Looking Back

Occupational Therapy Service: Individual and Collective Understandings of the Founders, Part 1

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Florence Stattel (1977) pleaded for a comprehensive history of occupational therapy, because such a history would provide perspective for contemporary understanding and future growth. Her rationale was also that occupational therapists might, in formulating a history, seize the awareness that occupational therapy has "extended an idea" in the universe (p. 649). The present paper is an attempt to explore those beliefs held by occupational therapists in the earliest years of our history and to examine the personal understandings of service found in the occupational therapy literature between 1917 and 1930. This seems an apt place to start. Any idea, including the idea of service, rarely exists in the abstract, but emerges instead from the larger context of the understandings and experiences of the person who holds it.

Sutton wrote in 1925 that "service is, or should be, one of the stellar ideals of occupational therapy" (p. 54). In 1972, a special task force of the American Occupational Therapy Association (AOTA) issued a comprehensive definition of occupational therapy that included the statement, "occupational therapy provides service" (AOTA, 1972, p. 204). An early characterization of the occupational therapist was that "she must have a deep desire to serve" (Northrup, 1928, p. 267). Because service is an idea articulated by most professions, some unique character of service must account for occupational therapy's emergence as a profession distinct from others. The ideas held individually and collectively by our founders reflect contemporary values and norms, forces that shaped their understanding of how they might serve others in a unique manner.

An Idea Extended

The service particular to occupational therapy involves three primary agents: patient, therapist, and occupation. These agents interrelate; forces across time shape both their nature and their relationships. The character and quality of service provided to any person thus exist within a particular context shaped by contemporary trends. Our current understanding of practice acknowledges distinct patient-therapist-occupation interrelationships as well as the trends that shape them. If, for example, one considers a hand therapist in private practice, the image of service in this context differs from that of a therapist treating patients in an acute psychiatric setting, even though both situations include the patient, the occupational therapist, and some form of occupation. The characteristics of a therapist that shape the type of service provided include his or her personal traits, education and experiences, frame of reference regarding occupation and patient rapport, understanding of professional roles, position and authority held within the treatment environment, and degree of commitment to standards within the particular agency. Similarly, the particular patient and his or her

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occupational performance strengths and problems, expectations for service, goals for treatment, attitude toward therapy, and environmental circumstances shape the service received. The particular occupations selected from self-care, work, or play-related arenas, whether targeting functional increases in cognitive, psychological, neuromuscular, sensory integrative, or social interactive performances, also characterize the service provided. There are many pictures of occupational therapy practice. Although no single picture of service exists, invariant features enable us to identify a practice as occupational therapy. The existence today of many forms of occupational service reflects the multifaceted yet singular understanding of our founders in 1917.

Historical inquiry discloses the invariant features of a service that may persist while also assuming different forms across time. A seminal idea can be extended while also being shaped in time. My particular inquiry aims to identify the founders’ characterizations of the relationships among patient, therapist, and occupation, in order to better grasp their understanding of service in the earliest decades of occupational therapy practice. My search has constituted an attempt to “search out those unusual roots carefully planted and nurtured by our forebears” (Bing, 1983, p. 800). These roots intertwine with major forces that shaped early service: hospital treatment, industry, and war. Additional societal trends toward science, education, sex stereotyping, and professionalization nourished the subsoil that shaped our growth.

I hope that this inquiry will help therapists to estimate the value of our current reflections about caring. Yerxa (1980), for example, said that “caring means being true to our humanistic and functional heritage with its concern for the quality of daily living of our patients” (p. 534). She appealed for our allegiance to that heritage. Johnson (1981) later cautioned against current forces that shape occupational therapy service into a form that might embarrass our forebears: “Part of the price we now pay is that our directions frequently seem to be predicated not upon the observations and concepts of our founders but upon external sources and influences” (p. 593). Many of us seem in this decade to regret the passing of a time in which we believe that it was somehow easier to care, to be humane, and to resist the forces that shape practice and service. The present inquiry aims to retrieve that time and to explore its influence in shaping the particular brand of caring that constituted occupational therapy.

Because the emphasis of this search is on the personal understandings that our founders had of the best way to serve in their time, a significant portion of the literature reviewed considers persons, personal stories, and personal philosophies. It seems apt to explore such narratives when researching a profession whose early aim was “not in the making of a product, but in the making of a MAN, of a man stronger physically, mentally, and spiritually than he was before” (Barton, 1920, p. 308). I also think it essential to consider, at least in broad strokes, what kind of world could want, shape, and nurture a service designed to reconstruct persons.

Crafting a New Service: Founders and Near Founders

In 1917, six persons gathered to found the National Society for the Promotion of Occupational Therapy: those attending the meeting at George Edward Barton and Dr. William Rush Dunton, Jr.’s, invitation were Thomas B. Kidder, Isabel G. Newton, Susan C. Johnson, and Eleanor Clarke Slagle. Because Susan Elizabeth Tracy was teaching a new course in occupation and could not attend, she was listed as an incorporator instead of a founder. Because Barton did not accept Dunton’s nomination of Dr. Herbert Hall, Hall was not included as a member of the founding group, but became an early member and later president of the Society. Tracy and Hall might thus be called near founders. Johnson (1981) described the group:

Our founders were physicians, architects, social workers, secretaries, teachers of arts and crafts, nurses, . . . Each brought a different perspective and came from a unique background and orientation, yet each observed the effects of occupation in their individual environments and believed in its curative powers. (p. 592)

Johnson (1981) characterized the group as a gathering of specialists who supported the wide use of occupation as a curative service. Each founder shared life in the world of 1917, a world quite different from that which we experience today. Dr. Sidney Licht (1967) permitted a colorful glimpse of contemporary self-care, work, and play in that era when writing about the founding of occupational therapy.

In 1917 there was neither television nor radio. For the first time that year, color movies ran in commercial theaters in New York. Admission to local movie houses was a dime for an adult and a nickel for a child. Children were not admitted unless accompanied by an adult. A loaf of bread cost a nickel; the annual cost of living for a family of four was $1,843. Dollar bills were longer and wider and obviously stretched farther. Homogenized milk had not been invented, but milk was delivered to homes 7 days a week by horse-drawn wagons. Neither electric refrigeration nor supermarkets existed. Oranges were prized Christmas stocking fillers, rare treats in winter. It cost a penny to send a postcard, a penny more to mail a letter. Most people who had telephones had party lines. There were no commercial flights. Ford’s touring car sold for $360. There were no traffic lights and no parking meters; 729 people were killed in automobile accidents during that year. Street lamps were turned on each night by janitors. That year, Binet developed the IQ test; Dewey endorsed new educational techniques that proposed learning by doing. Sanitation was not particularly good. Most cities had a hospital for contagious
diseases, and because antibiotics were nonexistent, a large part of medical practice was concerned with infection. A man with a bilateral inguinal herniorrhaphy was immobilized for 20 days. Houses were heated with wood or coal. The United States would enter its first world war, known then as the Great War. Though perhaps simpler because of fewer inventions and options, occupational tasks in 1917 were not easy by today’s standards.

Beyond these daily exigencies, other societal concerns and trends greatly influenced the ideas of the founders of the National Society for the Promotion of Occupational Therapy. The major forces that shaped their perceptions of the need for occupational therapy emerge from their respective narratives; these forces include industry, war, educational reforms, and the nature of hospital care. A brief overview may prove helpful.

A recently industrialized society was increasingly aware of the adverse psychological and physical effects of mechanization. Arts-and-crafts societies emerged in a number of cities to restore pride in individual and quality workmanship against the increasing monotony and vanishing autonomy of factory work. Powerful machines maimed bodies at an alarming rate. Social workers such as Jane Addams of Chicago’s Hull House recognized the negative effects of both industrialization and city living among poor persons and offered educational, recreational, and community-enhancing activities in neighborhood settlement houses. Advocates for reform in education, industry, and treatment of the ill used settlement houses as centers for generating changes in living and working conditions. Efficiency engineers such as Frank and Lillian Gilbreth promoted techniques to make persons and machines more effective on the job and at home. The crippling effects of war on neighboring countries and the ways in which their governments reconstructed their war heroes prompted a readiness in the United States to do the same. Hospital care was scrutinized. Inhumane conditions in state hospitals for “the insane” received public exposure, and the National Committee for Mental Hygiene sought to promote better treatment for institutionalized patients. Doctors, nurses, and patients increasingly criticized the failure of general hospitals to prepare patients for a society that valued effectiveness and productivity. Nurses and social workers strove for professional respect and credibility, often using contemporary pleas for reform as catalysts for changes in their practices. Each of our founder’s conclusions about the kind of service that would be most helpful connects back to personal experiences with and personal understanding of these broader issues.

Changes occurring within medical settings during these early years seem particularly important, because much of the expressed need for occupation as therapy came from hospital workers:

This was a time of significant medical advance. Medicine moved from a discipline concerned solely with treatment to one involved with preventing the occurrence and the recurrence of disease. However, as such infectious and epidemic illnesses as typhoid and small pox were being eliminated, new medical problems, which were to result in an increased number of chronic patients, became apparent. These included heart disease, arteriosclerosis, and diabetes. The number of the institutionalized mentally ill increased five times. . . . As more people were able to survive illness and accident due to rapid medical advances, more were left with lasting impairments. The war, a severe polio epidemic in 1916, industrial accidents, and the widening use of the automobile all contributed to the need for new methods of treating residual disabilities. (Woodside, 1971, p. 226)

Each founder of the Society drew a common understanding from this larger context of 1917: the right occupation might in some way help. Exploration of each founder’s unique view of patients, therapists, and occupations clarifies the manner in which occupational therapy became multifaceted yet rooted in one basic idea.

George Edward Barton

George Edward Barton was a successful architect who originated the idea of founding a society to promote occupation as therapy. Because his background included a year’s work in nursing and some studies in medicine, he had a working knowledge of medical matters (Staff, 1923). He was also knowledgeable of medical matters (Staff, 1923). He was also knowledgeable of medical matters (Staff, 1923). He was also knowledgeable of medical matters (Staff, 1923). He was also knowledgeable of medical matters (Staff, 1923). He was also knowledgeable of medical matters (Staff, 1923).

Barton’s early views on the subject of occupational therapy are of considerable interest. In his earliest writ-
ings he called the therapy “occupational nursing” (Barton, 1915a, p. 335). He regretted that the work was “unfortunately called Occupational Therapy . . . because the subject has so many different sides that most people . . . have such difficulty in making out what it is all about anyhow” (Barton, 1920, p. 304). He viewed occupational therapy’s goal as the making of a person, that is, a productive individual. He was critical of the hospital’s restricted role in treatment:

To get the patient well has been the aim and the end of it all. . . . But if the hospital world expands, as the public is demanding that it shall expand, so that to merely get the patient well is not the whole thing, but to get him well for something. (Barton, 1920, p. 305)

Barton (1920) argued that a man “is not a normal man just because his temperature is 98.6. A man is not a normal man until he is able to provide for himself” (p. 306). He believed that the hospital had lost a vital opportunity by becoming focused on the X-ray and laboratory, thereby turning out “paupers instead of producers” (Barton, 1920, p. 307). He maintained that a patient fared better during the convalescent period with something to do (Barton, 1920). Occupying his or her mind with something worthwhile enabled that patient to sleep and heal at night. Barton thought that worthwhile activity meant activity with earning power. He reminded his audiences that concern over the inability to earn often impelled a patient to seize a nurse and say, “In God’s Name, tell me what I’m going to do!” (Barton, 1915a, p. 335).

Barton (1920) believed that a “proper occupation” promoted physical improvement, “clarified and strengthened the mind,” and could become “the basis or the corollary of a new life upon recovery” (p. 307). He believed that a person’s spirit could resurrect in “greater strength and purity” to triumph over disability and despair (Barton, 1920, p. 308). He therefore chose a phoenix rising from the flames as the emblem for Consolation House. Barton recommended an extensive occupational diagnosis to include consideration of the patient’s education and inclinations; present status, habits, and ambitions; and expectations. The diagnosis would suggest the prescription: the proper occupation in the proportion necessary to produce the desired physical, mental, and spiritual results. Barton believed that any prescription from materia medica (as cited by Barton, 1915b) could be translated into occupational terms. He explained that if medicine prescribed benzol to a patient as a leukotoxin for leukemia, occupational therapy would put the same patient to work in a canning factory where the fumes of hot benzine would “keep her in good health” while she supported herself (Barton, 1915b, p. 139). Each human activity could be associated with a physical effect. Barton’s unique belief that every occupation had an effect analogous to that of a drug distanced some physicians and resulted in his being considered an extremist (Licht, 1948).

Barton thought that the teacher of the occupation must monitor its therapeutic effects. He called for scientific reeducation with an argument from Frank Gilbreth: “The teaching element is more important in this new phase of adequate placement than it has ever been before, because in every case a new or changed worker must be made useful, self-supporting, and interested” (as cited by Barton, 1920, p. 306). Gilbreth was himself elected to honorary membership in the Society at its founding meeting (Dunton, 1967).

Barton believed strongly that the teacher of occupation should be a nurse. He saw occupational work as an opportunity for the nursing profession to develop, expand, and become more important and useful (Barton, 1920). He exhorted nurses not to sit idly by while others took up this new line of work, leaving them to handle the “crescent basin” (Barton, 1915a, p. 338). Barton’s commitment to occupational therapy’s alliance with medicine is clear. He suggested that when Adam was cast from the Garden of Eden he was given a divine prescription to earn his bread by the sweat of his brow (Barton, 1915b). Barton used numerous medical analogies. One finds a now humorous medical reference in the paper entitled “Preparation of Patients for Inoculation [sic] of Bacillus of Work” (as cited by Dunton, 1967, p. 287), which Barton read at the Society’s founding meeting.

Barton was also the first secretary of the Boston Society of Arts and Crafts, a group allied with the arts-and-crafts movement against industrialization. He supported quality work crafted by conscientious persons. He was particularly fond of our Society’s, if not our therapy’s, name, including in his rationale a trait of the nonindustrialized worker:

I am strongly in favor of the National Society for the Promotion of Occupational Therapy as a title. I know that it is long but it does tell the story and the S.P.O.T. suggests the alert “Johnnie.” (as cited by Licht, 1967, p. 272)

Barton’s understanding of occupational therapy was that the person providing occupation would be an advanced nurse who would be teaching scientifically from a medical and occupational knowledge base. This nurse-therapist would ensure harmony between occupational and medical treatments and use a frame of reference for treatment broader but parallel to that of medicine. The therapist would regard the patient as a mental, physical, and spiritual being and consider the patient’s individual strengths, goals, and ambitions in these three realms when planning treatment. The addition of occupational therapy to hospital treatment would enable staff to remake a whole person who could lead a useful life.

Susan Elizabeth Tracy

Because Barton encouraged nurses to engage in occupational therapy, it seems fitting to next consider the legacy of one nurse who did: Susan Elizabeth Tracy. I refer to
Tracy as a **near founder** because although not one of the founders, she was invited to the Society's founding session. Licht (1967) believed that “no one did more in this country to resurrect and establish occupational therapy than did Miss Tracy” (p. 275). Moodie (1919), herself a nurse, argued that “Occupational Therapy, in other words, the application of various forms of handicraft to meet the individual limitations of invalids and the physically handicapped was first brought into being by Miss Susan E. Tracy” (p. 313). During her training, Tracy had noticed that those patients on surgical wards who kept occupied seemed happier than those who remained idle (Licht, 1967). After completing her course work she became director of the nurses’ training school at the Adams Nervine Asylum, Boston, where she initiated a program of manual arts. Her program was the first course in the United States designed to prepare instructors for patients’ activities (Licht, 1948). Tracy also taught nurses in practice in the Boston area, including those at the city’s Massachusetts General Hospital. One indication of her positive relationships with others and her ability to share her convictions is that an early surgical patient published her *Studies in Invalid Occupations* (Licht, 1967).

Tracy’s (1913) book communicates her values and her ideas about service. She valued the support of physicians. In the chapter that introduces Tracy’s ideas, Dr. Daniel H. Fuller of the Adams Nervine Asylum noted that “suitable occupation is a valuable agent in the treatment of the sick ... as an important adjunct to other forms of treatment, and sometimes it is quite all the treatment necessary” (Tracy, 1913, p. 1). Tracy no doubt perceived it important to include a physician’s endorsement. She must have thought it also meritorious to include Fuller’s characterizations of the quality of personal care required:

> Nurses are constantly being impressed with the fact that the technical and mechanical part of their work is but one aspect of their professional duty, that a broader conception must be attained—a sense of obligation to minister to the individual as well as to the disease. The value of wise human sympathy, of cheerfulness in work and mien, of tactful dealing with unreasonable and irritability, of skillful diversion of thought from pessimistic channels... are essential parts of the trained nurse’s equipment to do her work. (Tracy, 1913, pp. 9–10)

Although Fuller saw occupation as helpful in meeting a physician’s goals, he did not believe that a nurse had to be the provider. He believed instead in possession of the proper character:

> Without the constant cooperation of the teacher or nurse, without the daily expression of interest and the stimulus of example, the work is either never begun, or if begun, is thrown aside. 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. (Tracy, 1913, p. 3)

In subtitling her book *A Manual for Nurses and Attendants*, Tracy also extended the role of providing occupation to those competent persons who had not been trained to nurse.

Tracy (1913) believed that a physician could prescribe work for the patient “whose physical, nervous, mental and moral characteristics he had made the object of keen observation and study” (p. 5). The result of such broad prescription was “cure in the broadest sense, in that the mental attitude toward life has been changed” (Tracy, 1913, p. 3).

Tracy (1913) used Dewey’s definition of occupation as it related to education: “A mode of activity on the part of the child which runs parallel to some form of work carried on in the social life” (p. 13). She felt challenged to identify parallel occupations for hospitalized patients:

> The real problem of the nurse is to find means whereby she may initiate and actually lead and cooperate in forms of occupation suited to every invalid condition and any natural temperament. (Tracy, 1913, p. 18)

Tracy (1913) pleaded for a certain dignity and quality to the work, for employment of time on worthy materials and purposeful productions. She believed that although a handicraft teacher was perhaps suited to the hospital shop or workroom, sicker patients required special care: “When the shop is a sick-room, and the bed the bench, it is almost a necessity that the nurse be the teacher” (Tracy, 1913, p. 10). Whatever their background or training, Tracy (1913) believed that teachers of occupation in hospitals must have similar traits:

> They must possess resourcefulness, unfailing patience, quick perception of capacities and limitations, an enthusiasm which can anticipate for the patient the attractiveness of the finished product and the insight which substitutes a new piece of work or a new phase of the old before the patient is conscious of weariness or distress... (Tracy, 1913, p. 18)

Tracy (1913) then proceeded to a chapter-by-chapter consideration of methods for the teaching of occupations to children and to patients in restricted positions, in quarantine, able to use only one hand, possessed of waning powers, without sight, and with clouded minds. Regardless of the patient’s condition, Tracy believed that the teacher must be “thoughtful of the deeper needs of her patient” (Tracy, 1913, p. 10). She supported empathy, because “in a large majority of the cases the trouble is local and the patient is like an animal caught in a trap” (as cited by Licht, 1948). Consideration of deeper needs would benefit patient and nurse alike:

> If a nurse can prove to the patient who chafes against his limitations that there is really a broad highway of usefulness opening before him of which he knew not, the mental friction is diminished and satisfaction steals in, while the whole physical organism prepares to respond by improved conditions. In this connection the effect upon the nurse herself must not be overlooked. She too will forget the tiresome routine. (Tracy, 1913, p. 171)

Almost a decade later, Tracy (1921) was calling occupational therapy a “healing force which should be used whenever possible” (p. 399). She personified occupational therapy:
Suppose the door (to the hospital) is suddenly opened and Occupational Therapy is permitted to walk swiftly down the corridors to the wards. What is she looking for? If she is wise she is endeavoring to discover the human impulse for activity. It is certainly there. Here is a crowd of loafing, foot-swathed men on the veranda; no impulse to work visible. If work is proposed it may be, and often is, resisted. This is no signal for discouragement.

Of what is this crowd composed? A young house-painter who has fallen hurt from a staging and is pretty badly hurt. Next a psychopathic patient in bed held in a restraining jacket. Third a man who repairs furniture. Only one of his hands are (sic) available at present. Then a three-year-old baby with a new arm in place of the one crushed by an automobile. Occupational Therapy sets down her basket. There is always something interesting for each person. (Tracy, 1921, p. 596)

Tracy supported the employment of crafts teachers and attendants in hospital workshops. She valued occupation for the happiness and changed attitude that it produced and for that attitude’s curative effect on disabilities. To Tracy, the worthwhileness of handicrafts referred to the quality and purposefulness of the end product, not to its earning power. She saw occupation as a means for the nursing profession to help and care for the whole patient. She emphasized interpersonal traits without which a nurse-teacher could not engage the patient successfully.

Barton and Tracy differed slightly in their understanding of how to provide occupations to patients; the differences relate largely to their respective life experiences. The narratives of other founders and near founders explain the additional facets of our heritage as reflections of their personal perspectives about how occupation might help.

William Rush Dunton, Jr.

Also concerned with the care of hospitalized patients, particularly with patients with mental illness, was William Rush Dunton, Jr., a psychiatrist whose contributions to the early Society can scarcely be enumerated. Dunton responded readily to Barton’s suggestion that a national society be established. He was an organizer by nature, having himself founded both the Maryland Psychiatric Society and the Baltimore Physicians Orchestra (Licht, 1967). He was convinced of the merit of occupation in the treatment of persons with mental illness. Early in his 30-year career at Sheppard and Enoch Pratt Hospital, Towson, Maryland, he had discussed the value of occupation with its director, Dr. Edward Brush. In 1912, Brush appointed Dunton in charge of occupation, by 1915 Dunton had published a book on the subject.

Dunton described his early encounter with patients and occupation while he was an assistant physician. At that time, he organized dramatic performances for the patients, thus earning the “sobriquet of Charles Frohman Dunton” (Dunton, 1943, p. 245). He remembered an interaction with one patient:

At this period we had a scene painter as a patient and I was able by much bossing to make him paint some attractive sets. Each morning he would say: “Won’t you let me off today?” And I would harden my heart and refuse. It is probable that in later years I would not have been so brutal in my treatment of my scene-painter patient and I would have drawn him back to his vocation by easy stages, but experientia docet and I wanted new scenery. (Dunton, 1943, p. 245)

Dunton described his concurrent activities: “In order to interest patients I sought various craftsmen, such as bookbinders, leather toolers, and others who were kind enough to show me the rudiments of their craft so that I could by a little practice start a patient on a craft which attracted his interest and helped him on the way to recovery” (Dunton, 1943, p. 246). Dunton’s personal experience with occupation deepened his commitment to moral treatment, a treatment practice used by psychiatrists many years before.

Of all the founders, Dunton articulated more than most the belief that his use of occupation constituted an earlier form of treatment that he was simply extending into a new period of history. His practice in a psychiatric hospital enabled his ready access to articles in the American Journal of Insanity about moral treatment in the 19th century. As a psychiatrist, he was perhaps eager to claim occupational therapy’s roots among his forebears. Much of Dunton’s (1919) writing included references to moral treatment. He regretted the passing of moral treatment toward the end of the 19th century:

It is a strange thing that the physician is so often willing, even anxious, to discard remedies which have proved efficacious in his practice and in that of others, for something new to him and perhaps hubris unintended, so that we have fashions in therapeutics, some of which seem quite as bizarre to us in after years as do those of costume. (p. 17)

Although Dunton accurately identified one factor that contributed to its discontinuance, there were multiple societal, professional, and institutional circumstances
that contributed to the demise of moral treatment (Peloquin, 1989). Because moral treatment's particular form is not so much at issue here as is the core of its service, my discussion will be broad and brief.

Dunton (1919) cited Sir James Connolly, who in 1813 caught the essence of moral treatment when speaking of the York Retreat in Pennsylvania:

"The substitution of sympathy for gross unkindness, severity, and stripes; the diversion of the mind from its excitements and griefs by various occupations, and a wise confidence in the patients when they promised to control themselves led to the prevalence of order and neatness, and nearly banished furious mania from this wisely devised place of recovery. (p. 21)"

Stories of interactions among therapist, patient, and occupation contribute to an understanding of moral treatment. Leuret (1948) shared one:

"I had one patient, an old fiddler, whom I had not been able to draw out. He believed that he was being trailed by the police and consequently did not dare or care to huddle. In order to make him rise, walk, or feed himself, entreaty and even compulsion were necessary. I was unable to make further progress with him until I thought of the violin. I led the patient into the bathing-room, turned on the shower, and at the same time gave him a violin. He had to choose between them. I greatly feared that he would choose the shower. He hesitated for quite some time but finally the memory of his calling returned; he took the violin and played a tune of his choice. . . . Two months after resuming his instrument he was discharged cured, to continue the practice of his calling and for his entire treatment I had used only music. (p. 30)"

A more contemporary description of moral treatment is that it was "a grand scheme for activities of daily living, which placed the patient in a total program with the goal of arranging healthy living" (Kielhofner & Burke, 1977, p. 678). Bockoven (1971) indicated that the significant attitudinal features of moral treatment were "respect for human individuality and the rights of individuals . . . and respect for the need of every individual to be engaged in creative and recreational activity with his fellow citizens" (p. 223). Most recently, King (1980) argued that in moral treatment "caring for and caring about the patient was as implicit as occupation" (p. 523).

One must not unduly romanticize the practice of moral treatment. Asylum reports did verify that patients benefited from individual attention, engagement in a wide variety of occupations, small patient–staff ratios, a family atmosphere, and a system that classified and treated patients according to severity of illness. But the patients' benefit was not the exclusive motivation for the practice. Moral treatment brought prestige to asylums and physicians alike. Systems for the classification of patients and for the involvement of patients in occupations reflected a class and sex bias: wealthy patients had carriage rides while poorer patients labored in the fields. Conceptualizations of the good life were those held by upper-middle-class physicians who managed the asylums. Patient occupation was also a form of patient labor that helped to maintain the asylum. The particular form that moral treatment took lent itself to some distortions and to its eventual demise (Peloquin, 1989). Licht (1948) believed that "the disturbing element of this diminution is that it was world-wide, which points to a basic error in its conduct during that period" (p. 455).

Dunton warned always against repeating late-19th-century distortions of the use of occupation and in an issue of the American Journal of Occupational Therapy cited a cautionary segment written in 1892 by his former supervisor, Dr. Brush:

"Occupation is undoubtedly of very great importance in the treatment of the insane, but the idea of occupation which is satisfied by putting a row of twenty demented patients to picking hair or making fiber mats is as far short of the true aim of occupation as is the attempt to get labor out of cases of acute mania or melancholia already subject to exhaustive changes and waste . . . a misconception of its true value. (as cited by Dunton, 1955, p. 17)"

The ideal of moral treatment was that occupations of all kinds be used for the benefit of persons with mental illness. Shaw (1929) reflected early-20th-century thinking about this ideal: "By a new name, an old idea has had rebirth, and is called occupational therapy" (p. 199). The structural invariants of patient, therapist, and occupation mutually acting to improve the patient's condition constituted those strands of the 19th-century idea that Dunton believed the Society had extended into the 20th century.

The extension was timely. Clifford Beers, himself a patient in three mental institutions in Connecticut between 1900 and 1905, had framed a plea for the reform of contemporary abuses. Inhumane conditions after the demise of moral treatment had led Beers to organize the National Committee for Mental Hygiene. Through this organization, Beers (1917) advocated numerous hospital reforms, including individualized care of patients, occupations, recreation, and a more homelike atmosphere.

In the personal chronicle of his experiences, Beers maintained that he had contributed to his own cure through his initiative in engaging himself in reading, writing, and drawing. He often struggled against the system to procure materials with which to occupy himself. When reflecting about the origins of the use of occupation in treatment, Dunton (1921) admitted that "possibly the credit belongs to a number of patients, each one of whom found a tranquilizing influence in work casually undertaken and so continued it in the form originally begun, or in other ways" (p. 11). Dunton thus credited persons such as Beers with having influenced the development of occupational therapy.

The appendix to the 1917 edition of Beers's book details his organizational efforts for institutional reform. He included a letter from Julia Lathrop of Hull House, who had agreed to become an honorary trustee. Lathrop wrote that she had "felt for some time that a national society for the study of insanity and its treatment, from the social as well as the merely medical standpoint, should be formed" (Beers, 1917, p. 326). Lathrop's name is significant in the history of occupational therapy also
because of her association with another founder, Eleanor Clarke Slagle. Another letter supporting Beers came from Dr. Adolph Meyer, Director of the Phipps Clinic at Johns Hopkins Hospital in Baltimore. Beers (1917) thanked Meyer, “who, because of his profound knowledge of the scientific, medical and social problems involved, helped more than anyone else” (p. 322). Meyer also worked to support the growth of occupational therapy in substantial ways. He presented a paper entitled “The Philosophy of Occupational Therapy” at the Fifth Annual Meeting of the Society, in which he said:

A pleasure in achievement, a real pleasure in the use and activity of one’s hands and muscles, and a happy appreciation of time begun to be used as incentives in the management of our patients, instead of abstract exhortations to cheer up and to behave according to rules. The main advance of the new scheme was the blending of work and pleasure.” (Meyer, 1922, pp. 2–3)

One passage from Beers’s (1917) book resembles other passages in which he decried the lack of activity, even in the better institutions:

For one year no further was paid to me than to see that I had three meals a day, the requisite number of baths, and a sufficient amount of exercise. . . . As I shall have many hard things to say about attendants in general, I take pleasure in testifying that, so long as I remained in a passive condition, those at this institution were kind, and at times even thoughtful. (p. 68)

When Dunton read his paper at the founding meeting of the Society for the Promotion of Occupational Therapy, it consisted of a history filled with references to the use of occupation in antiquity and to the practice of moral treatment. He encouraged the use of work, recreation, and exercise among persons with mental illness by invoking the success of an earlier time (Licht, 1967). Dunton thus responded to the need and push for hospital reform from persons such as Beers by proposing occupational therapy as a viable solution.

Dunton’s views also reflected the influence of World War I on his thinking. The second part of my inquiry will begin with a continued discussion of Dunton’s views as the war affected them and will extend into an exploration of the views of other founders: Eleanor Clarke Slagle, Herbert Hall, Susan Cox Johnson, and Thomas Bessell Kidner.▲

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