Opening Feminist Histories of Occupational Therapy

Gelya Frank

Key Word: women, working

This paper frames the history of occupational therapy in feminist terms. It focuses on gender segregation in occupational therapy, the influence of class and race in shaping opportunities for occupational therapists, and the place of feminism in the goals and achievements of the occupational therapy profession. Such issues have been addressed by feminist scholars in histories of women in medicine, nursing, and other helping professions. These sources help place the achievements of occupational therapy within the context of women's historic entry and advancement in the American work force.

Histories of occupational therapy have shifted increasingly from chronicles to interpretive studies in historical contexts that use theoretical perspectives (Breines, 1986; Gritzer & Arluke, 1985; Kielhofner & Burke, 1977; Levine, 1983, 1986, 1987; Pelouquin, 1989). But even after two decades of feminism, the analysis of gender issues has been almost entirely overlooked (Irwin, 1987; Jantzen, 1972; Litterst, 1992; Mathewson, 1975). It is a startling omission for a field in which the membership is overwhelmingly female.

In the past 20 years, feminist histories have appeared of nursing (Ehrenreich & English, 1973; Melosh, 1982, 1984; Reverby, 1984, 1987), medicine (Morantz, 1982), other health professions and popular health movements (Leavitt, 1984), and the Progressive Era reforms contemporary with the founding of occupational therapy (Cook, 1977; Frankel & Dye, 1991). It would be a pity not to use them as an opening for feminist histories of occupational therapy.

Concerning the history of occupational therapy, we can begin by asking: How has the profession's particular pattern of gender segregation emerged and what effect has it had on the profession? In what ways have gender stereotypes contributed to the development of the occupational therapy profession? What differences in the power of women on the basis of class and race have existed within occupational therapy and between occupational therapy and comparable fields? What is the relationship between women's participation in occupational therapy and progressive social change?

The Founding of Occupational Therapy: Social Class and the Construction of New Opportunities for Women

Occupational therapy was officially established in 1917 with the founding of the National Society for Promotion of Occupational Therapy (NSPOT), later renamed the American Occupational Therapy Association (AOTA) (Reed & Sanderson, 1983). The initiative to form the organization is credited to three upper-middle-class men inspired by the Arts and Crafts Movement who recognized the benefits of the curative workshop—a physician, William Rush Dunton, Jr., and two architects, George Edward Barton and Thomas B. Kilner.

The female founders of occupational therapy, also inspired by the Arts and Crafts Movement, were a nurse, Susan E. Tracy; a teacher, Susan C. Johnson; and a social worker, Eleanor Clarke Slagle. The presence and visibility of women among the founders was due to their upper-middle-class background and their membership in organized professions that accepted women. (Isabel Newton, who worked for and soon married George Barton, and who served as the first secretary of the Association, did not accept a formal leadership role. "Except for Miss Newton," wrote Licht [1967, p. 276], "each of those present

Gelya Frank, PhD., is Associate Professor, Department of Occupational Therapy, University of Southern California, 2250 Alcazar, CSA 203, Los Angeles, California 90033.

This article was accepted for publication June 17, 1992.
was made chairman of a committee... Each of the members except Miss Newton spoke.

The new field began "to attract young women as nursing had since the days of Florence Nightingale" (Kahnmann, 1967, p. 281). The founders viewed the direct work with patients using activities as a role for women. These occupational therapy "aides" were subordinate to physicians, nearly all of whom were male. In World War I, the United States Surgeon General promoted exclusive recruitment of women as reconstruction aides to work with wounded soldiers. It was argued that women would promote the morale and motivation of incapacitated men with the least disruption of discipline (Litterst, 1992).

Women of select background were the first recruited for these positions. The Boston School of Occupational Therapy, founded in 1918, advertised for candidates on the society pages of newspapers in Boston and Los Angeles (Litterst, 1992). This picture of upper-middle-class background and ideals in the first generation is corroborated by Florence Cromwell:

My informal research indicates the early workers were largely of high middle or upper middle classes. As a time when not very many women went to college for the time-honored professions, more were apt to go to some finishing school and then do "good works" in their communities... It really was "good work," and done by ladies who had a real commitment to social needs and causes. (personal communication, January 21, 1992)

Nursing history provides a framework for further analysis of the early occupational therapists' social class and options. Nursing drew women from working-class and middle-class families (Melosh, 1984) and, by World War I, required 3 years of training (Rosenberg, 1987). Formal educational requirements for occupational therapy, by comparison, were minimal. Uniform national standards, the essentials for an acceptable school of occupational therapy established by AOTA in conjunction with the American Medical Association, were adopted in 1935, leading to the current requirements of at least a baccalaureate degree, including study of biological and behavioral sciences, pathological conditions, and specific occupational therapy techniques and a minimum of 6 months of full-time fieldwork. But in 1918 only a 6- to 12-week course was needed (Hopkins, 1983, 1988; Jantzen, 1972).

As early as the 1890s, nurses were in oversupply (Reverby, 1984). Most nurses worked in private duty. Demand for their services declined because of the drastic increase in hospital-based medicine, hospitals' reliance on the cheaper labor of nursing students rather than of graduate nurses, and the growing inability of the middle class to afford hiring nurses for lengthy home convalescences. Public health nursing leader Lavinia Dock counseled nurses in 1898 to specialize "by branching into auxiliary lines of work not strictly nursing, yet which can better be done by one having the training of nurses." (quoted in Reverby, 1984, p. 461). Some nurses shifted to occupational therapy, perhaps trading higher wages for better working conditions, including improved job security. Susan Tracy, who at the time of the founding of NSPOT was a private duty nurse, contended that occupational therapists should be recruited from among nurses only; not surprisingly, Slagle, the social worker, and Johnson, the teacher, disagreed with her (Loomis, 1992; Reed & Sanderson, 1983). Nurses needed their incomes. Even before the Depression, 53% of private duty nurses were responsible for partial or full support of one or more dependents (Melosh, 1984). From the 1880s until the mid-1890s, graduate nurses received $15 to $18 a week; by the late 1890s, they were commanding $20 to $25 a week. Other women's fields paid less. In February 1917, one month before the founding of NSPOT, the want ads of The New York Times listed the salary range for a stenographer as between $7 and $12 a week (Licha, 1967).

Occupational therapy offered interesting and useful employment for women between nursing, on the higher end of the scale of opportunity in the women's professions, and secretarial work, on the lower end. The monthly salary for a reconstruction aide in World War I was $50 in the United States and $60 abroad, but only single women were permitted to go to Europe (War Department, 1918). Litterst (1992) comments that although "fairly reasonable" (p. 24) for the time, the wages were not adequate to support a family.

The excitement and gratification offered by the new field in those early years is evident in the account of Winifred Brainerd (1967), who in 1911 became director of The Industrial Room at the Sanitarium, Clifton Springs, New York. Brainerd began by rejecting other career options that were less interesting and no more remunerative. For 5 years she had been a teacher and supervisor of handwork in the Indianapolis public schools and, during summers, an instructor of elementary handwork at the University of Virginia. She fell in love with occupational therapy because of the creativity and autonomy the practice afforded in a communal setting.

Research is needed to reconcile the image of nurses as working women competing for status, autonomy, and wages (Melosh, 1984; Reverby, 1984) with that of occupational therapists — some of whom were nurses — as social-minded young women doing "good works." Two questions are important to resolve: when and how the cohort of occupational therapists expanded beyond the upper-middle and upper classes, and how social class contributed to the shaping of the profession.

The second question may be easier to answer, considering the achievements of Eleanor Clarke Slagle, the best-documented figure in occupational therapy history (Cromwell, 1977; Loomis, 1992; Reed & Sanderson, 1983). Slagle came from an upper-middle class professional family related to Theodore Roosevelt and active in New York State Republican party politics. Her brother, John D. Clarke, was a Republican representative to the
United States Congress from the 34th district. Roosevelt’s wing of the Republican party, while avidly militaristic and interventionist, was often the standard bearer of progressive policies on the domestic front (McDonald, 1970).

Slagle was privately educated by tutors and attended college, including the summer session of Columbia University. In 1911, as a 34-year-old widow, Slagle enrolled as a social work student at the Chicago School of Civics and Philanthropy. In 1913, she moved to Baltimore to become Director of Occupations under psychiatrist Adolph Meyer at the Henry Phipps Psychiatric Clinic at Johns Hopkins Medical School. At the time of Slagle’s work there, Johns Hopkins was the premier elite institution of medicine in the United States. It was the model for the Flexner Report’s recommendations on medical education in 1910 and, shortly after, became the favored recipient of philanthropy to improve medical education from the Rockefeller Foundation (Brown, 1979).

Slagle left the Phipps Clinic after 2 years to become General Superintendent of Occupational Therapy at Hull House in Chicago. From 1915 to 1920 she was Director there of the Henry P. Pavill School of Occupations, occupational therapy’s first school. Slagle’s clinical position under Meyer may have been too limiting for the dynamic woman who went on, from 1921 to 1942, to serve as Director of Occupational Therapy in the New York State Department of Mental Hygiene, where she built up a staff of 225. As described by a contemporary, Slagle was “an impressive woman who literally built an empire through her belief in occupational therapy and by her political astuteness, achieved control over the Commissioners in New York State to support her programs” (Cromwell, 1977, p. 646).

Occupational therapy histories say little about the development of occupational therapy at Johns Hopkins under Adolph Meyer after Slagle’s departure. It is striking that no connection between occupational therapy and the Rockefeller Foundation seems to have been established. Perhaps the Rockefeller Foundation’s aim of advancing biomedicine, a reductionist science, was at odds with the holism of early occupational therapy (Kielhofner & Burke, 1977). Yet substantial gifts were offered by the Rockefeller Foundation to other organizations devoted to improving public health, such as Margaret Sanger’s birth control clinic (Reed, 1984) and the National Association of Colored Graduate Nurses (Hine, 1984).

Slagle’s use of formal and informal class-based networks and her beliefs contributed a role for a particular kind of woman in occupational therapy. The Boston School of Occupational Therapy did the same through similar upper-middle- and upper-class connections (Litterst, 1992). The Boston School’s advisory board was composed of prominent Boston physicians and its executive committee of well-placed educators and clergy — both groups all male. Schools in New York and Philadelphia were likewise tied to society circles, in which certain women served as links and exercised important influence:

Joel Goldthwait was on the surgeon general’s staff during World War I and was responsible for writing the guidelines for the formation of both physical therapy aides and reconstruction aides. Herbert Hall’s [a leading physician and proponent of occupational therapy] wife was a Goldthwait, and Joel Goldthwait’s wife was a member of the original founding committee of the Boston School of Occupational Therapy. . . . Of the three women who formed the personnel committee of the Boston School of Occupational Therapy in May 1918, two were related to men on the surgeon general’s staff. (Litterst, 1992, p. 21)

The efforts of such women were remarkable in creating a path that less educated or advantaged women soon would take to enter the labor force and public life. Complex, class-based tensions within the field would arise later around issues such as raising standards of entry-level education and licensure. In the 1950s and 1960s, AOTA rejected licensure as a threat to the autonomy and status of a proper profession. The profession lost ground under Medicare because of its consequent inability to bill directly for services (Gritzer & Arluke, 1985), but may have avoided some degree of further subordination to doctors and legislators.

The way that occupational therapists have tended to portray themselves nationally — as having a profession rather than a job — reflects the dominance of middle-class over working-class models of empowerment. A task for future feminist research will be to consider how women less well known than the founders, from other backgrounds, using other networks, also have shaped the field given changing social conditions and a broadened range of institutional settings.

Sources and Effects of Gender Segregation in Occupational Therapy

Gender segregation is defined by Strober and Lanford (1986) as a disproportion of females to males in an occupation relative to either the adult population or the labor force. As these authors pointed out, the prevalence of gender segregation in the United States overall is longstanding and tenacious. Today, as in 1900, two thirds of all men and women employed would have to change their jobs to achieve the same distribution across occupations. Strober and Lanford underscored at least two deleterious effects: (a) choices of jobs by men and women less according to their talents and skills than to societal stereotypes, and (b) differentials of about 60% in the wages of women full-time workers as compared with those of men.

Occupational therapy is a typical gender-segregated profession. In the United States, membership in the profession includes 38,900 occupational therapists and 9,500 occupational therapy assistants (AOTA, 1990). The percentage of female occupational therapists (94.3%) (AOTA, 1990), is comparable to that of female dietitians (95%) and registered nurses (94.5%) (see Tables 1 and 2).
Within occupational therapy, the predominance of females has been seen as natural and barely questioned. Hopkins (1983) stated simply that “very few men worked in the profession of occupational therapy so it was looked upon as a women’s field” (p. 13). From 1941 to 1946, she noted, the number of occupational therapists almost doubled to 2,265, but the number of men in the profession remained at 50, about 2.5%. The urgent demand for men to serve in the military during the war years does not account for their very low representation in subsequent decades.

Gender stereotypes have played an important part in establishing occupational therapy’s reputation as a women’s field. More than one male occupational therapist has attributed his choice of the profession in the late 1960s to the information he received from AOTA made no mention of the preponderance of women in occupational therapy. After choosing a particular university because of its occupational therapy program, he was unprepared to find himself in classes full of women.

The founders of occupational therapy, male and female, believed in women’s special aptitude for the work. In his introduction to the field’s first textbook (Susan E. Tracy’s Studies in Invalid Occupation), physician Daniel Fuller (1913) described the ideal occupational therapist as female: “The personality of the teacher and nurse therefore becomes an important factor. Her real enthusiasm and love for the work react most powerfully on the patient” (p. 5). Eleanor Clarke Slagle also presented conventional ideals of femininity in describing the occupational therapist (“aide”) in psychiatry:

For the work with mental patients one would naturally select the older woman. Do not, however, understand that there is not a place for the young woman—there is—but the responsibility of training them to understand behavior in terms of symptoms is one that all directors or teachers are not prepared to assume.... We sense the proper balance of qualities, proper physical expression, a kindly voice, gentleness, patience, ability and seeming vision, adaptability that will make it possible under most circumstances to meet the particular needs of the patient in all things, or in other words to play the part and ability to live, as it were, for a little time at least, in the world of the patient. ... Personality plus character also covers an ability to be honest and firm, with infinite kindness, infinite patience and infinite gentleness. (1922, p. 12)

Feminist scholars writing about women in nursing and medicine have drawn upon historian Nancy F. Cott’s (1977) account of the origin of the feminine ideal in America. Cott’s work indicated that the gender traits we think of as traditional and even natural originated during the period of rapid industrialization in the early 19th century. What Cott called a “cult of domesticity” emerged when middle-class women and men began to experience stress from work and home. This was expressed culturally by an increased emphasis on women’s emotional attributes versus productive labor.

That the female founders of occupational therapy were single or, in Slagle’s case, widowed, is consistent with that cultural model in which marriage and employment were incompatible for women of the middle to upper classes. The same pattern existed among the first female physicians, as well as many of the female social reformers of the Progressive Era (Cook, 1977; Morantz, 1982). It is now accepted, perhaps even expected, that women in the middle class should marry and work (Hochschild, 1989).

For women in occupational therapy who tended to marry in more recent decades, the profession proved favorable for working part-time or not working during child-bearing and child-rearing years (Jantzen, 1972). As leaders in the field noted with concern, the resulting truncated or intermittent career model weakened efforts to upgrade the profession (Brunyate, 1967). At the same time, less competitive entry requirements and salary

---

### Table 1

<table>
<thead>
<tr>
<th>Gender of Occupational Therapists</th>
<th>Gender</th>
<th>OTRs (%)</th>
<th>COTAs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td>94.3</td>
<td>91.8</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>5.7</td>
<td>8.2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Note.** OTR = registered occupational therapist, COTA = certified occupational therapy assistant.

The percentage of females among all therapists is much less, 76.6% (“Employment in health jobs,” 1991) (see Table 2).

### Table 2

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Women (%)</th>
<th>Black (%)</th>
<th>Hispanic (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrators</td>
<td>175,000</td>
<td>66.5%</td>
<td>7.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors and dentists</td>
<td>871,000</td>
<td>17.8%</td>
<td>3.0%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>1,673,000</td>
<td>94.5%</td>
<td>7.4%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>171,000</td>
<td>37.2%</td>
<td>4.1%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Dieticians</td>
<td>83,000</td>
<td>95.0%</td>
<td>20.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Therapists</td>
<td>525,000</td>
<td>76.6%</td>
<td>6.0%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Doctors’ assistants</td>
<td>67,000</td>
<td>39.6%</td>
<td>6.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed practical nurses</td>
<td>443,000</td>
<td>96.5%</td>
<td>17.6%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Laboratory technicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and technicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental hygienists</td>
<td>297,000</td>
<td>76.5%</td>
<td>15.1%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Health record technicians</td>
<td>87,000</td>
<td>99.1%</td>
<td>2.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Radiologic technicians</td>
<td>69,000</td>
<td>94.0%</td>
<td>15.4%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Service</td>
<td>123,900</td>
<td>76.4%</td>
<td>12.8%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Nursing aides, orderlies and attendants</td>
<td>1,452,000</td>
<td>90.8%</td>
<td>30.7%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Other aides, non-nursing</td>
<td>448,000</td>
<td>84.5%</td>
<td>21.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Dental assistants</td>
<td>187,000</td>
<td>98.7%</td>
<td>5.6%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

ranged kept the professional stakes down for women who valued the flexibility and could afford to drop in and out. Mathewson (1975) argued that the same socialization that suited women to be occupational therapists worked against them in terms of advancing the profession. The feminine role was too "nondominant, emotional, and sympathetic" (p. 602).

Explaining the sources and effects of occupational therapy's gender segregation in terms of socialization into female roles focuses on reasons why women choose the profession. A supply-side explanation, it says nothing about women who have chosen predominantly male fields despite their female socialization or whose actions deviate from the feminine ideal. Also important in explaining occupational therapy as a women's field is demand—changes in opportunities and discrimination in the labor market.

Some gender-segregated occupations have undergone reversals, as in the case of secretarial work, bank-telling, and teaching, which switched from male to female. These reversals are linked to decisions by men to leave the occupation for relatively higher pay and greater autonomy in other occupations, where they have first choice (Strober & Lanford, 1986). When men remain in what are considered women's fields, they are disproportionately represented in managerial positions (Strober & Tyack, 1980) and in the field's most prestigious and highly paid sectors (Strober, 1992). Strober and her colleagues suggested that when men begin to enter women's fields, like physical therapy or nursing, it is because they perceive economic gains relative to other options.

A health profession, occupational therapy competes for resources within structures highly stratified by gender and race ("Employment in Health Jobs," 1991; Ginzberg, 1983) (see Table 2). Women, who compose more than 70% of the health work force, are "notoriously absent from the higher professional echelons of doctors and administrators" (Rodriguez-Trias, 1984, p. 113). Men tend to be employed in the few most highly skilled and highly paid jobs, whereas large numbers of women occupy subordinate positions. Opportunities in this competitive arena, and in the work force more generally, affect the relative attractiveness of the profession to women and men.

Within occupational therapy, women aspiring to advancement have been sheltered by its gender segregation from overwhelming competition with men for jobs, leadership roles, and other forms of recognition. The percentage of men in occupational therapy is higher among occupational therapy assistants (8.2%) than among occupational therapists (5.7%) (AOTA, 1990). The statistics suggest that, although they are few, some less educated, working-class men have discovered a route to advancement in the labor market as occupational therapy assistants.

In the aggregate, gender segregation works against the interests of all women in achieving full economic equality. Yet gender segregation has worked in occupational therapy to advance the interests of some women within a larger historical framework of women's entry into the work force and economic empowerment. Without doubt, many occupational therapists enjoy working in and contributing to a professional environment shaped by women's culture, with its emphasis on care rather than competition.

Comparisons with other health professions and women's fields could help clarify occupational therapy's prospects given its gender segregation. Further, feminist analyses of the relationship between gender and caregiving (Abel & Nelson, 1990) could help distinguish the advantages and disadvantages of considering the nature of the work and its attitude of practice inherently female.

The Struggle for Recognition of Occupational Therapy in the U.S. Army: Differential Opportunities for White and Black Women

Fields like nursing and occupational therapy provided career opportunities for women at a time when other more prestigious and lucrative fields were closed. For example, between 1910 and 1960 (except during wartime), medical schools maintained quotas limiting women to about 5% of admissions (Morantz, 1982; Starr, 1982). (This policy was due in part to the elimination of competing medical sects that had been more receptive to women than the "regular" (i.e., nonsectarian) physicians who gained control of the profession through licensing laws based on the Flexner reforms.)

It is likely that during much of the history of occupational therapy, as in medicine and nursing, white women only needed apply. Minority representation in the profession was reported in 1985 to be "very low, about 7 to 8 percent" and had "changed very little since 1973" (AOTA, 1985, p. 6). In 1990, it was 8.5% (AOTA, 1990). Within the stratified health professions, representation of nonwhites increases as the level of hierarchy descends. This pattern is replicated within occupational therapy in comparisons of occupational therapists with occupational therapy assistants (see Table 3).

Table 3

<table>
<thead>
<tr>
<th>Race or Ethnic Origin</th>
<th>OTRs (%)</th>
<th>COTAs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian, Alcut, or Eskimo</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Black</td>
<td>2.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>White</td>
<td>91.5</td>
<td>90.2</td>
</tr>
<tr>
<td>Other</td>
<td>0.8</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Total 100.0 100.0

Note: OTR = registered occupational therapist, COTA = certified occupational therapy assistant.
Reflections by Florence Cromwell indicate that the exclusion of nonwhites in occupational therapy took place within the larger pattern of racial segregation in American society:

Given the settings of early pre-OT schooling, craft schools, teacher academies, nurse training... there were only white "ladies" there. Carlotta Welles and I knew a number of the early ladies by family and locale, and they were that kind. It would have been completely impossible to think of many regular school graduates of any ethnic or racial background being attracted to such settings. (personal communication, January 21, 1990)

Official policies of racial segregation in the military point to the absence of nonwhites in particular fields as more the result of discrimination than lack of attraction. Occupational therapy and nursing offer a case in point. Both world wars were critically important for recognition and advancement of occupational therapy (Gritzer & Arluke, 1985; Hopkins, 1983). As late as World War II, occupational therapists were fighting for equality as women in the military, while qualified black women professionals struggled separately to enter the services as nurses.

During and after World War I (1914–1918), physical therapists and occupational therapists (reconstruction aides) were women drawn from the civilian population. Beginning in 1931, civilian women directors of dietary, physical therapy, and occupational therapy services engaged in an active campaign to enhance their status. They offered recommendations to the U.S. Surgeon General for the following benefits: a graduated salary scale competitive with the private sector, salary increases based on experience and responsibilities, and military status similar to that of the Army Nurse Corps (Lee & McDaniel, 1968).

During World War II (1941–1945), military status in the Medical Department was granted to dietitians and physical therapists with Public Law 77–828, passed December 22, 1942 (Lee & McDaniel, 1968). Occupational therapists were excluded despite efforts of AOTA and its supporters to influence Congress. Appointments of women dietitians and physical therapists in the Medical Department were not fully commissioned. They entailed less pay than appointments of comparable rank in the Women's Army Corps and carried fewer privileges, such as allowances for dependents. The Army-Navy Nurses Act (Public Law 80–36), approved on April 16, 1947, finally authorized the establishment of the Women's Medical Specialist Corps. It provided regular army status for nurses, dietitians, physical therapists, and, at last, occupational therapists.

By the end of World War II, more than 1,000 occupational therapists were providing services in the military hospitals in the United States and abroad (Hopkins, 1983). The number of commissioned occupational therapists in the Women's Medical Specialist Corps was far smaller, peaking in 1954 at 141 out of 571 (Lee & McDaniel, 1968). From that small cohort emerged a number of occupational therapy leaders whose contributions would benefit the profession for decades to come. Ruth A. Robinson, Wilma L. West, and Mary Reilly were among those who achieved commissioned status and its rewards.

Ruth Robinson was the first Army Medical Specialist Corps officer to rise to the rank of Colonel. From 1944 to 1952, she served as Chief of the Corps. An awardee of one of the Army's highest honors, the Legion of Merit, Robinson served as President of AOTA from 1955 to 1958 (AOTA, 1967).

Wilma West served as Assistant Chief of the Occupational Therapy Branch of the Office of the Surgeon General from 1944 to 1946, attaining the rank of Major in the U.S. Army Reserve. A graduate of Mt. Holyoke College and the Boston School of Occupational Therapy, West took her master's degree in the Department of Occupational Therapy at the University of Southern California in the first graduate program offered in the field. She later provided innovative and effective leadership as Executive Director and as President of AOTA and served as a Consultant in Occupational Therapy in the Division of Health Services, Children's Bureau, Department of Health, Education, and Welfare (AOTA, 1967).

Mary Reilly achieved the rank of Captain in the U.S. Army Medical Specialist Corps. Her academic contributions in the 1960s and 1970s as Professor in the Department of Occupational Therapy, University of Southern California, generated a dynamic line of research on the forms and functions of human occupation (Clark et al., 1991; Kielhofner, 1983; Kielhofner & Burke, 1977; Reilly, 1962, 1974; Yerxa et al., 1990).

During most of World War II, the U.S. Armed Forces, including its hospitals and medical personnel, were officially segregated by race. Only in 1945, as the war in Europe was ending, did the army begin to accept a quota of black nurses from among civilian volunteers. Within the year, because of severe shortages of personnel, the army ended its use of quotas rather than institute an unpopular draft of white nurses. The policy shift resulted from an unrelenting campaign led by black civil rights groups and the National Association of Colored Graduate Nurses (NACGN) (Hine, 1984).

Racial segregation existed not only in the U.S. Armed Forces but throughout the country's civilian institutions of nursing and medicine. Most hospitals, whether for white patients only or with separate units for black patients, excluded black physicians and nurses from practice (Starr, 1982; Strelnick & Younge, 1984). Black nurses trained and practiced in black hospitals (Rosenberg, 1987). Only in 1948, after its victory in the military, was the NACGN successful in pressuring the American Nurses Association to extend membership to black nurses. Present histories offer no clue to where black occupational therapists might have trained and practiced.

The provisions of the Army-Navy Nurses Act of 1947...
and the establishment of the Women's Medical Specialist Corps meant opportunities especially for white occupational therapists and black nurses. Black nurses were sufficiently established and organized to fight for recognition and make important gains in the army. Although regular army status provided a stepping stone for talented white women in occupational therapy, patterns of segregation in the military and civilian life suggest that black women were not positioned to benefit equally from that opportunity.

Understanding the routes by which blacks and other ethnic groups entered occupational therapy therefore means knowing more about the differential opportunities associated with the military, state institutions, public and private hospitals, schools, academic departments, and private practice. We may expect interesting, if not heroic, accounts of the establishment of occupational therapy programs at institutions serving blacks, such as Tuskegee Institute and Howard University—but they need to be recorded and published.

Heritage of Progressive Era Feminism and Political Activism in Occupational Therapy

Occupational therapy was founded during the Progressive Era, roughly 1900 to 1920 (McDonald, 1970). The first wave of feminism, which began about the time of the Conference on the Rights of Women at Seneca Falls, New York, in 1848, was in force. Feminism drew mainly upon women of the middle classes who benefitted from having an education and aspired to fuller emancipation. Still unsettled in this period were such questions as women's rights to own property, to initiate divorce and retain custody of children, to use birth control, and to vote (achieved only in 1920 with the 19th Amendment). Feminism's second wave began in the late 1960s and continues today (Lerner, 1979).

First wave feminists influenced by the Arts and Crafts Movement, Jane Addams and Julia Lathrop, who were instrumental in establishing occupational therapy, were outspoken and active politically on a wide range of issues. Lathrop, who at one time had studied bookbinding at the Kelmscott Press under William Morris, was responsible for reforms in mental health and juvenile correction in the State of Illinois (Addams, 1935; Levine, 1987). Addams, founder with Ellen Gates Starr of the Hull House settlement in Chicago, took public positions and mobilized support on immigration and labor policies, maternal and child welfare, and, during World War I, antimilitarism (Addams, 1961/1910; Davis, 1976).

Eleanor Clarke Slagle received mentorship and support from Addams and Lathrop to some degree (Loomis, 1992; Reed & Sanderson, 1983). They advised her to enroll at the Chicago School of Civics and Philanthropy in a course in curative occupations and recreation designed by Lathrop and Rabbi Emil Hirsch. In 1915, returning from Baltimore, Slagle became General Superintendent of Occupational Therapy at Hull House. According to Loomis (1992), this appointment coincided with Slagle's appointments as Director of the Department of Occupational Therapy for the Illinois Department of Public Welfare and Director of the Henry B. Favill School of Occupations. (The latter was part of the Illinois Society for Mental Hygiene, but located in Hull House, and only received its name in honor of Dr. Favill in 1917.)

Addams, older than Slagle by 16 years and a woman of comparable social class, served as president of the Women's Peace Party, later renamed the Women's International League for Peace and Freedom (Cook, 1977). She worked through the American Union Against Militarism, parent organization of the American Civil Liberties Union. Addams' political activism brought her in contact and cooperation with other feminists, such as Lillian Wald, founder of New York's Henry Street Settlement, a leader in the public health nursing movement and president of the American Union Against Militarism. Members of Addams' network varied in the extent to which they worked within the mainstream. Some took positions more overtly socialist, as did Crystal Eastman, or anarchist, as did Emma Goldman.

Disability was construed by Progressive Era feminists of various persuasions as a social and political issue. In her 1915 essay, "Women, War and Babies," Addams decried the wholesale production of disabilities through militarism:

As women we are the custodians of the life of the ages and we will not longer consent to its reckless destruction. We are particularly charged with the future of childhood, the care of the helpless and the unfortunate, and we will not longer endure without protest that added burden of maimed and invalid men and poverty-stricken women and orphans that war places on us. (Cook, 1977, p. 48)

Eastman, an attorney and journalist who investigated labor conditions and work accidents, also took a radical stance concerning the prevention of disabilities (Cook, 1977). In 1907, she wrote New York State's first workers' compensation law, which became the model for most such laws in the United States. In 1911, she wrote a critique of well-meaning and useful, but basically palliative efforts such as Red Cross relief funds and workers' insurance and compensation, compared with the effectiveness of enforcing safe working conditions:

Me spirit revolts against all this benevolent talk about workingmen's insurance and compensation... when the strong young body of a free man is caught up by a little projecting set-screw, whirled around a shaft and hurled to death, when we know that a set-screw can be countersunk at a trivial cost, when we know that the law of the state has prohibited projecting set-screws for many years, then who wants to talk about 'three years' wages to the widow;' and 'shall it be paid in installments [sic], or in lump sum?:' and 'shall the workman contribute?' What we want is to put somebody in jail... What we want is to start a revolution. (Eastman, 1978/1911, p. 261)
What has become of the feminism and political activism in which occupational therapy was founded? It seems impossible that the founders of the field could remain untouched and uninvolved with the pressing politics of the Progressive Era reforms. By searching, we may find exceptions:

I had three aunts out of 5 females of that generation [born 1880 to 1900 and high school educated] who worked, but at secretarial or sales lady work (as widows); only one was into feminist kind of work as a labor specialist inspecting work places for regulatory compliance of women's labor laws. She was a college graduate and a real exception to her generation. (F. S. Cromwell, personal communication, January 21, 1992)

Levine (1983) wrote that occupational therapy’s involvement in the Arts and Crafts movement, and with immigration and labor reforms, never developed further than the medical model. Federal legislation for the rehabilitation of World War I veterans in 1919 placed occupational therapy strictly within the prevocational or medical phase performed by physicians in the Veterans Administration (then Veterans’ Bureau). This legislation resulted in the U.S. Surgeon General’s and, by extension, occupational therapy’s loss of control to civilian educators of vocational rehabilitation for wounded soldiers (Gritzer & Arluke, 1985, Low, 1992).

During this period, the strength of the American Medical Association was consolidating. After about 1920, an increasingly unified and powerful medical profession took reactionary positions through the association on such public health reforms as universal health insurance, birth control, support for public dispensaries and clinics, free vaccinations, and free treatment by physicians, nurses, optometrists, or dentists for children in schools (Starr, 1982).

The increasing conservatism of the medical profession never totally eclipsed a concern among some physicians with issues of social justice (Falk, 1973; Lundberg, 1991). Urban and academic physicians associated with the nation’s elite medical schools and leading hospitals remained outspoken advocates of public access to medicine other than fee-for-service (Harris, 1966). Evidence of progressivism might be expected among occupational therapists associated with these sectors of medicine, in universities, and in agencies not dominated directly by medicine.

The Maternal and Child Health Bureau (MCH) is an example. Jane Addams and Lillian Wald campaigned for the creation of the United States Children’s Bureau, established under the Secretary of Labor (Cook, 1977, Ladd-Taylor, 1991). This agency was the forerunner of MCH, now located in the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services (Rosenthal, 1983). Beginning with the effective placement there of Wilma West as a consultant, MCH has been a long-standing supporter at the federal level of training occupational therapists and upgrading the academic base of the profession. In a statement in the mid-1960s, West put forward a politically progressive agenda for occupational therapists with goals of preventing disabilities and promoting health through community-based services for mothers and infants, preschoolers, and children and youth of school age:

Health and medical care in the future, then, will emphasize human development by programs designed to promote better adaptation, rather than by technologically oriented programs offering specific solutions to specific difficulties. . . . In economic terms, it [the new type of health program] must also be viewed as a capital investment designed to break into the poverty-sickness cycle. (1967, p. 312)

The MCH legacy needs to be explored. As recently as the late 1980s, MCH supported through doctoral training grants the establishment of a new academic discipline, occupational science, in the Department of Occupational Therapy, at the University of Southern California (Clark et al., 1991; Yerxa et al., 1990). MCH recognized a need for faculty with knowledge specifically about occupation to educate occupational therapists who will provide direct services. A study of relations between MCH and occupational therapy would document a tradition of assistance to mothers and children originating in feminist activism and social reform.

Conclusion

The founding of occupational therapy can be regarded with pride as a historic achievement of women who entered the work force to do good works and created, in the bargain, opportunities for women to achieve economic independence, professional status, and power. Like the first wave feminists, many of the founders were women from upper-middle-class backgrounds. Their advantages and education readied them, perhaps goaded them, to find fulfillment in creative service to humanity in the public sector.

Gender segregation in occupational therapy resulted directly from the exclusive recruitment of women. Gender stereotypes and a female culture emphasizing care over market competition contributed to occupational therapy’s identity as a women’s field. Yet the aspirations of women in occupational therapy, such as for equality in the military and professional status in civilian institutions, went beyond the subordinate role of aide endorsed by male and female founders. Eleanor Clarke Slagle embodies this tension; her career displays a split between the conventional ideologies of womanhood she espoused for occupational therapy aides and her own impressive exercises of political power.

As occupational therapists stimulated demand for their services, and as routes of entry into the profession proliferated, women with less education and advantage quickly joined the ranks. With the increasing bureaucratization of health care, many more served as workers filing...
a job than as free-wheeling program innovators like pioneer Winifred Brainerd. Two career tracks in occupational therapy came to exist—a full-time, lifetime career track that helped to advance the field competitively in the stratified health professions (exemplified by Ruth Robinson, Mary Reilly, and Wilma West), and a part-time or intermittent track with time out to be a wife and mother. Both career tracks have been advantageous to women, but not necessarily the same ones.

Economist Myra Strober’s work suggests that occupational therapy never became remunerative enough relative to other jobs to attract large numbers of male competitors. Future historians may find evidence also of subtle and not-so-subtle forms of discrimination against them. A close historical comparison between physical therapy and occupational therapy is certainly needed, given their similar start but diverging profiles along the dimensions of salary and gender.

Differences in the power of women on the basis of race and class are evident in occupational therapy. For decades the number of nonwhites in the profession, especially of blacks and Hispanics, has been small relative to the population. Blacks are disproportionately represented as certified occupational therapy assistants compared with registered occupational therapists, a pattern that mirrors stratification by race or ethnicity in the work force more generally.

Occupational therapy will have to take an active role in competitive recruiting and retention strategies to tip the balance. Initiatives from within the profession and recent federal grants to train minorities will be important to follow (especially as nonwhite women and men of any race or ethnicity both qualify as minorities). The successful outcome of struggles by white occupational therapists and black nurses in the military during World War II testifies, however, to the power of collective efforts for change.

The high society image of occupational therapy’s founders has obscured an important tapestry of the profession. Progressive Era feminism and politics of social reform are part of occupational therapy’s heritage. Like letters found in the attic from a well-travelled maiden aunt, this heritage should be brought out and treasured. Not only does it inform the profession’s continuing advocacy for the occupational needs of people with disabilities and chronic illnesses on the margins of biomedicine. Recognized explicitly, it may empower new generations of occupational therapists to see the profession as a pivot for activism to advance the position of women and to create needed social reforms. ▲

Acknowledgments

I thank the following scholars for their encouragement, lively criticism, and substantive contributions: Charles Christiansen, EdD, OTR, FAOTA, Florence Clark, PhD, OTR, FAOTA, Florence Cramwell, MA, OTR, FAOTA, Ruth Levine, EdD, OTR, FAOTA, Gina Montanez-Sanchez, PhD, Karen Sacks, PhD, Myra Strober, PhD, and Wilma West, MA, OTR, FAOTA.

References


---

**Home Rehabilitation Exercises**

*Especially for therapists working with clients to regain full range of motion...*

Home Rehabilitation Exercises: **Hand**, focuses on range of motion exercises for the hand.

Home Rehabilitation Exercises: **Shoulder, Elbow, Forearm, Wrist** includes range of motion exercises for the shoulder, elbow, forearm, and wrist.

Both booklets have space to note precautions based on your clients’ specific needs.

$3.00 each or 10 for $25.00 AOTA member

$4.20 each or 10 for $35.00 non-member

Order now with MasterCard or VISA! Call 1-800-SAY-AOTA (AOTA members), 1-800-654-5584 (MD members), or (301) 948-9626 (non-members).

---

**1993 Tandy Leather Catalog**

Easy leathercraft kits, group packs, how-to books and videos — all this and more are in Tandy's new catalog. And you get all at Wholesale Prices, so you SAVE up to 40%! For your FREE 108-page catalog, Wholesale Price List and information on FREE demonstrations for qualified groups, call: TOLL FREE 1-800-433-5546

Or write to: Tandy Leather Company, Dept. AJ1192, P.O. Box 2934, Ft. Worth, TX 76113.