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## A post World War I look at occupational therapy : historical, political and social aspects

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**Northern Illinois University**

**A Post World War I Look at Occupational Therapy: Historical, Political and Social Aspects**

**A Thesis Submitted to the**

**University Honors Program**

**in Partial Fulfillment of the**

**Requirements of the Baccalaureate Degree**

**With Upper Division Honors**

**Department of**

**Allied Health and Communicative Disorders**

**By**

**Rebekka S. Juszczak**

**Dekalb, Illinois**

**May 2012**

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### Abstract

The rehabilitative science of Occupational Therapy (OT) has undergone extreme changes since its conception. What first began as a departure from traditional segregation and institutionalization of those with physical and mental disabilities has now developed into a refined service that can be utilized by individuals with an array of disabilities. The maturation of OT occurred as the medical needs of World War I (WWI) demanded an increased need to rehabilitate the wounded soldiers and veterans who sustained disabilities. While post WWI OT played a critical role, support for the profession was still lacking until long after the completion of the war.

Most Occupational Therapists (OTs) in the United States could summarize the history of OT with ease but many people do not realize the impact that the United States Government and Military had in transforming OT into a respected science. It was not until the end of WWI that society began to see people with disabilities in a different perspective and sequentially, OT matured to fit the needs of the country. The United States Government and Military have played a significant role in the rehabilitation of its wounded soldiers and in the development and advancement of OT. Although historically, the profession had not been given enough respect, modern OT is now seen as a critical member of the rehabilitation team.

### Post World War I Look at Occupational Therapy: Historical, Political and Social Aspects

According to Harris (1918), it was believed that for every million soldiers sent overseas to fight in World War I, approximately 10,000 would return wounded and/or disabled each year and required extensive treatment and rehabilitation services for integration back into American society. While it is not unusual for war to yield wounded soldiers and fatalities, WWI brought about a vicious classification of warfare unlike any other ("New methods and horrors of warfare," 1918). Scientifically engineered weaponry and combat techniques were responsible for hundreds of thousands of deaths and severe injuries. Abysmal battlefield conditions were also a heavy contributor to the staggering number of casualties of WWI. Soldiers who did not die from their injuries were often left with permanent disabilities as remnants from valiantly serving their country. Being sensitive to the needs of the disabled soldiers, The United States Government offered support that would help them return to a purposeful life. The modern science of Occupational Therapy emerged as a beacon to assist these individuals to reach optimal levels of function despite the horrific scars that WWI left upon them ("New methods and horrors of warfare," 1918).

Prior to WWI, Occupational Therapy was limited to a different population of people with disabilities. Leupo (n.d.) stated that people with disabilities were once regarded as the "infirm" or "invalids," and were cast away from mainstream society in institutions such as insane asylums and mental hospitals. In addition, early treatment of these individuals included inhumane practices of bleeding patients as well as submerging them in ice baths to rid them of their ailments. Such primitive methods continued until the emergence of the Moral Treatment Movement in the late 1700s when humane and purposeful treatment was introduced to people with varying disabilities ("The history of Occupational Therapy," n.d.).

### **Occupational Therapy Prior to WWI**

According to “The history of Occupational Therapy” (n.d.), Phillipe Pinel, a French physician, believed that treatment of people with disabilities should center on the human spirit, therefore he structured his treatment plans in ways that emphasized goal directed activities and purposeful tasks. In addition, Pinel incorporated music, literature, and occupation based tasks in order to relieve the emotional stress that was endured by people with disabilities. These occupation based tasks are now commonly known as Activities of Daily Living (ADLs) within the rehabilitation community. William Turke, a well respected English Quaker was disgusted by the way patients were treated in asylums, and therefore, advocated for moral treatment of the mentally ill. Turke believed in using kindness and humanistic approaches to diminish the symptoms of the patients while promoting maximum functioning levels. Similar to the views of Pinel, Turke believed that occupation based purposeful activities were the best methods for treating people with various mental and physical disabilities and their treatment practices were similar in nature.

Patients in facilities that practiced the Moral Treatment Model were given tasks based on arts or crafts projects (“The history of Occupational Therapy,” n.d.). Completion of simple tasks yielded feelings of accomplishment while helping the patient to improve their functional abilities in small, easily attainable steps. Patients at higher functioning levels were given more challenging tasks that mirrored activities that would be found in a paying job. It was believed that mastery of such tasks would lead the patient to achieve independence and an opportunity to hold a regular paying job. While the practice of OT is now a scientifically based intervention, the original humanistic principles still apply and help distinguish OT as a unique therapy that



balances evidence based practice with compassionate concern for the client (The American Occupational Therapy Association, n.d.).

### **The Great War**

According to "Great War & jazz age," (n.d.) on April 6<sup>th</sup>, 1917, the United States broke their neutral stronghold and joined France and England to fight on the side of the Allied Powers of World War I. By then, the war had been going on for three years and it taken its toll on Germany. The desperate attempt of Germany to succeed led them to forge tight relations with chemists who developed weapons that provided them with an advantage on the battlefield ("New methods and horrors of warfare," 1918). These weapons proved to be effective in fighting but devastating to the Allied troops. Many soldiers faced death as a direct result of their injuries but a larger proportion were left with disabling injuries in which there was no cure.

According to "New methods and horrors of warfare," (1918), Germany was the first to debut the use of toxic gas as a weapon of war. Liquid poison was concentrated into bullet-like shells that would break open on enemy lines and immediately convert into a gas form that would asphyxiate nearby soldiers. Soldiers often sustained permanent impaired vision, total blindness and respiratory ailments from poison gas exposure. Gas masks were ultimately invented as a response to this type of warfare but there was little warning as to when a gas attack was underway and soldiers still endured the effects of poison gas. In addition to gas bombs, WWI brought the beginning of air borne arson with bombs being dropped on enemy lines from airplanes ("New methods and horrors of warfare," 1918). As soldiers lacked protection from above, injuries and deaths from airplane bombs were inevitable and many limbs and lives were lost. The use of fire was also utilized extensively during WWI as the Germans invented what is known today as the flame thrower. This device could release fire up to 100 feet away from the

machine and was used enthusiastically by the Germans until the Allied powers replicated the design and began using similar weaponry against Germany's troops. While lives are often lost and soldiers become injured during war, the environmental conditions in which WWI was fought played a heavy role in the degree of sustained disabilities ("New methods and horrors of warfare," 1918).

The weaponry used during WWI took the lives of many men, but more soldiers died or were unable to continue fighting due to disease and the appalling conditions of trench warfare. The majority of the war was fought in trenches that had been dug in the earth. Although trenches seemed to be ideal in providing protection from enemy artillery fire, soldiers endured inhospitable conditions during trench warfare ("New methods and horrors of warfare," 1918). The constant wet conditions resulted in many men contracting trench foot, a condition in which feet tingle, swell, feel heavy, blister, and turn blotchy as a result of long exposure to water (Centers for Disease Control and Prevention, 2005) (CDCP). This can be prevented by keeping feet dry, clean and by changing socks frequently, but trench warfare did not allow for soldiers to take the time to prevent trench foot as fighting was relentless. The CDCP (2005) added that many soldiers therefore lost their toes and entire feet due to untreated trench foot. Others faced extreme diseases such as malaria due to the cramped conditions of the trenches. In addition, without the proper isolation of sick men, everyone was at risk to contracting contagious diseases, the most common being trench fever.

Trench fever, a strain of the *Bartonella quintana* bacteria affected approximately 1 million soldiers during WWI (Foucault, Brouqui, & Raoult, 2006). It was first documented in 1915 and can be characterized by high fever spikes, dizziness, rashes, and enlargement of the spleen. The aforementioned authors stated that, if left untreated, the body could undergo partial

or full paralysis as well as death. Conditions of the trenches were not ideal for recovering from illness and there were infestations of vermin, extreme hot and cold weather conditions as well as limited supplies of food and clothes ("New methods and horrors of warfare," 1918). Trench warfare and fighting during WWI was unique in that while technology was advanced in weaponry and war tactics, there was no safety net for protection of the soldiers. More soldiers were left with permanent disabilities than soldiers that had died as a result of combat. With the armistice of WWI in 1918, the rehabilitation industry was ready to step up and take care of the veterans who had stepped up during the country's time of need.

### **Occupation Based Therapy**

According to Vogel & Gearin (n.d), OTs were contracted to work for the United States Army in France after WWI ended in 1918. A wounded soldier was able to begin therapy while he was still recovering in the hospital overseas (Hall, 1920). Therapy would often start with the soldier completing small tasks with his hands such as wood carvings and weaving in order for him to return flexibility to his fingers. In addition, the thought was that these activities would help distract his mind from the permanent physical injury he acquired from the war. Small craft based therapy proved to be very valuable during the post war era. Materials for the crafts were readily available, portable and the wounded soldier could complete the craft on his own time (Hall, 1920). According to Harris (1918), due to the vast publications in America about rehabilitating the wounded soldier, people began to think that OT's foundation was rooted in completing simple art projects such as basket weaving, and therefore the soldiers were treated in a patronized and demeaning manner. In reality, it was not expected that every wounded soldier was going to go through the rest of his life relying on weaving baskets to support himself and his family. As is common with many other disabilities, the soldier needed to go through an

adjustment period in which he learned how to adapt to life with his new limits (Hall, 1920). As the soldier began to cope with his disability he was then able to progress to other forms of therapy.

According to Kidner (1923), after the soldier progressed through bedside therapy he was able to transition to the next step of rehabilitation called a Curative Workshop. A Curative Workshop was similar to a regular workshop but soldiers with disabilities would work on tasks of carpentry and engineering (Hall, 1920). In this setting, the soldier had more strength and was given tools to complete projects of a more complex nature. The aforementioned author states that similar to the idea of small crafts, the soldier was not expected to complete therapy and rely on carpentry and engineering as a sole mean for survival and self support. The tasks were meant to engage the mind while working on the physical coordination and strength of the soldier. In addition, once the soldier was rehabilitated to his best functioning ability, the decision was made whether he could return to active duty or be discharged from the Military and sent on the pathway of vocational rehabilitation.

### **Transitioning the Soldier**

According to Harris (1918), the United States Government did not feel that it was sufficient to only compensate the veteran monetarily for his patriotic services and sacrifice. The moral obligation of the Government was also to restore the status quo as best as possible. Under the Vocational Rehabilitation Act of 1918, a veteran returning home was eligible to go through federally funded re-education to help him integrate better into a civil life (Harris, 1918). Carried out under the jurisdiction of the Federal Board for Vocational Education, each eligible and willing veteran was assigned a District Vocational Officer who managed their case. In addition, the District Vocational Officer would then meet with the veteran and go over possible

occupations in which the veteran could succeed. Medical practitioners were often consulted as well to verify if a certain occupation would suit the veteran based on their disability. As stated by Morgan (1918), as the veteran then went through the necessary training in his new occupation, the Government awarded him and his family a monetary allowance as well waiving the cost of training classes. Following the completion of re-education, the United States Department of Labor was sought out to match the veteran with a job near his home and family. The veteran was provided with transportation to his job and once he demonstrated that he could competently execute his job, the federal allowance ceased and a pension was awarded to him in addition to the wages he earned at his job (Harris, 1918). According to Stoddard (1918), with the Government enthusiastically supporting the efforts to return the soldier to civil life, it was easy for the veteran to embrace his disability and find a new way in which to contribute to society.

A similar vocational re-education program was initiated in Canada and the results demonstrated that some of the veterans were actually earning more money and holding better jobs after going through the government supported rehabilitation (Harris, 1918). The aforementioned author states that farm hands who once had earned \$25 a month were re-educated after their injuries and were helped to find work as managers of a creamery, a job that paid \$110 a month. Similarly, a grocery store employee originally made \$10 a week before losing his dominant arm. After being re-educated in commercial business, he was able to find a job at an insurance firm where he made \$90 a month. Following WWI and the Vocational Rehabilitation Act, there was great promise and opportunity for veterans with disabilities to succeed and get a second chance at life (Harris, 1918). As stated by Moses (1922), unlike the individuals who had disabilities and were housed in institutions, the rehabilitated veterans were seen as being "whole." They had acquired their disabilities while fighting for the good of the

country and therefore, society was less resistant in offering them positive attitudes and every opportunity to make the best of his condition ("World War I rehabilitation," n.d). This positive attitude towards disabilities helped OT become a well known rehabilitation science and it was not long before OTs were branching out to help people other than veterans wounded while in the Army.

### **Development of the Therapist**

During WWI, OTs, PTs, and Dieticians were added to the medical program of the United States Army due to the large number of wounded veterans and veterans sustaining long term disabilities (Vogel, E, Gearin, H. n.d). While these therapists and dieticians worked closely with the Army, they were not considered to be part of it. These professionals, consisting of only women, were not eligible for benefits from the Military insurance program which meant that they were not entitled to extended stays at Military hospitals if they were injured while on duty overseas. The women were not entitled to receive medical treatment at any federal hospital nor were they given competitive wages or retirement pay for disabilities or illnesses incurred while on duty. The American National Red Cross provided some medical equipment as well as the uniforms for these women as they were not permitted to wear the insignia of the United States Army. It was soon realized that these PTs, OTs and dieticians deserved more for serving the thousands of fallen soldiers, and a long battle to advocate for their rights began.

According to Vogel & Gearin (n.d), in 1919, it was suggested by Lena Cooper, Supervisor of Dieticians at the Walter Reed General Hospital, that all female civilian workers employed by the U.S. Army hospitals be given a status comparable to that of the Army Nurse. Her advocating went unheard and it was not until 1931 in which Grace Hunter, Chief Dietician at the Walter Reed General Hospital brought to the Surgeon General's attention that no changes

had been made to the wages or status of dieticians since WWI. Due to the inappropriate compensation for these professionals, many therapists and dieticians were leaving the Army hospitals due to competitive salaries elsewhere. Emma Vogel, Supervisor of PTs at the Walter Reed General Hospital, and Alberta Montgomery, Supervisor of OTs at the Walter Reed General Hospital, also consulted the Surgeon General about that matter and proposed that there be a single organization in which to put dieticians, PTs, and OTs. Despite the avid advocating of professionals in the rehabilitation field, the only change that occurred was an increase in the salaries. It was not until many years down the road that additional revisions were made.

As stated by Vogel & Gearin, (n.d.), the National Economy Act of 1933 was responsible to cut funding for the therapists and dieticians within Army hospitals and many of them left their professions to find work elsewhere. By April 1938, there were only 45 dieticians, 35 Physical Therapists, and 9 Occupational Therapists employed in United States Army hospitals. In order to hold the rehabilitation industry together, the battle to award military status to the therapists and dieticians resumed. It was thought that these rehab professionals did not need to be awarded Military status because their services were not provided in the war zone or on the front lines of fighting. However, the services given by PTs and dieticians were deemed as more important in times of war and therefore these services were awarded military status, and not the OTs. Dr. Winfred Overholser, Chairman of the Committee on Neuropsychiatry and Superintendent of St. Elizabeths Hospital, testified that OTs needed to be included in the bill with the other two professions in order to not lose OT personnel as well as the need to recognize OT as a critical rehabilitation service. In 1942, a bill passed that awarded PTs and dieticians Military status and directed OTs working with the Military to continue to hold civilian status. It was not until nearly five years later when OTs were recognized by legislators.

According to Vogel & Fearin (n.d), in 1946, the Surgeon General proposed the formation of two separate corps: the Army Nurse Corps and the Women's Medical Specialist Corps. The latter would consist of dieticians, PTs and OTs and each professional would be awarded Military status equivalent to that of an Officer. Justification for the formation of the Women's Medical Specialist Corps included the need to secure retention of these professional services in the Army as all three were interrelated and equally important. Furthermore, the public image of the Army would be tarnished if they did not award Military status along with appropriate salaries (Vogel & Gearin, n.d.). While this monumental step in rehabilitation history occurred nearly 30 years after the completion of WWI, the significance of these professions were recognized as important to the rehabilitation of wounded veterans and civilians.

### **Conclusion**

Although OT can be dated as early as the 1700s, its development is deeply rooted within the aftermath of WWI. As soldier after soldier returned home with multiple disabilities, it was the task of the OTs to not only treat the physical affliction but to also address the human spirit. The use of occupation-based tasks guided the veteran to regain his abilities and adjust to his disability. As OTs guided the veteran to integrate back into mainstream America, the veteran was also met with abundant opportunities awarded by the United States Government. Furthermore, the discriminatory views that society had about people with disabilities began to dissolve, and both the veterans and civilians with pre-existing conditions and work related injuries were given the support they needed.

While Occupational Therapy was not a fully respected profession until well into the 1940s, its importance has always been understood by the people who utilized it. If it was not for the legislation that gave people with disabilities fair opportunities, many people would not be



able to rehabilitate after work related accidents, war injuries, psychological disorders and nearly every other recognized disability. Within today's society, OT is held in high regard and the focus of treatment remains focused on the wellbeing of the client. The OT works with the client to restore the highest level of functioning while promoting ongoing optimal lifestyle.