical, social and economic rehabilitation of the patient. . . . The accepted function (of occupational therapy) . . . is the scientific utilization of mental and physical activities for the purpose of raising the patient to the highest level of integration; to assist him in making his initial adjustment to the hospital; to sustain him while his body responds to physical treatment and his mind to psychotherapy; or to assist him in making a satisfactory adjustment to chronic illness." (69, p. 24)

In the report she would also call for an atmosphere as normal as possible, where a patient could be encouraged to respond in as normal a manner as possible: a balanced program of work and play, with flexibility to meet individual needs: "There must be organized a succession of steps through which the patient will be gradually led to his highest level of integration. . . . At each level . . . the patient experiences a feeling of success and self-respect. One cannot overemphasize the importance of careful planning . . . in order that there be a systematic progression up this ladder of integration." (69, p. 24)

In another context, supportive care, as a vital concern to the therapist, would also be described, particularly in the care of the physically disabled: "To name only a few of its treatment objectives, occupational therapy may function as a diagnostic evaluative instrument; as corrective treatment; . . . or a design for effecting prevocational evaluation. Incorporated in each . . . is a treatment phase referred to as supportive care. This is a most fundamental and yet less definitive and indeed the least spectacular element of the total rehabilitory program. In supportive care, the occupational therapist (is concerned) with the behavioural factors which have and will affect the patient's response to the rehabilitation program. . . ." Convincingly, she would say: ". . . it can be said with conviction that successful rehabilitation can be effected only when the patient has attained a true state of rehabilitation 'readiness.' " (70)

Not just a woman of words, she would find one or more ways to activate her philosophy. She might well become active with a group of former patients and assist in organizing an association of and for individuals who have been hospitalized—for instance, the mentally ill. Such an endeavor would be the first of a kind. Through such an experience, she would conclude: "One difficulty which presented itself again and again was the need to instill in these (former) patients a philosophy toward their own rehabilitation; . . . an organized effort beyond the hospital which would offer special training, guidance and professional evaluation of their potentials." (71, p. 3)

This would lead her to even greater endeavors on behalf of a whole category of patients. As an example, she would find that the 1920 Federal Vocational Rehabilitation Act excluded former psychiatric patients. In the manner of Dorothea Lynde Dix, whom she probably emulated, she would wage a relentless battle to right such a wrong. By enlisting the assistance of physicians' associations and veterans' groups she would see the legislation change. As part of her campaign she would write: "The former mental patient, in his struggle for economic

rehabilitation, incurs the burden imposed on the physically handicapped 'plus' the stigmatization based on the popular misconception of mental disease. He must cast aside self-pity or the idea that the world owes him a living. The world does owe him understanding and guidance." (72, p. 114) Finally, amendments to Public Law 113 were passed and signed by President Franklin Roosevelt. Psychiatric patients could now qualify for the benefits of the vocational rehabilitation act.

With such efforts the therapist's personal beliefs about emotional illness become even more strongly felt: "The majority of mentally ill are (sick) through no fault of their own . . . any more than one who has contracted a physical illness. Persons suffering from mental disease are generally ill as a result of an accumulation of unsuccessful efforts . . . to adjust to his environment." (72, p. 83)

Two continuing concerns of all occupational therapists would be commented upon: the qualifications of the therapist and the use of media. One is as significant as the other. "The personality of the therapist," she would say, "must command respect, admiration, hope and confidence, . . . for no therapy is better than the therapist who directs it." (72, p. 83) Therapeutic media have a number of inherent qualities, such as providing a vehicle for objectively recording patient performance, and, for the patient, affording opportunities for ". . . creative expression and evidence of accomplishment. The therapist should have a wide variety of activities (available) in accordance with the interests, aptitudes, and mental state of the patient. A craft track mind has no place in preparing such a program," she would state (72, p. 103).

The accumulation of experiences as a clinician, and educator, or an administrator, or possibly a combination of these, would lead this *therapist of the second generation* to arrive at a new definition of occupational therapy. It would precede by several years an altered definition by the national organization. It would incorporate the social and behavioral sciences, with a diminished emphasis upon medicine. Human development would appear for the first time as a focus for the treatment of physical and psychosocial dysfunction. She would declare: "Occupational therapy's function is to provide skilled assistance in influencing human objectives; its approach is inextricably conjoined with the behavioral factors involved. It is interested in how the process of growth and development is modified by hospitalization, chronic illness or a permanent handicap." (73, p. 2)

This re-focus was quite explainable and understandable to her since occupational therapy, and its ancestral emphasis, has always been the totality of the human organism. She would say, "It was inevitable, therefore, that there evolve an ever increasing emphasis in occupational therapy . . . a greater understanding of the part that the developmental process plays in the preventive and therapeutic factors of this form of treatment." (74, p. 3)

The foregoing has been a descriptive composite of a whole generation of therapists and assistants. The composite is actually the story of one individual; her observations alone have been cited. That individual is *Miss Beatrice D. Wade, OTR, FAOTA*.

The story is far from finished. Without a doubt, someone sometime will chronicle the lives and works of those who are still making contributions from that era to the present generation. Among them are Marjorie Fish, Virginia Kilburn, Mary Reilly, Ruth Robinson, Clare Spackman, Ruth Brunyate Wiemer, Carlotta Welles, and Wilma West. Each one,

together with many others, continues to serve us well as clarifiers and definers of reasonable and reasoned alternatives. As counselors, they confirm old values and clearly point out *new directions* as well as our faithfulness or infidelity to those timeless principles established by our professional ancestors.

Lessons From Our History

The history of occupational therapy is the most neglected aspect of our professional endeavors. Seemingly, *old values* are least considered when charting *new directions*. On occasion we have been accused of taking leave of our historical senses. More to the point is that we have no historical sense. The problem primarily lies in not taking the time to assiduously locate our profession's diggings, to excavate what is relevant, and, then, to learn from what has been unearthed.

Archival materials from the past 200 years have been abundantly used in the development of this paper. Location and excavation has been difficult at times; however, it is reassuring to note that records and accounts still exist that are extremely relevant to today's endeavors. Lessons can be learned and they must. May I encourage each of you to determine for yourself what you have learned from this paraphrastic journey to our profession's diggings. To assist in this endeavor, may I cite a few lessons I have gained.

Mind and Body Inextricably Conjoined

No less than our professional ancestors, we must refuse to accept any alternative to the belief in the wholeness of the human—that the mind and body are inextricably conjoined. Illness, treatment, and the return to a healthful state simultaneously affect the physiological and emotional processes. Indeed, should these processes ever become separated, then occupational therapy would be of no value. The patient has died!

The Natural Science of the Human

The inextricable union of the human leads to another lesson. The science fundamental to our practice is the natural science of the human. No amount of neurophysiology, psychology, sociology, or child development alone can determine the differential diagnosis, treatment, or prognosis of the patient undergoing occupational therapy. The current trend toward specialization, with its varying emphases upon one or another science, to the neglect of other human sciences, and indeed to the neglect of other nonscientific aspects of occupational therapy, borders on superstition and mythology. It is the continuous acquisition and scientific synthesis of the ingredients of the human organism and its surround that guarantees authentic occupational therapy.

The Human Organism's Involvement in Tasks

Occupational therapy is the only major health profession whose focus centers upon the *total* human organism's involvement in tasks—a making or doing. In spite of the many grafts we have effected, our roots remain in the subsoil of the *art,* the *craft:* a paradigm of the total activity of the human. Just as those who have come before us, we think of ourselves and

others fundamentally as makers, as users, as doers, as tools. We look at: ". . . craft as a way in which man may create and cross a bridge within himself and center himself in his own essential unity." (75, p. vii) The procedures one goes through in rearranging and reassembling the basic elements in art or craft operate upon and within the doer: ". . . his material modifies him as he modifies it, in proportion to his openness, his awareness of the exchange that is taking place." (75, p. x)

The Differentiation of Occupational Therapy

Any definition, any description, any differentiation between ourselves and other health providers must have as its major theme occupation and leisure. Without it, we become a blurred copy, a xerography of a host of others.

Without the dynamics of human motion inherent in purposeful activity, we become quasi-physical therapists. Without the interaction between human objects and the objects of work and leisure, we become quasi-social workers, psychologists, or nurses. Without the demonstrated and proven interrelationships between healthful, normal growth and development, activity, and the pathology of illness and disabling conditions, we become quasi-physicians and psychiatrists.

The more we intermingle our fundamental philosophy and our treatment techniques with others, the more we intermarry, the more likely we will become enfeebled, the more likely we will degenerate, the more likely we will eventually disappear. Though speaking in another context, the Durants offer a lesson we must accept: "All strong characters and peoples are race conscious and are instinctively averse to marriage outside their own . . . group." (76, p. 26)

A Refusal to Accept the Common Verdict

As Hugh Sidey has noted, "History is a marvelous collection of stories about men and women who refuse to accept the common verdict that certain achievements (are) impossible." (77, p. 18) The history of occupational therapy is the story of the ideals, deeds, hopes, and works of *individuals*. Changes and advancements came from those who eliminated inhumaneness, which prevented or discouraged the sick and disabled from achieving their potential. These same individuals were willing to assume the care and responsibility for those *who were not highly valued by the society:* the mentally ill and retarded, the severely disabled—all those defined as "non-producing, . . . an economic burden." (65, p. 277)

In numerous places and on countless occasions these same individuals were derided, hated, or, at best, ignored, because they pressed for change in the human condition. Yet, they persevered, knowing there was nothing innately unusual about themselves or what they wished to achieve. Few ever saw their names inscribed on monuments.

They were a *cast* quite diverse in character, and largely obscured because of the immensity of the saga being enacted. A few received *speaking parts,* primarily through reporting their own clinical findings. Only very few were singled out to be stars. None ever became members of the *audience,* passively observing events. All were *actors*.

The very same can be said of the present occupational therapy generation. We are actors, not observers. We continue to willingly strive on behalf of those who are not highly valued

by the society. We refuse to see this as a burden. Rather, we perceive it as an obligation, as an opportunity, as a way of life.

Legacy of Experience

Too often we are disposed to think that those lessons another generation learned do not apply to the present generation. We should be remindful that there are two ways to learn: by our own experience and from those who have made discoveries, regardless of how long ago they were made. The experience of others is a magnificent heritage, and the more we learn from them, the less time we waste in the present, proving what already has been proved.

Those of us who are teachers and clinicians have a special obligation to pass on the legacy of experience, the knowledge of timeless principles and practices that do not change merely because times change.

Who They Were, What They Did

The legacy of experience suggests one more lesson. So often we are caught up in our daily activities we tend to forget what it is we owe those who came before us. All probably agree that each occupational therapy generation seemingly acquires a sense of self-sufficiency. It is true that we of the present occupy the positions that once were filled by others.

It is, however, of great import that we realize we are influenced by those who came before us more than we can truly know. Who they were and what they did has immeasurable bearing upon what we are and what we do. No generation is capable of isolating itself from its past. The past, plus what we are and what we do, greatly assists in fashioning our future.

The archives, the portraits and photographs, the published accounts, the personal memorabilia and scrapbooks are records of considerable moment. At the least, they are a profound reminder of the possibility that someday, someone may be looking back and may be wondering who we were and what we did.

Conclusion

It is altogether fitting and proper to conclude this lecture with the observations of two former Presidents of the Association, Mr. Thomas B. Kidner and Mrs. Eleanor Clarke Slagle. In 1930, Mr. Kidner offered a personal impression of the state of occupational therapy at the annual meeting of the Connecticut Occupational Therapy Society. In part, he said: "May we, therefore, look on occupational therapy—with increased faith as the years go by—as a natural means of aiding in the restoration of the sick and disabled to health and working capacity (which means happiness) because it appeals to all our human attributes." (57, p. 11)

Mrs. Slagle, a year after she retired in 1937, made this observation: "The story of the profession of occupational therapy will never be fully told, nor will that of the patients who have so abundantly appreciated the opportunities of the service. There has been no fanciful crusading 'for the cause'; it has meant that a few have perhaps borne many burdens, but in the slow process that make permanent things of great value, it can be said that there is a fine body of professional workers, experienced and well trained, coming forward and being welcomed

to a really great human service, that of helping to show the way to the person with large disabilities to make the best of his incomplete self." (78, p. 382) Finally, in an editorial "From the Heart," she concluded: "The integrity of your profession is in your hands. I bid you all Godspeed in your work." (79, p. 345)

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