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Living Forward, Understanding Backwards, Part I

In Part I of this article, AOTA President Robert K. Bing examines the founding principles of occupational therapy developed and published in 1925, and offers comments from some pioneering occupational therapists that help determine how the principles were enacted in practice. In Part II, to be published in next month's AJOT, Bing continues with more comments from the profession's pioneers, and he advances some thoughts on the principles for contemporary practice and future endeavors.

A century ago important events were taking place in settling the vast Great Plains; habitation and habilitation were well underway. Prior to the 1870s, most people believed that the area between the Missouri and Trinity Rivers, and the Rocky Mountains was a vast desert wasteland (1, p II). During and immediately following the Civil War, westward migration built rapidly; settlers arrived and established their homesteads. However, they faced nearly insurmountable problems. The farther west of the Missouri and Trinity Rivers they moved, the more difficult it became to eke out an existence and sustain a way of life.

Probably the best summary of the total problem is found in Webb's *The Great Plains: As one contrasts the civilization of the Great Plains with that of the Eastern Timberland, one sees what may be called an institutional fault, (comparable to a geologic fault), roughly following the 98th meridian. At this fault the ways of life and living changed. Practically every institution that was carried across it was either broken and remade or else greatly altered. (2, pp 8-9)

The pioneer settlers threw themselves on this barrier, the institutional fault, equipped with those tools, weapons, ideas, and institutions designed by Mother Necessity that had served long and well in the eastern woodlands. Their efforts to conquer the land failed until they developed a system of pioneering that was adapted to the new circumstances.

For instance, without the timber so abundant in the East, the settlers dug up the plentiful, thick sod and built their houses and, in some cases, fences, with it. The shallow streams and rivers, often dry in the summer, could not support life; therefore, the windmill was invented to gain access to the water, which was well below the surface of the land. Barbed wire was invented in lieu of the nonexistent wood. The pioneers began with what was immediately available, such as the wind and sod. Almost on a daily basis, adaptations had to be made, and soon these adaptations became a part of the way of life.

What served the pioneers best were their beliefs, ideals, and religious practices, which they brought with them as they emigrated to this new land. For the most part, these have remained unchanged, and today, one can see the continuous reenactment of practices embodying the ideals and values of a century ago.

This brief account of U.S. history illustrates a similar set of circumstances in occupational therapy. Throughout this century, occupational therapy has migrated across numerous institutional faults and has been thrown by Mother Necessity into the clutch of altered circumstances. Like the pioneers, we have begun our new life with what we brought with us or what was immediately available. We have had to discard, remake, or modify many of our artifacts and ways of behaving to survive and thrive. What have changed least throughout these past decades are our values, beliefs, and basic principles.

These migrations have taken their toll. Some of our adaptations have been so extensive that we no longer recognize their origins, and thus, we have become separated from our "rootedness," our uniqueness. In our zeal to succeed, we have selected some artifacts and ways of living that are historically or ethically ours and, in consequence, we are sometimes confused and frightened about our present and future. We see others picking up the traditional artifacts we dis-
carded and modifying them for effective use. As we debate issues that we think are related to our survival, we are largely ignoring those basic founding principles that have remained unchanged. These principles spoke eloquently of our uniqueness then, and they can again assist us in re-establishing a sense of balance in our present clutch of circumstances.

In this paper, I will examine the founding principles developed and published in 1925. Then comments from some pioneering occupational therapists and preceptors will be offered that help determine how the principles were enacted in practice and how they influenced the adaptations that have taken place. Finally, some thoughts on the principles for contemporary practice and future endeavors will be advanced.

The Founding Principles
The year was 1925. A committee of AOTA, made up of physicians and chaired by William Rush Dunton, Jr., one of the founders of the 20th century occupational therapy movement, met, deliberated, distilled, and compiled an outline of lectures on occupational therapy for medical students and physicians. In that document, they enunciated 15 principles or "rules for guidance in occupational therapy." (3, p 280) To a large extent, these were a modern restatement of moral treatment precepts practiced for more than 100 years in Europe and the U.S. that had essentially disappeared during the last quarter of the 19th century. Within a few phrases, the framers of the "1925 Principles" encompassed a definition, objectives, and statements on the use of a variety of occupations with different kinds of patients, therapeutic approaches, and the qualities and qualifications of the therapist.

The first principle affirmed that: "Occupational Therapy is a method of training the sick or injured by means of instruction and employment in productive occupation." (3, p 280) One is immediately struck by the significance of the relationship of learning through doing and purposeful activity. This emerged as a dominant theme in several other principles.

An internal frame of reference is evident in that the act of doing should be viewed from the perspective of the patient. For example, the treatment objectives "...sought are to arouse interest, courage, and confidence; to exercise mind and body in healthy activity; to overcome disability; and to re-establish capacity for industrial and social usefulness." (3, p 280)

Rules were established covering the extent of activities to be used, and attention was given to their properties and effect on the patient. The use of crafts and work-related occupations was emphasized; however, games, music, and physical exercise were not overlooked. "Novelty, variety, individuality, and utility of the products enhance the value of an occupation as a treatment measure." (3, p 281) A warning was given: While quality, quantity, and salability may have some merit, these must not obscure the main purpose or objective. Belief in the variable properties of occupation is evident in the statement: "As the patient's strength and capability increase, the type and extent of occupation should be regulated and graded accordingly." (3, p 280)

The framers of these principles went on to enunciate the quality of work to be expected as a therapeutic approach. "Inferior workmanship or employment in an occupation which would be trivial for the healthy, may be attended with the greatest benefit to the sick or injured, but standards worthy of entirely normal persons must be maintained for proper mental stimulation." (3, p 281)

A clear statement of the relationship between purposeful activity and the duality of mind and body is found in this principle: "The production of a well-made article, or the accomplishment of a useful task, requires health exercise of mind and body, gives the greatest satisfaction, and thus produces the most beneficial effects." (3, p 281) Involvement in group occupation was advised "...because it provides exercise in social adaptation and the stimulating influence of example and comment." (3, p 280)

The credibility and status of occupational therapy was evident in the statement that this form of treatment should be prescribed and administered under constant medical advice and supervision and correlated. ." (3, p 280) with concurrent treatment. Further, in the application of occupational therapy, "...system and precision are as important as in other forms of treatment." (3, p 280) Evaluation rested solely with measuring the effect of the occupation on the patient, the extent to which objectives were being realized.

One final principle addressed the qualifications of the practitioner: "Good craftsmanship...
ability to instruct... understanding, sincere interest in the patient, and an optimistic, cheerful outlook and manner are... essential.” (3, p 281) Elsewhere in the outline of lectures, the committee recommended that therapists and aides should have a “… therapeutic sense, the teaching instinct and a good mental balance. Personality constitutes over 50 per cent of the value of these workers.” (3, p 277)

A number of issues were joined: (1) purposeful work and leisure; (2) the inextricable union of body and mind; (3) occupational therapy as an educative process; and (4) the therapeutic use of one's personal qualities.

The literature from 1925 to 1941, the period of remarkable development in our profession, gives evidence of how the principles became manifest.

**Purposeful Work and Leisure**

Dunton discussed the crucial importance of interest and attention in several of his published works. To him, interest was “the state of consciousness accompanied by a more or less pleasurable emotional state. That is to say, an emotion is produced by the performance of a task, motor action, or by sensory stimulus.” (4, p 6) He footnoted that observation with the following: “The author believes that attention as distinguished from interest lacks the emotional content or accompaniment. ... This question of interest is of great importance and is, perhaps, the primary objective to be attained in all cases for whom occupational therapy is prescribed.” (4, p 6)

Early in her endeavors as a practitioner, Clare Spackman delivered a paper in which she brought up the perplexing problem of engaging the patient’s interest (5). “One of the therapist’s problems is in approaching the patient who refuses occupational therapy, yet he is often the one who needs it the most... Many patients scorn occupational therapy as being child’s play or beneath their dignity, or are frankly uninterested and apathetic...” (5, p 3) Her recommendation was to approach the patient through his or her interests. “There are few people who have not some interest to develop. It is the ability to discover this interest and to make the right suggestion at the right time that takes both experience and imagination.” (5, p 3) Spackman counseled: “The therapist’s greatest danger in her approach is failure to make her first contacts... sufficiently vital. Being in a hurry, and a tendency to consider only the physical motion necessary is her greatest pitfall. The need of psychological treatment... is as necessary as any other.” (5, p 5)

Martha Gilbert, an occupational therapist at the Choctaw-Chicksaw Sanitorium near Talihina, Oklahoma, certainly practiced purposeful work and leisure. This was an institution administered by the federal government that contained 75 beds for Indian children with tuberculosis and related diseases. In 1929, times were difficult, not only because of the Depression, but also because Indian children with chronic diseases were not highly valued, except by those who cared for them on a daily basis.

Gilbert developed a comprehensive occupational therapy program of appealing activities that activated the interest and attention of her patients. She reported: “Supplies for craft work were very meagre but the children were eager to learn, loved to draw and march to music and calisthenics to victrola records. There was no playground apparatus but long walks were permitted and the recreation period after supper was often a hunt for wild flowers or for nuts and wild berries...” (6, p 110)

For hand work, she used “... native growths and utilized pocketknives to fashion objects of interest... In Summer, clay from the hillsides; in Fall, leaves from the trees; and in Winter, anything from paper dolls to hooked mats and rugs were fashioned...” (6, p 111) Gilbert and her patients also cultivated a garden out of the barren, wind-driven soil. “To this little garden,” she reported, “the more able patients carried rich soil from the creek bottom in small cans and jars and a bucket brigade formed... kept the plants alive through a most unfavorable season... We harvested our peanuts with much gusto, used them in candy-making and picked our flowers to adorn the shops and schoolrooms...” (6, pp 111-112)

The children’s cultural background was a vital part of her treatment program. “We try to make much of the holidays; invent a game to suit our Indian puppets or try a health or ceremonial play or pageant to give us an excuse for ‘dressing up.’” (6, p 113)

**Conjoint Body and Mind**

The chief occupational therapist at Philadelphia General Hospital addressed the AOTA annual con-
ference in 1927. Ida Sands pressed the issue of occupation being curative through three spheres. She stated, "Occupational therapy through carefully selected and graded work develops resistance: (1) Spiritually—by keeping up self respect and developing ambition and initiative; (2) Mentally—by developing coordination and mental poise; (3) Physically—by developing weak muscles through adapted occupation." (7, p 118)

She defended the importance of spirituality in occupation in this way: "I have put spiritual rehabilitation first because it is often a delicate process. This form of rehabilitation is approached by the occupational therapist through understanding...that subtle quality which enables a person to estimate the needs and...possibilities of another." (7, p 118)

Sands related a pertinent anecdote about an examination given to a group of nurses. One question asked what qualities are desirable in an occupational therapist. A nurse answered: "...a continuous, bright, happy smile!" (7, p 119) Sands' retort, apparently not to the nurse, was: "The maudlin sentimentality of which this would be indicative is sometimes considered (by others) the peak of efficiency in occupational therapy." (7, p 119) She went on to point out: "Curative work...means much more than this sort of banality. It means through normal activity, through achievement, wholesome surroundings, by wise counsel at times, by enlarging the interests and in every way strengthening the personality of the individual to meet life." (7, p 117)

(President Bing will continue this discussion in Part II, in next month’s AJOT.)

REFERENCES
3. An outline of lectures on occupational therapy to medical students and physicians. Occup Ther Rehab 4(4): August 1925
7. Sands IF: When is occupation curative? Occup Ther Rehab 7(2): April 1928