

Instructor Resource Manual

CHAPTER FOCUS

This chapter provides a description of the history of the occupational therapy (OT) profession, including the names of individuals who were involved in its inception. The major social influences that preceded and gave rise to the field of occupational therapy are examined so that readers may recognize how societal influences and legislation have helped shape the field of occupational therapy. This chapter reviews the concepts that have persisted throughout the history of occupational therapy and examines how these concepts and the profession's history affect the current practice of occupational therapy.

TEACHING STRATEGIES

1. Refer to Box 2-1, Dunton's Principles of Occupational Therapy. How could you update these principles to reflect current occupational therapy practice?
2. Research and write a short paper on the Moral Treatment Movement of the 1800s.
3. Compile short biographies on the founders of occupational therapy by reading three or four sources.
4. Search back volumes of *American Journal of Occupational Therapy* (and the older *Archives of Occupational Therapy and Occupational Therapy & Rehabilitation*, if available). Use lists of article titles to show the changes in emphasis from decade to decade.
5. Research and write a short paper on any single social influence, legislation, or technical development. Elaborate on how the event affected the practice and profession of occupational therapy.
6. Research and make a wall chart with a time line that depicts significant events and changes in American Occupational Therapy Association (AOTA) since its inception.

ADDITIONAL TEACHING STRATEGIES

1. Play a game of "Who am I?" Divide students into teams. Provide short descriptions of the key players, and require the team to agree as to who that person is. The team with the most correct answers wins.
2. Provide teams with a list of important occupational therapy names (past and present). Require each team to locate a picture of the person and brief description of what he or she contributed to occupational therapy. The team with the most pictures and descriptions wins. You may make this fun by including some of your own faculty. This activity may be adapted by dividing the teams into decades (to avoid replication) and requiring the students to present the pictures and descriptions to the class. (Many of the

photos are available on the Internet.)

3. Ask students to research key legislation with the state occupational therapy association representative. What are the prevailing topics and how might they affect occupational therapy practice in your state?

CRITICAL THINKING ACTIVITIES

1. Byron is a 35-year-old married man with three children; he sustained a spinal cord injury that left him unable to walk. He is independent in self-care, but he must use a wheelchair. Byron works in an old building on the third floor. There is no elevator in this building.
How can the Americans with Disabilities Act help Byron access his office? Does he have any other legal rights that may assist him in returning to work?
2. Marvin is a 10-year-old boy in the fifth grade who has cerebral palsy that affects his motor skills for writing and manipulating objects. Marvin is able to move from place to place, although it takes him longer than the other children and the quality of his movement is poor. He sits in a regular chair and benefits from using a laptop computer. His parents are concerned that he will fall behind even more in sixth grade and would like to review possible accommodations to help him.
Describe how the Individuals with Disabilities Educational Act (IDEA) will help Marvin be successful in the school. What does this law allow?
3. Your grandmother had a friend who was an occupational therapist (OT) (in 1953). She worked with clients in a psychiatric institute. Primarily, the friend engaged clients in arts and craft activities. Your grandmother does not understand what you will be doing or why you need to go to college to do arts and crafts.
Describe the profession of occupational therapy. How is occupational therapy different today? What do you think occupational therapy was like when her friend was working?

ANSWERS TO REVIEW QUESTIONS

1. What major social influences gave rise to the field of occupational therapy?
In the 1800s Moral Treatment was grounded in the philosophy that all people, even the most challenged, are entitled to consideration and human compassion. Prior to the Moral Treatment Movement, the “insane” were confined and frequently abused.
In reaction to the expanding use of tools and machines, a contingency of proponents of the arts and crafts developed in the early twentieth century. Arts and crafts allowed people to experience pleasure in making practical and beautiful items for everyday use.
At the turn of the century, there was concern for those who experienced illness or injury, leading to the founding of the profession. In 1917, the National Society for the Promotion of Occupational therapy was

formed. Meyer proposed a holistic perspective and developed the psychobiological approach to mental illness.

WWI resulted in many veterans with disabilities who required training to return to work. Reconstruction Aides helped them return to work, employing the concept of activity as therapy. OTs helped veterans return to civilian work. The name of the organization was changed to The American Occupational Therapy Association (AOTA) in 1921; it promoted growth of the profession through publications. WWII created a demand for more OT practitioners. As changes in medicine occurred, neuroleptic drugs (mid-1950s) changed the practice of occupational therapy. The ability to control behaviors through medication led to the national “Deinstitutionalization Plan.” OT practitioners began to work in the community (as jobs in institutions decreased) and in hospitals (for the physically disabled). Rehabilitation hospitals emerged between 1942 to the 1960s. The 1960s brought about a change to a more technical specialization and a reductionistic approach. The occupational therapy assistant (OTA) was initiated in 1950s. The 1970s and 1980s represented a growth period in technology. OT practitioners saw the need for working with clients in their communities. However, the focus remained on a reductionistic approach. The 1990s brought a change back to the roots of the profession: occupation. Practitioners began to examine how to use technology and advancements in medicine to serve clients in their communities and to help them return to their occupations. The profession has developed a new vision for 2000 and continues to support the emphasis on occupation and community.

2. Who are some of the key people involved in the evolution of the occupational therapy profession?

Two men from different parts of the world are credited with conceiving the Moral Treatment Movement: Phillippe Pinel and William Tuke. Phillippe Pinel, a physician in France, introduced “work treatment” for the “insane” in the late 1700s. He used occupation to divert the patients’ minds away from their emotional disturbances and toward improving their skills. He used physical exercise, work, music, and literature in his treatment.

William Tuke became aware of the terrible conditions in an asylum in York, England, and suggested establishing the York Retreat. The environment at the York Retreat was like that of a family in which the patients were approached with kindness and consideration.

In the United States, a Quaker named Benjamin Rush was the first physician to institute Moral Treatment practices.

Adapting the Arts and Crafts Movement for medical purposes was a treatment concept developed by Herbert Hall, a physician who graduated from Harvard Medical School. He worked with invalid patients, providing medical supervision of crafts for the purpose of improving their health and financial independence.

The treatment usually prescribed at the time was total rest. Hall’s alternative to the “rest cure” was arts and crafts activities, beginning with participation on a limited basis from bed and gradually increasing the

level of activity until the patient went to the workshop where he or she worked on weaving looms, ceramics, and other crafts. He called this approach the “work cure.”

George Barton was a resourceful architect who went to Boston to incorporate the Boston Society of Arts and Crafts. After personally experiencing a number of disabling conditions—tuberculosis, foot amputation, and paralysis of the left side of his body—Barton was determined to improve the plight of convalescent individuals. In 1914, Barton opened Consolation House for convalescent patients in Clifton Springs, New York, where occupation was used as a method of treatment.

William Rush Dunton, Jr., considered the father of occupational therapy, was a psychiatrist who spent his career treating psychiatric patients. In 1891, he was hired as the assistant staff physician at the Sheppard Asylum (later named the Sheppard and Enoch Pratt Hospital) in Towson, Maryland. Having studied the treatment programs of Pinel and Tuke, he was interested in implementing a similar program at the Sheppard Asylum.

In the early 1910s, the hospital introduced a regimen of crafts for its patients. Although hospital staff performed necessary medical procedures and provided a structured environment, the patients were expected to actively participate in their rehabilitation by working in the workshop. Dunton was known for his writings on the value of occupation for treatment. In 1915, he published *Occupational Therapy: A Manual for Nurses*. It describes simple activities that the nurse can use or adapt in the treatment of patients. Dunton served as Treasurer and President of the National Society for the Promotion of Occupational Therapy and edited the association’s journal for 21 years.

Often referred to as the mother of occupational therapy, Eleanor Clarke Slagle began her career as a student in social work. She attended training courses in curative occupations in 1908 at the Chicago School of Civics and Philanthropy, which was affiliated with Hull House and Jane Addams. After this training, she worked at state hospitals in Michigan and New York. In 1912, she directed a new occupational therapy department at the Henry Phipps Psychiatric Clinic of Johns Hopkins Hospital in Baltimore, Maryland and developed the area of work for which she is most noted, “habit training.” She organized the first professional school for OT practitioners, the Henry B. Flavill School of Occupations. Today, AOTA presents the Eleanor Clarke Slagle award, a prestigious honor to therapists who have made significant contributions to the profession.

Susan Tracy was a nursing instructor involved in the Arts and Crafts Movement and in the training of nurses in the use of occupations. While working at the Adams Nervine Asylum, a small mental institution in Jamaica Plain, Massachusetts, she supervised the nursing school, developed the occupations program, and conducted postgraduate courses for nurses. Tracy’s book, *Studies in Invalid Occupations*, is the first known book written on occupational therapy.

Susan Cox Johnson was a designer and arts and crafts teacher from Berkeley, California, who became the

Director of Occupations at the New York State Department of Public Charities. In this position, she sought to demonstrate that occupation could be morally uplifting, that it could improve the mental and physical state of patients and inmates in public hospitals and almshouses, and that these individuals could contribute to their self-support.

Thomas Kidner was influential in establishing a presence for occupational therapy in vocational rehabilitation and tuberculosis treatment. When the United States passed the Vocational Rehabilitation Act in 1920, Kidner encouraged occupational therapists to capitalize on this opportunity. He also became very interested in tuberculosis when he realized that large numbers of men disabled in World War I were diagnosed with the disease.

Adolf Meyer, a Swiss physician who became professor of psychiatry at Johns Hopkins University, was committed to a holistic perspective and developed the psychobiological approach to mental illness. He advocated that each individual should be seen as a complete and unified whole, not merely a series of parts or problems to be managed.

3. What key concepts have persisted throughout the history of occupational therapy?

Moral treatment is grounded in the philosophy that all people are entitled to consideration and human compassion. Arts and craft allow people to experience the pleasure in making practical and beautiful items for everyday use. Activity will help patients return to their occupations. Helping clients re-engage in their daily habits will restore health. Clients should be viewed in a holistic manner.

4. How has the profession changed over time?

Changes in medicine, technology, and resources have impacted occupational therapy. As society became better able to take care of psychiatric clients, they were no longer held in institutions, and therefore, OT practitioners worked with clients in the community. The use of medications and technology has changed many of the techniques therapists use. At one point in the profession, these changes resulted in a reductionistic view of the client, yet the emphasis has moved back to a holistic look at clients and a focus on occupation. Funding and legislation influence the type of practice and settings in which OT practitioners work.

5. What are some key pieces of federal legislation that has influenced the practice of occupational therapy?

The Soldier's Rehabilitation Act established a program of vocational rehabilitation for soldiers disabled on active duty, with the focus on rehabilitating them and returning them to productive living.

In 1920, Congress passed the Smith-Fess Act, also known as the Civilian Vocational Rehabilitation Act (PL 66-236), to provide vocational rehabilitation services to civilians with physical disabilities. Medicare (PL 89-97) was enacted in 1965, and it amplified the demand for occupational therapy services even further. Those who are 65 years of age or older or those who are permanently and totally disabled receive assistance in paying for their health care. It covers occupational therapy services in the inpatient

setting and limited coverage for outpatient services. The Rehabilitation Act of 1973 mandated that state agencies provide disabled persons with programs to meet vocational goals, such as physical restoration, counseling, educational preparation, work adjustment, and vocational training. The act prohibited discrimination in employment or in admissions criteria to academic programs solely on the basis of a disabling condition.

The Education for All Handicapped Children Act of 1975 (PL 94-142) established the right of all children to a free and appropriate education, regardless of handicapping condition. The Handicapped Infants and Toddlers Act (PL 99-457) passed in 1986 extended the provisions of PL 94-142 to include children from 3 to 5 years of age and initiated early intervention programs for children from birth to 3 years of age. PL 94-142 was reauthorized and named the Individuals with Disabilities Education Act (IDEA) in 1991. IDEA requires school districts to educate students with disabilities in the least restrictive environment (LRE). Specifically, the IDEA requires states to establish procedures ensuring that students with disabilities are educated to the maximum extent appropriate with students without disabilities. The Individuals with Disabilities Education Act Amendments of 1997 (IDEA 97) further improves the educational opportunities for children with disabilities by improving educational results for children with disabilities. The law stipulates that the assistive technology needs of children with disabilities must be considered along with other special factors by the individual education plan (IEP) team in formulating the child's IEP. The Technology Related Assistance for Individuals with Disabilities Act of 1988 (PL 100-407) addresses the availability of assistive technology devices and services to individuals with disabilities.

The Medicare Prospective Payment System (PPS) delineated what the government would pay for each inpatient stay of a Medicare beneficiary using descriptive categories according to the individual's diagnosis, called diagnosis-related groupings, or DRGs. Americans with Disabilities Act (ADA) (PL 101-336), which was passed in 1990, provides civil rights to all individuals with disabilities and guarantees equal access to and opportunity in employment, transportation, public accommodations, state and local government, and telecommunications for individuals with disabilities.

The Balanced Budget Act of 1997 (BBA) was designed to reduce Medicare spending, create incentives for development of managed care plans, encourage enrollment in managed care plans, and limit fee-for-service payment and programs.

ADDITIONAL RESOURCES

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