

# Occupational Therapy Values and Beliefs, PART II

## *The Great Depression and War Years: 1930–1949*

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*We continue to explore our past while creating the Centennial Vision for the future.*

*“Mankind, in order to be happy and to maintain both physical and mental health, must be constructively occupied” (p. 293).<sup>1</sup> Occupational therapy “has a normalizing influence. It is natural for men to be occupied” (p. 18).<sup>2</sup>*

**H**elen Willard, an occupational therapy educator, and Jane Myers, an occupational therapist, captured and summarized important philosophical assumptions (above) that form the values and beliefs guiding occupational therapy during the period from 1930 to 1949. Others contributing to their beliefs emphasized the need to build or restore self-confidence as a change agent.<sup>3–5</sup> As Eleanor Clarke Slagle stated, “the distinguishing characteristic of treatment by occupations is the psychological fact that the patient is really working for himself” (p. 298).<sup>6</sup> This idea echoed the importance of constructive occupation that Willard and Myers were promoting. Overall, and not in any hierarchical order, the values and beliefs most often expressed during the period 1930 to 1949 related to the concepts of work, occupation, activity, normalcy, stimulation of the mind, function, health, and adjustment.

### **CONTINUING THE THEMES**

This article continues the process of identifying and organizing the beliefs, values, and ideas gleaned from the period 1930 to 1949. The formative years were discussed in “Occupational Therapy Values and Beliefs: The

Formative Years, 1904–1929” in the April 17, 2006, issue of *OT Practice* (pp. 21–23). Themes were identified from the literature based on historical context, including the people, places, and events that shaped the time frame. The operating assumption proposed by James and Mary Maxwell in 1984 continued as an organizing rationale. The Maxwells proposed that occupational therapy was created by drawing information and ideas from multiple sources of knowledge.<sup>7</sup> In other words, there is no single area of study or type of technology that led to the formation of occupational therapy as an established profession in the early 20th century. Instead many sources of knowledge, from the academic, service, and trade fields, shaped a unique body of information about the environment, and about occupying and using the mind, body, and soul in ways that would support the improvement of mental and physical well-being. This includes facilitating the person’s ability and capacity to function in social and community life as a participating and contributing member.

### **THE THEMES THEMSELVES**

The literature survey continues to be categorized into nine themes: (1) economics; (2) education; (3) health and medicine; (4) philosophy; (5) politics and government; (6) professions and professionals; (7) psychology and psychological concepts; (8) religion and spirituality; and (9) social themes and movements. However, the specific subjects changed in title and emphasis. Economic concerns included the Great

Depression. Education included the accreditation of training (educational) programs and the role of the American Medical Association (AMA) in setting the standards for training and for inspecting the schools. Health and medicine included cardiac conditions, cerebral palsy, curative workshops, habit training, industrial therapy, kinetic therapy, poliomyelitis, reconditioning of military personnel, therapeutic occupation, and tuberculosis. Politics and government included World War II, with career opportunities for occupational therapists in the military. Professions and professionals included the American Hospital Association (AHA), the AMA, the American Psychiatric Association and the roundtable discussion meetings, the Baruch Committee Report on Physical Medicine, discussion of combining occupational and physical therapy departments, definitions of occupational therapy, geriatrics, the history of occupational therapy, neurology, neuropsychiatry, New York State occupational therapy institutes, orthopedics, pediatrics, physical medicine, regulation of personnel, rehabilitation, research in occupational therapy, scope of practice, and sponsorship by medicine. Women in leadership roles in the American Occupational Therapy Association (AOTA) increased as they formed professional networks and partnerships. Psychology and psychological concepts included discussion of the terms *activity* versus *occupation* versus *work*. Social themes and movements included the Junior League, whose members continued to provide funds and volun-

## Figure 1. Historical Values and Beliefs Subjects

Accreditation  
American Hospital Association/AOTA Annual Meetings  
*American Journal of Occupational Therapy*  
AMA Council on Physical Therapy and Council on Medical Education and Hospitals  
American Psychiatric Association  
APA/AOTA Round Table meetings  
Baruch Committee Report  
Cardiac Conditions and OT Practice  
Cerebral Palsy Syndromes and OT Practice  
Combining Occupational and Physical Therapy Departments  
Curative Workshops  
Definitions of Occupational Therapy  
Founders  
Geriatrics and OT Practice  
Great Depression  
Habit Training  
History of Occupational Therapy  
Industrial Therapy  
Junior League  
Kinetic (Functional) Occupational Therapy  
Mental Hygiene  
Neurology and Neurosurgery and OT Practice  
Neuropsychiatry/Mental Hygiene and OT Practice  
New York State Occupational Therapy Institutes  
Occupational Therapy Services  
Orthopedics and OT Practice  
Pediatrics and OT Practice  
Physical Medicine and OT Practice  
Poliomyelitis and OT Practice  
Reconditioning of Military Personnel  
Registration of Practitioners/Registration Examination  
Rehabilitation Medicine and OT Practice  
Research in Occupational Therapy  
Scope of OT Practice  
Sponsorship by Medicine  
Terminology: Activity or Occupation  
Therapeutic Occupations  
Tuberculosis and OT Practice  
Women in Leadership Positions in the AOTA  
Women and OT in the Military  
World War II

teers to countless curative workshops across the county. Although the themes of philosophy and religion and spirituality were included, no topics were identified for either theme.

### DIFFERENCES

There were significant differences between the values, beliefs, and ideas in the periods 1905 to 1929 and 1930 to 1949. These included the expanded sponsorship by medicine, the rise of physical medicine and rehabilitation, differentiation from physical therapy, networks and partnerships by occupational therapists, changing theory in neuropsychiatry, expansion of pediatric practice, and the loss of progressive ideology.

Sponsorship as a concept applied to organizations and professions occurs within a framework of power and recognition. An organization or profession that has greater power, more recognition, or wider acceptance may use its influence to advance the cause of the less powerful organization.<sup>7</sup> Sponsorship has certain benefits and certain costs to both the sponsor and the sponsored organization. The sponsor may not be consistently altruistic and may act in an exclusionary and authoritarian or sovereign relationship toward the sponsored organization.<sup>8,9</sup> Although the sponsorship would be challenged in the next decade, medicine became the sponsor of occupational therapy practice during these early years, with the AMA becoming the sponsor at the organizational level. Both the practice of medicine and the AMA had greater power and recognition than did occupational therapy or AOTA at the time.

During the period of 1930 to 1949, several key events occurred to increase the degree of sponsorship assumed by medicine and the AMA over occupational therapy and AOTA. These events included the agreement between the AMA and AOTA to have the AMA establish educational standards (the Essentials) for recognizing and approving occupational therapy educational programs, the election of physicians to serve as president of AOTA, the requirement that a prescription be written by a physician before occupational therapy services could be provided to a patient, supervision of most hospital occupational therapy departments

by a physician (which began with the Veterans hospitals), and an advisory board to AOTA in which a majority of members were physicians. For example Thomas Kidner, the president of AOTA from 1922 to 1928, was responsible for establishing the contact with the AMA that led to the relationship between the AMA and AOTA to accredit the occupational therapy training programs.<sup>10</sup>

A strong suggestion beginning in 1930 to combine physical and occupational therapy departments under one hospital unit,<sup>11</sup> and the rise of physical medicine beginning in 1936, form the basis of the struggle by occupational therapists to separate themselves from physical therapists. During the previous period the primary problem of boundary and scope was with vocational education and training. Separation from vocational education and training continued, but the issue of clarification from physical therapy was added. Frank Krusen, MD, saw occupational therapy as simply a highly specialized branch of physical therapy.<sup>12</sup> In articles about physical and occupational therapy, occupational therapy was usually given second billing and explained only briefly.

Several women's networks and partnerships were developed or maintained through the time period. Eleanor Clarke Slagle was a central figure in several. She made use of political networks in New York State to foster a relationship with First Lady Eleanor Roosevelt. Slagle started a roundtable discussion group for occupational therapists at the annual meetings of the American Psychiatric Association. Fostering an ongoing relationship, she maintained an alliance with the AHA to have the AOTA annual meeting with the AHA meeting. Slagle also organized yearly institutes for chief occupational therapists in the New York hospitals in which prominent physicians were asked to speak.<sup>13</sup>

Changes in psychiatry also affected occupational therapy practice. Although habit training and Adolph Meyer's ideas about psychiatric illness dominated the earlier literature on occupational therapy practice in mental illness, new ideas were expressed between 1930 and 1949. These approaches included psychoanalysis (Freud), total push

(Myerson and Tillotson), communication (White), and dynamic psychiatry (Hinsie). Although the Veterans Administration hospitals and large asylums in New York, Pennsylvania, and Massachusetts continued to support habit training programs, other institutions and hospitals appear to have changed their emphasis to some other approach, adopting a new psychodynamic rather than a traditional somatic view.<sup>14</sup>

Children are mentioned much more frequently during this period than between 1917 and 1929. Occupational therapy in connection with cerebral palsy, cardiac conditions (rheumatic fever), and poliomyelitis is discussed in numerous articles.<sup>15–20</sup> The role of occupational therapy varies from functional training to diversion.

The loss of inspiration from the Progressive era is difficult to calculate, but the change in the tone and content of articles is noticeable. Philosophy is rarely discussed, and only broad general statements are provided, such as treating the whole person and man's inherent need for occupation. References to religion and spirituality were not found. The social movements that contributed many ideas and programs during the previous era had largely fallen silent, with the exception of the Junior League. The period from 1930 to 1949 is devoted primarily to practical matters, with war years dominating and a need for accreditation and recognition of the profession in hospitals and health care systems, including the Veterans Administration and state hospitals. The theory and philosophy of occupational therapy were not primary subjects.

## METHODOLOGY AND REPORTING FORMAT

Primary resources were *Occupational Therapy and Rehabilitation* (1930–1949), *Journal of the American Medical Association* (1930–1949), and a variety of other medical and related journal articles. Books were not a significant source during the time period because few occupational therapy texts existed, and the information was generally derived from previously published articles.

Forty subjects were explored, from which the values and beliefs statements

were drawn (see Figure 1 on p. 18). Six subjects continued from the early years: (1) curative workshops, (2) habit training, (3) mental hygiene, (4) orthopedics as a practice area, (5) therapeutic occupations, and (6) tuberculosis as a practice area. Important issues were the accreditation of educational programs and the criteria for registering occupational therapists and occupational therapy assistants (during this period, assistants were not the equivalent of today's assistant). Once identified, the value and belief statements were organized into the seven principles selected for the first report, with the additions of sections on qualities and qualifications, attitudes, and ethics (see Figure 2 on pp. 20–22). The section on ethics is the first attempt to outline ethical statements for occupational therapists. There were no new statements for the eighth principle on socio-cultural influences, so it was deleted.

Caldwell and Watkins may have summarized best the rationale for using occupation in therapy by stating that the occupation is not therapeutic in and of itself.<sup>21</sup> Rather, the attitude the patient has toward the occupation and the “creation of values that endure beyond the period of activity” are the real therapeutic contributions (p. 38).<sup>21</sup>

## NEXT STAGE

This second phase of the AOTA Ad Hoc Committee on Historical Foundations reviewed occupational principles that related to such topics as occupational therapy treatment outcomes described as personal change or therapeutic application, prevention, and philosophical assumptions and educational requirements.

The members of the Ad Hoc Committee on Historical Foundations are continuing to review the literature for values and beliefs pertinent to occupational therapy. The next report will include principles identified from 1950 to 1969. ■

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## FOR MORE INFORMATION

**A Professional Legacy: The Eleanor Clarke Slagle Lectures in Occupational Therapy, 1955–2004.** Edited by R. Padilla, 2005. Bethesda, MD: American Occupational Therapy Association. (\$52 for members, \$74 for nonmembers. To order, call toll free 877-404-AOTA or shop online at [www.aota.org](http://www.aota.org). Order #1234-MI)

**Perspectives for Occupation-Based Practice: Foundation and Future of Occupational Therapy** (2nd ed.). Edited by R. P. Fleming Cottrell, 2005. Bethesda, MD: American Occupational Therapy Association (\$65 for members, \$89 for nonmembers. To order, call toll-free 877-404-AOTA or shop online at [www.aota.org](http://www.aota.org). Order #1165A-MI)

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## Figure 2. Summary of Principles Drawn From Values and Beliefs: 1930–1949

### Principles related to goals and outcomes

#### Mental

- To provide worthwhile patterns of expression, self-esteem, and confidence.<sup>1–6</sup>
- To reawaken the patient's interest in life to restore morale and normalcy.<sup>2,7</sup>
- To facilitate the production of sublimations, give an outlet for repressed energy, and relieve boredom.<sup>2,5</sup>
- To arouse the interest, occupy the mind, and stimulate the ambition of patients so that improved morale will hasten both mental and physical recovery and overcome temporary handicaps.<sup>8,9</sup>
- To stimulate creative thinking and prevent formation of invalid and bad habits and the mental stagnation and depression that often accompany illness.<sup>10,11</sup>
- To promote an attitude that is more wholesome by providing for activities adapted to the patient's capacities and calculated to divert their attention from their own problems.<sup>12,13</sup>
- To give a new outlook on life to those unfortunate people who are crippled and quite unable to move about, but who yet can carry on occupation of some kind.<sup>14</sup>
- To train mental patients in orderly habits of thought and action and lead the patient again to normal activities.<sup>15</sup>
- To provide pleasant occupation that contributes to the cure of the child.<sup>10</sup>

#### Physical

- To heal or promote functional improvement of the body or mind.<sup>13</sup>
- To improve the quality of the patient's response to other forms of treatment, probably by improving general vitality.<sup>1</sup>
- To restore function to disabled joints; develop manual skills and coordination; and develop muscular strength, endurance, and work adjustments.<sup>2,11,16,17</sup>
- To bring interesting proper exercises during cure (i.e., tuberculosis).<sup>15</sup>

#### Social

- To resocialize the patient, raise morale, and foster a spirit of friendliness.<sup>2,3,18</sup>
- To develop group responsibility and cooperation, and reintroduce social habits.<sup>2,5</sup>
- To give opportunity for social contacts in normal activities.<sup>2</sup>
- To aid the patient in his adjustment to a life pattern changed by a disability either temporary or permanent.<sup>11</sup>

#### Work

- To maintain the habit of work or to assist in the reestablishment of the work spirit.<sup>13</sup>
- To provide prevocational training and aid in exploring interests.<sup>15,16</sup>
- To continue the education or training in some work in which the patient's physical condition will not be a deterrent.<sup>2</sup>

### Principles related to the process of occupational therapy

*Note: Those by Hill<sup>20</sup> are based on Dunton's principles of 1918*

- "The occupational therapist is trained to work under the direction of a physician and should be capable of suggested programs designed to recreate specific functions or to encourage restoration of impaired functions" (p. 1135).<sup>19</sup>
- In applying occupational therapy, the treatment should be prescribed and administered under constant medical advice and supervision and correlated with other treatment of the patient.<sup>20</sup>
- Occupational therapy is always subject to the limitations required by the medical authority in charge of the case. (Vocational rehab = economic; OT = functional improvement of the body or mind)<sup>13</sup>
- System and precision are usually as important as in other forms of treatment. Dosage should be exact. The object to be attained should be kept in mind and treatment should not degenerate into mere diversion.<sup>20</sup>
- "There are four principal stages in the com-

plete program—physical restoration, guidance, training, and placement. . . . The first, the physical restoration, is peculiarly within the province of the medical fraternity. It is in conjunction with that phase that occupational therapy has so far made its greatest contributions. . . . My contention is that occupational therapy by assuming a broader perspective can be still more helpful" (p. 10).<sup>7</sup>

- "Occupational therapy. . . was first used and developed for the more chronic patients, but is now being recognized as beneficial in treating the acutely ill as well. Its value lies in the fact that the patient who is kept rationally busy develops and maintains a healthy mental and physical tone which materially aids recovery and shortens convalescence" (p. 757).<sup>21</sup>

### Principles related to the therapeutic application of occupation

- Occupational therapy adds variety and interest to a barren and monotonous daily schedule which the average psychiatric patient is powerless to enliven because of his own lack of spontaneous enthusiasm and initiative.<sup>12</sup>
- "Similarly, in the informality of occupation, the patient will frequently manifest the inner psychological drives and needs even more clearly than in the conference room with the psychiatrist" (pp. 1546–1547).<sup>12</sup>
- "Much of the value of occupational therapy is derived from the manual activity and the satisfaction of concrete achievement" (p. 294).<sup>22</sup>
- "To liberate and develop the personality, occupational therapy pursues the use of functional activity, employing various methods of occupation, play, habit training, and group activity" (pp. 100–101).<sup>23</sup>
- Novelty, variety, individuality, and utility of the product enhances the value of the occupation as a treatment measure.<sup>20</sup>

### Principles related to prevention and the therapeutic nature of occupation

- Occupation prevents or slows deterioration.<sup>24</sup>

## Figure 2. Continued

- “Work (occupation) is the greatest stabilizer of the human system. Nothing can bring about normal behavior quite so soon as the concentration required by a set task, or the stimulus of interesting work” (p. 23).<sup>25</sup>
- “Occupation of the mind is often the best form of rest. Occupation of the hands is the means by which the mind may best be occupied” (p. 55).<sup>26</sup>
- The first consideration should be the assignment of such tasks as will benefit our patients.<sup>27</sup>
  - Adaptability to the patient's working position
  - Adaptability to patient's physical needs
  - Variability
  - Freedom from dangers and annoyances
  - Appeal
  - Stimulation of creative expression on the part of the patient
  - Suitability to budget and space allowance
  - Further application to previous vocation or hobby (pp. 42–44)<sup>28</sup>

### Principles related to philosophical assumptions

- “No occupational therapy can hope to succeed unless the patient is treated as a whole individual, with proper consideration for his economic, social, psychological and physical needs” (p. 191).<sup>29</sup>
- “Occupational therapy is based on the concept that work is essential to the health of every individual. . . . We must not lose sight of the fact that it is not work but the attitude toward work which is the real criterion for an evaluation of work as therapy. . . . Work may be defined as the creation of values that endure beyond the period of activity. . . . Work in the sense used here throughout may be interchanged with activity or occupation and connotes any overt expression of interest directed outside of the individual. It may range from the simplest physical effort to the highest mechanical or intellectual skill” (p. 38).<sup>30</sup>
- “Mankind, in order to be happy and to maintain both physical and mental health, must be constructively occupied” (p. 293).<sup>31</sup>
- Occupation has a normalizing influence. It is natural for men to be occupied.<sup>2</sup>

### Principles related to education

- “The Committee [National Registration com-

- mittee chaired by Kidner] and other members consulted felt that the inspection of the schools had better be undertaken by some organization apart from the AOTA” (p. 2).<sup>32</sup>
- “The Council on Medical Education and Hospitals of the American Medical Association in cooperation with AOTA establishes standards, inspects and approves schools, and publishes lists of acceptable schools” (p. 541).<sup>33</sup>
- In 1930, the Minimum Standards required 165 hours of instruction, including mental sciences, 35 hours; physical sciences, 50 hours; medical lectures, 25 hours; occupational therapy, 45 hours; and electives, 10 hours; plus 1,000 hours of training in occupations. Six months of hospital practice training was required.<sup>34</sup>
- “It is recommended that hospitals or institutions specializing in general, orthopedic, tuberculous [sic], and children's diseases be used wherever possible” (p. 423).<sup>35</sup>
- The 1938 Essentials required 30 hours of theoretical instruction, including 15 semester hours of biologic sciences, 4 of social science, 4 in the therapy of occupational therapy, 4 in clinical subjects, and 3 elective and 30 semester hours of technical instruction in arts and crafts, education therapy, and recreational therapy. Nine months of clinical affiliations were required; the 1943 Essentials changed the wording to 36 weeks.<sup>36</sup>
- “Occupational Therapy Technicians: This course should be at least 2 years in length and is best offered in colleges. It should preferably be combined with work required for a bachelor's degree” (p. 409).<sup>37</sup>

### Principles related to sociocultural influences

Combined with the other principles.

### Principles related to the qualities and qualifications of an occupational therapist.

#### The therapist:

- Must have a sincere desire to help and serve the patient.<sup>38</sup>
- “Is especially interested in the weak, the maimed, the blind, the mental casualties, the failures in life—those with whom society in general want no personal contact” (p. 294–295).<sup>39</sup>
- Should be sensitive to self and to others, emotionally responsive, a good leader and

teacher, and intellectually hospitable.<sup>40</sup>

- Should be resourceful, handy with tools, and skilled in the crafts.<sup>40</sup>
- “Should have a diverse knowledge to break down barriers that the patients may have built up” (p. 246).<sup>41</sup>
- “Should not consider themselves mere supervisors of patients, but should at all times be on hand to instruct, praise, and to assist the patients with the work” (p. 55).<sup>27</sup>
- Should have a real human interest in helping patients.<sup>42</sup>
- Must have a liking for all types of people and an objective viewpoint.<sup>39,42</sup>
- Must be a pillar of security, yet she must have an easy naturalness and facility of being approachable with patience and politeness.<sup>39</sup>
- Has a scientific understanding of the patient: His physical condition, mental reaction and capacities, and his economic position and the object of the occupational therapy treatment.<sup>38</sup>

### Principles related to attitudes of the occupational therapist

- The attitude of the therapist should be objective.<sup>42</sup>
- “The occupational therapist should have an attitude in which service is uppermost” (p. 313).<sup>43</sup>
- The therapist demands no greater reward than the satisfaction of accomplishment and occasional verbal recognition.<sup>43</sup>
- “He will respect intelligence and experience and willingly submit to judgments based on them” (p. 313).<sup>43</sup>
- “He will read, write, or teach others what he believes is useful to other professionals” (p. 313).<sup>43</sup>

### Principles related to ethics for the occupational therapist

- Her first duty is toward the patient: his comfort areas always to receive first consideration.<sup>44</sup>
- It is her duty to do all she can to eliminate conditions which she considers adverse to her best professional services.<sup>44</sup>
- The therapist must be discreet concerning her criticisms and not talk them over with patients and the people with whom she comes in contact in her social life.<sup>44</sup>
- Loyalty to the patient demands that his rights

## Figure 2. Continued

be respected and his private affairs should not be used as a general topic of conversation.<sup>44</sup>

- In dealing with patients, honesty, frankness, and wisdom are essential attributes.<sup>44</sup>
- The therapist will be careful to curb her ambitions and not profit at the expense of others.<sup>44</sup>
- The therapist has a duty to the demands of absolute justice, charitable judgment, and helpful service.<sup>44</sup>
- High personal standards of conduct create high professional standards.<sup>44</sup>

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