Evolving Identities: Thomas Bessell Kidner and Occupational Therapy in the United States

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A founder of the National Society for the Promotion of Occupational Therapy, Thomas Bessell Kidner (1866–1932) played a prominent role in the early development of occupational therapy in Canada and the United States. We describe Kidner’s early life and how his work using occupations evolved. We then examine ideas and assumptions about occupations as treatment and trace Kidner’s involvement through to his leadership role within the American Occupational Therapy Association. Through our analysis of primary and secondary source materials, we have extracted recurring themes and related them across and within the materials to discern Kidner’s influence on the profession. From among his many contributions, three areas emerge as particularly relevant to current practice: occupational therapy’s role in return to work, relationships with medicine, and the profession’s image. Kidner’s story gives us a window on our history and an opportunity to see how the profession has evolved.


Each of the founders of the National Society for the Promotion of Occupational Therapy (NSPOT) brought a unique perspective to that first meeting on March 15, 1917, in Clifton Springs, New York. Their views helped shape not only the fledgling organization but also the very profession itself. Among these people, Thomas Bessell Kidner stands out for his contribution to our ideas about occupation. His identity within the profession appears to have evolved in parallel with that of the American Occupational Therapy Association (AOTA). We describe and analyze Kidner’s contributions as they affected the profession in his day and in the years to come. By documenting his story, we gain a window into our history. We can reflect on our origins and consider how our profession has evolved.

Background

Kidner had been brought from England to Canada in 1900 to help organize manual training in elementary schools in the province of Nova Scotia. His educational background in building trades preliminary to architecture had prepared him for this work, which was in considerable demand at the time (Kidner Family Papers [KFP], n.d.). Educational reforms popular at the turn of the last century suggested that children developed better if they were “learning by doing” than if they were learning by rote (Dewey, 1915). The handicrafts used in manual training provided children with an opportunity to develop skills such as concentration, perseverance, hand–eye control, and problem solving; they also contributed to a more holistic education, which incorporated art and valued creativity. In 1904, Kidner moved to the province of New Brunswick where he carried out much the same role. In 1911, when secondary schools were beginning to include technical
education, Kidner went west to Calgary, Alberta, to develop that field. Kidner wrote about the value of handicrafts from both a pedagogical and a philosophical perspective; he was a regular contributor to the journal *Educational Review*, and in 1910 he published a book titled *Educational Handwork* (Kidner, 1910).

In 1914, when Canada, then a member of the British Commonwealth, went to war against Germany, it was thought that injured soldiers would be treated abroad before being sent home. As these numbers grew, however, the soldiers were soon returning home for treatment, and a program for their rehabilitation was needed. Kidner was appointed vocational secretary of the Military Hospitals Commission of Canada and moved from Calgary to Ottawa to take up the post in January 1916. It was his responsibility to see to it that soldiers who could return to their former jobs were helped to do so and that those who could not were retrained for other work. In either case, the rehabilitation process began with occupations at the bedside and on the ward and progressed to off-ward activities, which often included curative workshops. The last step was vocational training, often in an industrial workshop, with placement to follow in an appropriate work setting. The occupations begun early on during convalescence were similar to those Kidner had used in manual training classes. Return to work was the goal, and occupations were seen as a means to that end (Friedland & Davids-Brumer, 2007).

Kidner’s program soon began to receive visitors from the United States. For example, Eleanor Clarke Slagle visited in 1917 while she was director of the Henry B. Favill School of Occupations (Loomis, 1992), and members of the U.S. Federal Board for Vocational Education visited in 1918. Elizabeth Upham-Davis of Milwaukee-Downer College had heard Kidner speak during a hearing “in the Capitol” in April 1918 and reported “he is someone I admire tremendously.” After visiting Kidner in Ottawa in June of that year, she wrote her college president (Miss Sabin) to say that visiting Canada had been a great inspiration; she had confirmed her ideas on what needed to be done in their new educational program and how it could be accomplished (Upham Davis–Sabin correspondence, 1918). Kidner was then asked to come to the United States to advise on vocational planning (Prosser, 1918). He was seconded to the Surgeon General’s Department where he assumed the role of advisor on rehabilitation to the Federal Board of Vocational Education. When Kidner arrived in the United States, he brought with him his ideas about occupations: as a method of learning, as treatment for illness and injury, and as a foundation for work.

When the secondment ended in 1919, Kidner moved to the United States permanently, working with the National Tuberculosis Association (NTBA) as the head of its Advisory Service on Institutional Construction. Meanwhile, his voluntary work with AOTA (formerly NSPOT), begun in 1917, continued. Most notably, Kidner served as president of AOTA from 1922 to 1928, returning in 1930 as acting president after the deaths of both the president (C. Floyd Haviland) and the vice president (B. W. Cart). Kidner left the NTBA in 1926 to form a partnership with architect Isadore Rosenfeld and worked as an independent consultant from 1927 until his death in 1932 at the age of 66 (KFP, n.d.). Addresses given at the memorial meeting held by AOTA after his death noted the great loss to the profession and the personal loss of a dear and loyal friend—of a poet and a musician, of one who was well read, genial, highly literate, and generous (“Addresses Made at the Memorial Meeting for Thomas Bessell Kidner,” 1932).

**Purpose and Research Questions**

The purpose of this article is to show the early development of occupational therapy through the story of Kidner’s life in the United States. As Kidner’s role with the profession developed and evolved, so did the profession itself. We asked, “What do we learn from Kidner’s story about the profession and about the paths it has taken?” We show how a “series of events and sets of ideas . . . have contributed to the profession’s evolution” (Schwartz & Colman, 1988, p. 242).

**Approach**

We accessed primary sources, including Kidner’s published writings and correspondence, family papers, photographs, minutes of meetings, and public records. News clippings, articles that mention Kidner, and obituaries provided secondary sources of information. Archives accessed include the Archives of the American Occupational Therapy Association, the National Archives of Canada, Milwaukee-Downer Archives, the Bristol Records Office, and the Department of Occupational Therapy Archives at the University of Toronto.

Using methods appropriate to interpretive biography (Denzin, 1989), we sought patterns of meaning and experience. We identified turning point moments (e.g., World War I, coming to the United States, role with AOTA) and attempted to explore relationships and uncover issues (e.g., approaches to recovery from illness and disability in the postwar United States, economic vs. altruistic ideas about return to work, and the attraction of the medical model).

Our exploration is limited by the accuracy and thoroughness of the information available (i.e., what was recorded, what was saved and made available for posterity,
and what we were able to find). Attempts at finding family members resulted in contact with a nephew, two granddaughters, and a great-grandson, all of whom supplied some information, thus enhancing the validity of the work. We reviewed documents for internal consistency (i.e., consistency within documents) and external consistency (consistency with empirical evidence, other documents, or both). We analyzed content thematically and examined similarities and contradictions within and across materials.

Our findings are presented in two parts. In Part 1, we describe the thinking about occupations as treatment that prevailed at the time Kidner arrived in the United States, including occupations as a step in preparing injured soldiers for return to work, occupations for those with tuberculosis, and the relation between occupational therapy and vocational rehabilitation. In Part 2, we analyze Kidner’s work with AOTA during the years of his presidency (1922–1928): building the infrastructure of AOTA, influence on the profession’s development, and promotion of occupational therapy. (Table 1 provides a brief summary of Kidner’s contributions over these time periods.) We conclude with comments on the implications of Kidner’s contributions for present-day practice.

**Part 1: Kidner’s Role in Shaping the Occupational Paradigm**

By the time Kidner came to the United States, the value of occupations as treatment was already being acknowledged, particularly in the area of mental health (see, e.g., Goss, 1913; Herring, 1912; Moher, 1911; Ripley, 1915). The program for training asylum attendants in the use of “invalid occupations,” established in 1908 at the Chicago School of Civics and Philanthropy, sought to substitute educational activities for custodial care. The occupations were similar to those used in elementary schools, where games, exercises, and handicrafts required the mind and body to work together (Twentieth Biennial Report, as cited in Loomis, 1992, p. 35). It was now acknowledged that “the rest cure” was in many cases a mistake as a patient should be encouraged to look outward, not inward, to forget real or imaginary ills instead of being given the opportunity, through inaction, for brooding on them” (Rompkey, 2001, p. 7).

Central to the philosophy of using occupations as treatment was the idea that occupations were a means of improving health and productivity; they could prevent secondary illness (particularly depression), help with motivation, and build self-esteem (Friedland, 1988; Harvey-Krefting, 1985; Levine, 1987; Peloquin, 1991; Reitz, 1992; Wilcock, 1998). This view about the value of occupations for building self-esteem was also found in other parts of the world. For example, Ach (1910/2006), a German psychologist, stated, “After repeated energetic acts of will accompanied by success, one realizes. . . . I have the strength, the power, to carry out whatever I will. I can do whatever I will” (p. 14). In an early use of the term, Ach noted this approach “is receiving more and more notice in the so-called occupation-therapy” (p. 15).

The general public was also being made aware of the value of occupations during illness. In the novel *The Woodcarver of Lympus* (Waller, 1904), occupation helps overcome the depression suffered by the protagonist who has been permanently injured in a logging accident. On learning to do woodcarving some 19 months later, he exclaims, “Oh the work, the work, the blessedness of it” (p. 71); he later notes that he has “learned by experience that deprivation of labor is death, work only, life” (p. 109).

**Occupations to Prepare Injured Soldiers for Return to Work**

With the idea that complete rest was necessary for cure gradually being supplanted and the need to rebuild self-

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Employment/Focus of Work</th>
<th>Ideas/Results for Occupational Therapy</th>
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<tr>
<td>1897–1910</td>
<td>Teacher and organizer of manual training for children</td>
<td>Valuing “learning by doing”</td>
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<tr>
<td>1911–1915</td>
<td>Organizer of technical education for adolescents</td>
<td>Skills for work (and return to work)</td>
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<td>1916–1919</td>
<td>Vocational secretary, Military Hospitals Commission (Canada)</td>
<td>Occupations (“doing”) as treatment for injured soldiers; occupations (skill development) as preparation for return to work</td>
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<tr>
<td>1918–1919</td>
<td>Advisor in rehabilitation to Federal Vocational Board of Education (United States)</td>
<td>Occupations (“doing”) as treatment for injured soldiers; occupations (skill development) as preparation for return to work</td>
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<td>1919–1926</td>
<td>Head, Advisory Service on Institutional Construction, National Tuberculosis Association; design of sanatoria; return to work for people with tuberculosis</td>
<td>Occupations (graded and prescribed activities) as “means” for increasing muscle strength or joint range in treatment of physical dysfunction</td>
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<tr>
<td>1927–1932</td>
<td>Consultant, hospital design and construction</td>
<td>Designated spaces for occupational therapy departments</td>
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<td>1917–1932</td>
<td>Founding member of National Society for the Promotion of Occupational Therapy; president, AOTA, 1922–1928; chair of various committees throughout</td>
<td>Building the infrastructure of the profession (registry and standards); establishing priorities for growth of profession (e.g., alignment with medicine, return to work, public relations)</td>
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esteem acknowledged, it was reasonable to think that occupations could also help injured soldiers of World War I during their convalescence. The occupations that were used at the bedside, on the ward, and in the workshop were much the same as those Kidner had organized for manual training programs in the schools in Canada. As the soldier progressed in his treatment, he prepared for employment by attending a preindustrial workshop.

The goal of returning injured soldiers to work (whether they were in Canada or the United States) was motivated by several concerns. The idea of decreasing the dependency of injured soldiers on the state was integral to the retraining plan (Morton & Wright, 1987). That they would receive a pension from the Army was not in question (Kidner, 1918, p. 144), but that they should become contributors to society was the goal. For as the postwar period began, it was becoming clear that economic issues threatened to overwhelm the country.

Moral issues also were at play; the argument was that just as it was right that society should help these men, so was it wrong for the men to be idle. In his book Redemption of the Disabled, Harris (1919) expressed this seemingly tough approach to reestablishing American soldiers when he stated,

There will be no more pensioned men in semi-charitable jobs; the redeemed disabled will be given regular pay for regular and efficient work. There will be no more burdens on the communities; for these men will pay their taxes and bear their share of whatever other burdens the community may have to shoulder. (pp. 44–45)

The approach was strengthened by the fact that injured soldiers remained militarily obligated to “do their duty,” which in this case was to become rehabilitated. In describing Canada’s work for its wounded soldiers, Todd (1917) stated, “There must be a general appreciation . . . not only of that which Canada owes her disabled soldiers, but of that which a disabled soldier, still a citizen, continues to owe to his country” (p. 355). Price (1996) noted that the U.S. Army attempted to maintain control during the rehabilitation period and presented rehabilitation exercises in the same manner as Army drills. Soldiers remained in uniform during their convalescence and were expected to behave as soldiers. Kidner commented on this need for discipline, saying,

In many cases they [the soldiers] were being spoiled by over-indulgence, in most luxurious surroundings with nothing to do but sit around and smoke cigarettes. In consequence, many of them, following out the old adage of idle hands finding mischief to do, got drunk and there were various disciplinary troubles, due largely, it was considered, to the lack of occupation. (Special Committee on Returned Soldiers, 1917, p. 102)

However, it is of interest to note that Kidner (1918) also believed that at a later point in the rehabilitation process, the soldier should be “demilitarized” and treated as a civilian because only then would he see himself as an individual and be motivated to improve.

**Occupations for Tuberculosis**

The high incidence of tuberculosis (TB) among soldiers during the war was thought to be caused by overcrowding and poor sanitation in the trenches (Shryock, 1977). Kidner (1918) was concerned about the inadequate treatment for TB, pointing out that its incidence was much higher than amputations or blindness but received much less attention. The lack of attention was not surprising because the stigma surrounding TB as a disease of the poor and immigrant classes meant that it was kept hidden. However, Kidner was not deterred; he showed particular interest in the needs of this population and advocated on their behalf early on. By 1919, in his role as the head of the Advisory Service on Institutional Planning for the NTBA, he was able to speak to his concerns more fully. He focused on the use of time during convalescence and the need to return the person with TB to being a productive member of society (Kidner, 1922c).

Treatment for TB was initially limited to rest, fresh air, and good food. During the early stages of the cure, diversional occupations were often provided to prevent what Kidner (1922c) termed “that almost intolerable ennui which in nearly all cases results from a period of prolonged idleness, such as the cure demands” (p. 365). Occupational therapy activities were welcomed once the medical staff could be assured that they would do no harm. In addition to securing their approval for occupations, Kidner tried to engage the help of physicians in motivating patients. He suggested that, in addition to “prescribing” work for their patients, physicians could assist greatly by “verbal hortation” (Kidner, 1922c, p. 368). He also noted that some physicians were in a particularly good position to promote the idea of work, having been patients themselves at an earlier time (Kidner, 1924b, p. 182).

Kidner worked with others’ during the war to develop a classification of patients according to their convalescent status (bed, porch, exercise, and workshop) and the types of occupations each could do. However, the premise behind such a system was not directed to the idea of using occupations to lift spirits and to build self-esteem, or even to combat idleness; rather, it was a move toward medicalizing the choice of activity. Creighton (1993) described how graded activity became incorporated into occupational therapy for TB when manual work was introduced as an alternative to the prescribed exercise of hill climbing. Graded activity supported a more mechanical and controlled approach to treatment.
and soon included measurement of joint range and muscle strength. Indeed, treatment of TB provides a good example of the complementary yet very different goals of improving function at a performance component level and promoting well-being in a more holistic manner, and it heralds the beginnings of the shift to a more medical perspective.

In his work with the NTBA, Kidner’s main focus was on the design of sanatoria. He always included space for occupational therapy; for ward occupations; and for curative workshops that, astonishingly, were to accommodate 75% of all ambulant patients (Kidner, 1922a). Good lighting and ventilation were needed, and patients were to be protected from prevailing winds and smoke, the noise and dust that came with the delivery of coal, and any effects of the placement of boilers for heat (Kidner, 1927). Kidner, however, does not appear to have appreciated the importance of the environment beyond this utilitarian aspect, or what Cutchin (2004) has called “container environments.” In contrast, Tracy (1917) had already written about the psychological implications of work space for occupations noting, for example, the subtle influence of basements and pointing out that “morale goes down with the floors” (p. 42). She had also commented on the social environment, describing “that rare spirit of renewed life and purpose that is seen when work really enters a ward” (p. 44).

Kidner (1922c) predicted that “work for the tuberculous . . . will continue to develop and become of increasing importance in this country” (p. 376). His prediction did not, of course, prove true; TB has been curable by drugs since 1946, and the lengthy period of convalescence has been eliminated. However, some strains of TB have since become drug resistant, and developing countries continue to struggle to contain the disease.

**Occupational Therapy’s Relationship With Vocational Rehabilitation**

Kidner went to great lengths to make clear that ward or bedside occupations and curative occupations, both of which generally entailed crafts of some type, were not designed to carry over into a job; rather, they were to establish a sense of doing and a feeling of accomplishment that would create the frame of mind required for future employment. To further delineate the purview of occupational therapy, Kidner (1925a) stated that the purpose of the preindustrial workshop was “to assist the patient in his readjustment to normal living by affording opportunity for the development of habits of industry [italics added] that have been impaired by disease or accident” (p. 188). Nonetheless, he became enmeshed in the debate over the relationship between occupational therapy and vocational rehabilitation, and he expanded his view of the role for occupational therapy. For example, he saw a role in vocational rehabilitation for those with “technical training in industrial processes and school methods, with a training in occupational therapy superimposed” (Kidner, 1924b, p. 119). He later modified this position further, saying,

As I see it, the scope of occupational therapy is becoming broader all the time, and there is a great zone—perhaps rather a “twilight” zone at present—between pure Occupational Therapy and Vocational Rehabilitation which in my judgment can best be occupied and covered by Occupational Therapists who have the vision. (Kidner–Dunton correspondence, 1927)

The struggle to determine the relation between these disciplines continued through the 1920s and beyond. For example, LeVesconte (1935), a Canadian educator during this early period, commented that she was “not in accord with those . . . who maintain that vocational training is not occupational therapy—for many it is the best therapy, because it means continued satisfactory adjustment to community life” (p. 12).

Gutman (1995, 1997) has suggested that occupational therapy in Kidner’s day was beginning to be viewed as a way to retrain the physical body and to develop prework skills (or what might now be called work hardening). There was, however, an attempt to keep occupational therapy very separate from vocational training, preferring that it be seen as a medical health profession that could retrain disabled muscles, joints, and nerves. To establish this position, occupational therapy strengthened its presence within hospital settings, tried to find its place among other hospital-based professions, and began using meaningful occupations to a lesser extent.

A related and much discussed issue at the time was the disposition of the articles made in occupational therapy. For example, ambivalent views were expressed in an editorial in the occupational therapy section of *The Modern Hospital*, which stated,

> Our efforts in occupational therapy would be wholly justified if no product of commercial value ever resulted from the labors of our patients, but if we can add the encouragement, the delight of a small money return, shall we not be wholly justified? (Swain & Lowney, 1922, p. 52)

To complicate matters further, revenue generation was often seen as necessary for sustainability of the profession, making it difficult to deal objectively with the issue. Kidner (1931) weighed in on the process versus product debate, saying that many people had “mistaken what might be termed the by-products—the objects produced by patients—as the objective of the work” (p. 1).

Thus, by the early 1920s, Kidner had already contributed substantially to ideas about occupations—as a method of learning for schoolchildren, as treatment for illness and injury, and as a foundation for work.
Part 2: Kidner's Work With the American Occupational Therapy Association

From the time of the NSPOT founders’ meeting in March 1917, Kidner had taken an active role in the association, serving in various capacities until 1922 when he assumed the presidency. Working at the NTBA and living in New York, where the AOTA offices were located, Kidner appeared to enjoy his role as president. He managed his position with attention to procedure, a sense of inclusion, a desire for participation, and a measure of humor (“Addresses Made at the Memorial Meeting for Thomas Bessell Kidner,” 1932). Although he appeared self-confident from the start of his involvement with NSPOT, his growing prestige within the organization during the ensuing years allowed him to take strong positions and to push forward his points of view.

Building an Infrastructure for the Profession

Kidner used his skills as a builder not only to design hospitals and institutions but also to help build the profession. His main concern during his presidency was to build a strong and accountable profession, and he saw the development of standards of training and a registry for therapists as the means of reaching this goal. The standards and the registry both worked toward the same ends: to protect the public, to protect the profession, and to facilitate the profession’s advancement. By setting training standards, only those with appropriate education and experience would be entered into the registry. For those who did not meet the standards for education but had appropriate experience, Kidner developed a secondary register (Kidner, 1930a). “Only the register,” he said, could protect patients “from quacks and pretenders, with a smattering of knowledge of handicrafts, posing as occupational therapists” (Kidner, 1930b, p. 222).

Kidner spoke of the need for standards and a registry in his first presidential address, and he referred to them in each succeeding address. His annoyance with the delays in approving and implementing the plans was apparent in 1926 when he stated, “I may say frankly, that if we cannot establish such a register, as all similar groups of professional workers in the hospital field and in other professions have done, we may as well cease our efforts” (Kidner, 1926, p. 404).

With state and local societies being formed, there was a need to plan for their differing roles and their relationship to AOTA. Kidner (1924a) believed that they should all be part of a network and that AOTA should recommend and set out model programs. He saw an ever-expanding role for AOTA in providing consultation; for example, Kidner visited Britain in 1925 in an early effort to help that country establish its society (Kidner, 1925b). At the individual mem-

ber level, Kidner (1929b) was hostile to therapists who did not pay dues but who benefited from the work that the organization did on their behalf.

Kidner promoted continual study, stressing its importance for individual and professional advancement (Kidner, 1929a). He saw occupational therapy as a vocation, as something of a divine calling, which implied a responsibility to provide the best that an individual could give, and to guard against complacency. He also stressed the importance of research, asking, much as we do today, “What methods are used in measuring the results of OT?” and “What are the results that should be considered?” (Kidner, 1925b, p. 412). He was concerned with cost-effectiveness and noted that “hard-nosed business men will not be put off with answers in which we say the value of our product is the restored patient” (“Sixth Annual Meeting,” 1923, p. 248).

Promoting the Profession

Work carried out by reconstruction aides during and just after the war was described by the media and caught the public’s attention (see, e.g., Ambrosi & Schwartz, 1995). News stories of the day proclaimed the new profession and noted the wonders it could achieve. In an article titled “A Plea for Occupation Therapy” published in The Woman Citizen, Mabie (1919) wrote,

Now that the value of occupation therapy has been so clearly demonstrated in the military hospitals, it seems as though the time... might be approaching when all our hospitals, except those treating short time or emergency cases, will provide occupation. (p. 344)

Such attention by the media was the result of a concerted effort by AOTA that saw the public as an important ally. Kidner (1925b) noted that “a constructive campaign is continually carried on for the education of the public as to the nature of and the need for occupational therapy” (p. 414). He exhorted therapists to be involved, saying “that old motto of political reformers, ‘organize, agitate, educate’ might well be adopted” (Kidner, 1922b, p. 501).

From his days as vocational secretary, through his role with the NTBA, and certainly as president of AOTA, Kidner served as something of an ambassador for occupational therapy. He traveled widely and spoke at various meetings, from women’s philanthropic groups to scientific gatherings. He even spoke about occupational therapy on the radio (Kidner, 1924d). One tribute after his death, referred to Kidner as “the personification of the purpose underlying the original conception of [the AOTA]—for the PROMOTION of occupational therapy.” (“Addresses Made at the Memorial Meeting for Thomas Bessell Kidner,” 1932, p. 438)
Choosing to Align With Medicine

Looking back over Kidner’s time as president of AOTA (1922–1928), the new profession appears to have been at a crossroads. Occupational therapy in its preprofessional period had drawn on its work in mental hospitals as well as programs in settlement houses, while inculcating the ideology of the Arts and Crafts movement (Friedland, 2003). Although related, these were somewhat disparate movements, and there was as yet no paradigm for the form occupational therapy was to take. In those early days, philosophies of boosting morale, decreasing dependency, and encouraging productivity prevailed, and there was relatively little concern for improving specific physical functions and taking what was considered a more scientific approach. Although not made explicit at the time, there were decisions to be made. With the war over and work with wounded soldiers diminishing, what direction should the profession take?

Our retrospective analysis of Kidner’s writings and our examination of the literature on early occupational therapy history (see, e.g., Gutman, 1995, 1997; Kielhofner, 1982; Levine, 1987; Peloquin, 2005) suggests that there were several options for the direction that the profession might take. First, it could continue as in wartime using occupations to build self-esteem and a sense of volition and for psychological preparation for later employment. Although much was written and said about the importance of this approach, it would have been as undervalued in the 1920s as it remains today, and the profession would likely not have grown (Baum, 2006).

Second, occupational therapy could focus on actual return to work and help clients build needed skills. Although medical knowledge would have been required, the profession itself would have been developed in nonmedical, vocational settings. Occupational therapy would have been more concrete and circumscribed, highly regarded by the public (Ambrosi & Schwartz, 1995), and easier to explain. Many physicians of the day spoke of occupational therapy as synonymous with what they termed the “work cure.” Indeed, Dunton, a physician and the first president of AOTA, had made it known that he preferred the term “ergo therapist” (ergo from the Greek, meaning work) to occupational therapist (Proceedings, 1919, p. 13). But this direction was not popular within the profession.

Another option was to use occupations within the larger frame of building healthy communities. Drawing on the ideology of the Settlement House Movement—where life skills were taught to new immigrants and the poor—occupations would be used to build capacity within communities. Because early occupational therapists often saw themselves as teachers (and some were previously qualified as such), this approach would have been popular. For example, Jessie Luther, the occupational therapist who oversaw the Labor Museum at Hull House in Chicago in its early days, also taught crafts in the community at the Grenfell Mission in Newfoundland (Rompkey, 2001). The profession would have moved closer to teaching and to social work—and the work would have been recognized as being needed—but would not have been highly valued. Social services and teaching, being “female” professions, were poorly paid and brought little prestige.

Finally, occupations could continue to be used as “means”—but for the purpose of developing physical, rather than psychological, function. Activities would be adapted and graded, as in the treatment of TB, so as to strengthen muscles and increase joint range. The medical model would apply. The approach would be more concrete—and easier to explain—but would turn out to be hard to justify given the developing profession of physical therapy and its ability to do the same thing and more (Friedland, 1998). There was an attractiveness to being allied with medicine, however subservient the role might be, and it soon became clear that this approach would prevail. Hospital work was considered important, and the hospital system was clearly going to grow. Analytic and seemingly more “scientific” approaches brought a status that the humanistic approach lacked.

Although there were many forces at play as these choices were being made, Kidner, as the president of AOTA, was in a good position to influence the direction of the profession during its formative years, and he appears to have chosen to align more closely with medicine. Although he valued psychological interventions, little in his writings discusses using occupations to treat mental illness8 and still less involves promoting healthy communities through skill development. By contrast, Kidner wrote extensively on the use of specific occupations for the TB population. Here he worked closely with doctors and promoted a directive and somewhat mechanical approach according to the stage of the disease. Although his own expertise had been in the area of return to work, he equivocated about the role for occupational therapy in that sphere.

Looking for new opportunities to grow the profession, Kidner latched onto the possibilities for development within the rehabilitation field in general and orthopedics in particular (Gritzer & Arluke, 1985). These changes, in turn, further dictated the need for a more medical approach. With the new role came the detailed analyses of physical processes involved in each craft and a generally more reductionistic approach (Colman, 1992; Report of Committee on Installations and Advice, 1928). Kidner (1922b) urged therapists to enter the new field of orthopedics and to develop
the needed knowledge, saying, “in no field of medical treatment are the results more patent to an observer” (p. 500). Finally, the publication of his book *The Science of Prescribed Work for Invalids* in 1930, was a clear attempt to put the work on a more medical footing (Kidner, 1930c).

To support the profession’s evolution as an allied health discipline, Kidner fostered strong relationships with medicine. He helped arrange for AOTA’s annual meetings to be held in conjunction with those of the American Hospital Association, and he made use of his many affiliations to promote and sustain the profession (Licht, 1967). He began discussions with the American Medical Association, which would later become the accrediting body for educational programs. He saw occupational therapy education as best housed within larger institutions, preferring medical schools to teachers’ colleges or liberal arts colleges (Kidner, 1925b) and appointed a committee to prepare lectures for medical students on occupational therapy (Kidner, 1924a).

Although his work before 1920 was solidly within the fields of education and vocational rehabilitation, Kidner was soon aligned with medicine, deferring always to doctors, insisting on their prescriptions for occupational therapy, and seeking their endorsement. He was so convinced about the role of medicine in occupational therapy that he was initially reluctant to serve as president of AOTA because he himself was not a “medical man” (Kidner–Dunton correspondence, 1922).

### Linking Kidner’s Contributions With Current Practice

Parts 1 and 2 described areas in which Kidner made significant contributions to occupational therapy: He introduced occupations to treat injured soldiers and those with TB during their convalescence and as preparation for return to work; he addressed the relationship between occupational therapy and vocational rehabilitation; he developed a strong infrastructure for AOTA, which included a focus on promoting the profession; and he helped to align the profession with medicine (Table 1). Today, occupational therapists do not focus on treating those with TB, and AOTA is an extremely strong and sound professional organization. However, some of Kidner’s other contributions remain issues of interest, if not concern, as the profession continues to evolve. We consider these contributions as a whole and discuss them under three headings: occupational therapy’s role in return to work, our relationships with medicine, and the profession’s image.

### Occupational Therapy’s Role in Return to Work

The economic imperative to return to work those who have had industrial accidents is as at least as strong today as it was in Kidner’s day. The Industrial Rehabilitation Act, passed in June 1920, recognized that those people with disabilities in industry far outnumbered the number of injured in war and that something needed to be done. In his 1924 presidential address, Kidner commented that all medical, nursing, and auxiliary treatments had “but one aim in view; that is, to enable the sick person to go to work again. That is the objective of occupational therapy and that should be its motivation throughout” (Kidner, 1924a, p. 431). Although occupational therapy no longer sees return to work as its sole objective, we have maintained our interest in the area throughout our history (Hanson & Walker, 1992) and over the past decade have shown a renewed appreciation of that important role. Occupational therapists continue to build work tolerance, teach energy conservation, perform physical demands analyses and functional capacity evaluations, make environmental adaptations, and conduct labor market surveys. The job of actually returning the client with a mental or physical disability to the workforce, which was seen to be the realm of vocational rehabilitation for much of the last century, is also considered appropriate for occupational therapists today (Kielhofner et al., 2004; Lysaght, 1997; O’Halloran & Innes, 2005; Sandqvist & Henriksen, 2004).

Although the importance of work as a determinant of health is accepted in academic circles and recommended at policy levels, in practice it is not fully realized and the supports required are rarely provided. Indeed, Kidner’s vision of providing intensive rehabilitation services to people with disabilities has yet to reach its full potential. Many injured workers remain on long-term disability benefits when long-term rehabilitation and greater flexibility and support in accommodations would likely result in some form of employment. Among this population of people with work-related injuries there are once again injured soldiers in our practice. With 12,912 U.S. soldiers wounded and unable to return to duty in Iraq (U.S. Department of Defense, January 2, 2008), occupational therapists find themselves working with soldiers who have sustained amputations, burns, and traumatic brain injuries along with the emotional sequelae of war, such as posttraumatic stress disorder. Helping these soldiers to return to productivity is again the goal of occupational therapy (AOTA, 2007; personal communication, LTC Stephanie Daugherty, July 26, 2007; Walter Reed Army Medical Center, 2008).

### Relationships With Medicine

It is perhaps surprising to see how firmly Kidner placed the profession in the hands of medicine despite his own beginnings in education and his role in return to work. Kidner saw opportunities within medicine not only for survival but also for acceptance and for growth (Gritzer & Arluke, 1985).
Members of AOTA considered links with medicine essential at the time and thought themselves fortunate in having as president a man who “through his association with so many physicians is able to spread the knowledge of this work in kindred fields” (“Eighth Annual Meeting of the American Occupational Therapy Association,” 1924, p. 491). Kidner was supported in his efforts by Dunton and Slagle, both former presidents of the association, and people with whom he had close personal friendships as well as strong professional relationships. The determination to align more closely with medicine can be seen as an early turning point in what Hooper and Wood (2002) have referred to as the “long conversation,” where pragmatism (representing restoring persons to satisfying lives) began to give over to structuralism (and its knowledge of how to fix body parts). It shows how fragile what Peloquin (2005) has called our profession’s ethos was when confronted with the opportunity for a more prestigious alignment.

Much of our practice (and our teaching and research) remains closely aligned with medicine. It is interesting to reflect on how the profession might have developed had it been able to withstand the pull toward medicine. Of course, it may well not have survived; on the other hand, it might also have sped up our focus on occupation as the essence of the profession and spurred on the development of occupational science.

**Image of the Profession**

Kidner set the bar high when it came to promoting the profession. He was tireless in his own efforts, and he exhorted others to do the same. Indeed, the profession has found difficulty gaining such attention in the intervening years, and therapists are once again being challenged as individuals to play their part (Baum, 2006). His call to “organize, agitate, and educate” (Kidner, 1922b, p. 501) has been heeded but perhaps not to a great enough extent. We have learned to organize and agitate, but it appears that much educating remains to be done. The general public and many within the health professions still do not know about occupational therapy and what benefits it can provide.

Kidner expected each occupational therapist to act as an ambassador for the profession. We could do well to follow his plan today. As advocates for the profession, we would be promoting our work with the general public. We would be writing letters and opinion pieces for newspapers, promoting our work by means of magazine articles, the Internet, and television. We would be using our expertise for media enquiries and interviews on topics of the day in which our perspective can help (e.g., seniors’ driving, school-based services for children with special needs, rehabilitation of injured soldiers). Like Kidner, we would give talks to external groups, for example, philanthropic groups like the Junior League who were (and still are) in a position to help. Holding positions on boards, in government itself or in its agencies, is another way of making our presence felt. There is clearly still a need for our professional associations and individual therapists alike to heed Kidner’s call to promote the profession.

**Conclusion**

Today, occupational therapists struggle with the scope of their practice and voice concern over the breadth of the field. Kidner himself had embraced what he saw as the almost unlimited opportunities afforded to occupational therapy, stating, “There are very few forms of human ailments, whether they be physical, mental or moral, in which treatment by occupations would not be of great value” (Kidner, 1931, p. 3). These “unlimited opportunities” were all rooted in the use of occupations. Whether it was in manual training for children at school or using much the same activities as treatment for injured soldiers, Kidner’s work focused attention on the power of occupation and challenged us to think more deeply about its centrality in daily life. His call for outcomes-based research in occupational therapy was important to our legitimacy as a health profession. However, it also anticipated current thinking about occupational science. Now we research not only the effectiveness of occupational therapy, but why it works. We scrutinize occupation itself to understand the link between occupations and health (Yerxa, Clark, Jackson, Pierce, & Zemke, 1990).

An emotional need exists for a stronger identity within our profession. Many occupational therapists struggle with their identity and, as a result, find it difficult to explain the profession to others. Knowing more about our past can make today’s therapists more confident in their practice and more optimistic about their future. Kidner’s story provides us with a window through which we can view our history and reflect on how we have evolved.

**Acknowledgments**

We are grateful to the relatives of Thomas Bessell Kidner whom we have been able to find in the United States, England, and Canada. They have each assisted in the process of historical recovery by sharing their knowledge of Kidner and providing family records. Thanks are given to research assistants Victrine Tseung and Marianne Sofronas Greizis and to Naomi Davids-Brumer, coauthor of “From Education to Occupation: The Story of Thomas Bessell Kidner,”
published in the Canadian Journal of Occupational Therapy in 2006, which deals with Kidner’s time in Canada.

This research has been supported through a grant to Judith Friedland from the Social Sciences and Humanities Research Council of Canada. Some information from this article was included in poster presentations at the World Federation of Occupational Therapists in Sydney, Australia in 2006 and at the Canadian Association of Occupational Therapists Annual Conference in St. John’s, Newfoundland and Labrador, Canada, in 2007.

Notes
1. The Macdonald Manual Training Fund paid the salaries of teachers of manual training for 3 years if they would come to Canada to teach in the provinces (Frost & Michel, 1998).

2. The term curative was used to describe occupations that took place in a workshop away from the ward. It is something of a misnomer because it referred to helping the person as a whole to be reestablished in daily life. There was little interest in the notion of curing per se, that is, of treating pathology.

3. Occupations in mental hospitals were often synonymous with work. Although work appeared to be helpful, it was also fraught with difficulties; for example, left-leaning critics complained that institutions were “using” patients’ labor to help pay their bills; families, who were paying for their relatives’ care, thought that work was inappropriate; and laborers complained that work was being taken away from them (Moher, 1911).

4. The pension was determined by the soldier’s disability in the open labor market and not by his earning capacity. Payment was given during training according to the number of dependents and for 1 month after the course was complete (Kidner, 1918, pp. 144–145). Kidner noted elsewhere that “the stumbling block was the fear, widely prevalent amongst convalescent men, that any attempt to improve their earning capacity would injuriously affect the amount of their pension” (Special Committee on Returned Soldiers, 1917, p. 126).

5. J. F. Byers (1918), a captain in the Canadian Army Medical Corps; J. H. Sexton; and Kidner developed the scheme.

6. In 2003, the World Health Organization (WHO) estimated that 8.9 million people worldwide had TB and that 1.75 million people would die from it each year. HIV is the single most important factor affecting increased incidence (WHO, 2008). The incidence of TB among disadvantaged groups (e.g., aboriginal peoples, inner-city poor people) in the United States and Canada remains disproportionately high (Ogilvie, 2006).

7. Kidner chaired the International Committee from 1917 to 1919 and the Research and Efficiency Committee from 1920 to 1922; after his presidency, he chaired the Committee on National Registration.

8. Dunton, also a founder of NSPOT and a close friend of Kidner’s, had written extensively (and prescriptively) on the use of occupations in treating mental illness.

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