Reclaiming Our Heritage: Connecting the Founding Vision
to the Centennial Vision


I am delighted to have the pleasure of exploring with you the Founding Vision of occupational therapy. As the Centennial Vision is poised to lead the profession in the beginning of the 21st century, I would like to take us back in time to the early years of the 20th century, when the profession of occupational therapy was founded. There are many parallels between that founding period and now. In this lecture, I will examine the ideas and values that underlie the vision articulated by the founding generation of occupational therapists and describe the similarities and differences between the Founding Vision and the Centennial Vision. I propose that the commonalities within the two visions create continuity between our past and present—that the Centennial Vision does not represent a new set of values but rather builds on values that the profession has held since its inception in 1917.

It is the purpose of history to elucidate connections in the hope that we can learn from our rich past and feel more related to it. Understanding the connection between the values articulated in the Founding Vision and those expressed in the Centennial Vision can give practitioners of today a sense of continuity and community with earlier generations of occupational therapists and an understanding that many of the contemporary values we currently hold were first articulated by occupational therapy’s founding generation almost 100 years ago.

Let us first compare the two visions. The Founding Vision states, “The particular objects for which the corporation is formed are as follows: The advancement of occupation as a therapeutic measure; for the study of the effect of occupation upon the human being; and for the scientific dispensation of this knowledge” (National Society for the Promotion of Occupational Therapy [NSPOT], 1917).

The Centennial Vision states, “We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (American Occupational Therapy Association [AOTA], 2007, p. 613). These visions share a focus on (1) successful promotion of occupation as a vital force to meet society’s needs and (2) engagement in and dissemination of scientific research that supports the effectiveness of occupational therapy.

In short, within both visions there is a concern with occupation and science. Let us examine the similarities and differences with which the founding generation and today’s generation view these concepts.

Progressive Era: 1890–1920 and Hull House

Before we discuss the Founding Vision of occupational therapy, it is helpful to understand the ideas and events that shaped the early years of the 20th century, frequently
referred to as the Progressive Era (Hofstadter, 1969). Similar to today, the United States faced many problems at the beginning of the 20th century, including war, immigration, industrialization, exploitation of workers, poor schools, and inadequate medical care. However, despite the daunting list of problems, the Progressive Era represented a time of great optimism and confidence in the idea that societal problems could be successfully addressed through progressive reforms.

The reformers were people with strong views about democracy and social justice, and they held a firm belief in the power of science to influence proposed social, educational, and medical reforms. In particular, the reform movements involving arts and crafts, moral treatment, scientific management, and women’s suffrage would have a significant and direct influence on the founders of the profession of occupational therapy.

A perfect example of the reformers is Jane Addams of Hull House. In 1889, Jane Addams and Ellen Gates Starr established Hull House in the neighborhood that was the point of entry for immigrants who came to Chicago (Addams, 1911). The purpose of Hull House was to create social and economic reform by providing educational programs and social services.

By the 1920s, the programs at Hull House served more than 9,000 people and included courses for children and adults taught by volunteer professionals from all walks of life, including doctors, lawyers, college professors, craftspeople, artists, and musicians. Addams used her celebrated connections to persuade renowned professionals such as John Dewey and Adolf Meyer to present lectures. It was at Hull House that Eleanor Clarke Slagle took her “invalid occupations” course, and thus became educated in the concept of occupational therapy.

**Founders**

On March 15, 1917, in Clifton Springs, New York, NSPOT—later to become AOTA—was legally incorporated. It was a modest beginning: Five founders gathered together in a small village in upstate New York. And it was a bold act: These individuals were committed to creating an organization that would spread a vision throughout the United States—a vision of something in which they deeply believed and one they hoped would change society.

Those at the founding meeting included Eleanor Clarke Slagle, a social welfare reformer; George Edward Barton, an architect; William Rush Dunton, Jr., a psychiatrist; Susan Cox Johnson, a teacher; and Thomas B. Kidner, an architect (Figure 1). Susan Tracy, a nurse who valued “invalid occupations,” was invited but was unable to attend. Herbert Hall, a physician, is also considered to be a founder, although he did not attend this meeting. As one of my graduate students characterized the founders, they were two doctors, two architects, two Susans, and one Eleanor!

Time does not permit me to discuss all of the founders, so I have chosen Eleanor Clarke Slagle, George Edward Barton, and William Rush Dunton as those who best exemplify the themes I will explore.

**Eleanor Clarke Slagle**

Eleanor Clarke Slagle (Figure 2) strongly believed in the promise of therapeutic occupations and spent her long professional career “spreading the gospel of occupational therapy,” as she described her mission in a letter to Dunton (Slagle, 1918). At the retirement banquet held in her honor in 1937, Slagle’s compatriot, Harriet Robeson, described her as a “pioneer by nature, with a searching mind and a keen interest in social problems and their psychological aspects” (Robeson, 1937, p. 3).

To give you an idea of Slagle’s influence, speakers at her retirement banquet included Eleanor Roosevelt, Adolf Meyer, and the Commissioner of Mental Hygiene for the State of New York.

Robeson (1937) described Slagle’s contribution in this way: “Mrs. Slagle has directed and laid the solid foundation

![Figure 1. Front row, from left to right: Susan Cox Johnson, George Edward Barton, Eleanor Clarke Slagle. Back row, from left to right: William Rush Dunton, Jr.; Isabelle Newton Barton; Thomas B. Kidner.](image1)

![Figure 2. Eleanor Clarke Slagle.](image2)
stones on which our profession and our national organization rests today” (p. 4). During her years with AOTA, Slagle held many jobs within the association. Robeson invites us to “imagine the duties of a President, Treasurer, Executive Secretary, Specialist, Traveling Salesman, Promoter, Advocate, and Ghost Writer, combined into one job and that would be but a part picture of the office Mrs. Slagle has filled these past 20 years in the AOTA” (Robeson, 1937, p. 3).

Much of Slagle’s work for AOTA was done on a volunteer basis because she also held a full-time job. Slagle provided steady leadership for the association from 1917 to 1937. Robeson (1937) said of Slage’s tenure, “Officers have come and gone. Boards have changed; but Mrs. Slagle has remained, steadfastly to guide our craft through often foggy seas” (p. 3). The Eleanor Clarke Slagle Lectureship was created in recognition of her significant contribution to the profession.

To provide a little history about the Slagle Lectureship, it was here in Houston 56 years ago that the AOTA House of Delegates and the Board approved its creation. The motion reads in part,

O.T. Honorary Guest Lectureship: As is done in medicine and other professional scientific fields, we [the AOTA membership at large] extend the single honor each year at our Annual Conference of having an Honorary Occupational Therapy Guest Lectureship, to be called out of deference to one of our most outstanding O.T. pioneers—the “Eleanor Clarke Slagle Lectureship.” . . . The lecturer each year would be some outstanding occupational therapist who has made significant contributions to the field. (AOTA, 1953)

The minutes of the discussion show that the delegates raised issues such as geographical representation, payment of travel expenses, educational background, whether a non-occupational therapist could be considered to be a Slagle lecturer, and whether 10 years of experience was a good minimum for such consideration. One of the delegates wanted to know what would happen if you had a “red-hot OT” with just 8 years of experience? The response was, “If they are so good at 8 years, think how wonderful they will be at 10 years” (AOTA, 1953). The debate ended in unanimous approval of the creation of the Slagle Lectureship.

Slagle was an exception for the times: She sought out educational experiences at a time when many women did not, she lived alone and financially supported herself (she had been married and later separated from her husband), and she had professional ambitions. The most “acceptable” professions at that time for women were nurturing jobs such as nursing, teaching, or social welfare. That three women—one from each of the “acceptable” professions—were involved in the founding of our profession is noteworthy and had a significant influence on the development of occupational therapy.

We will let Slagle describe in her own words her early education in occupational therapy. She wrote,

Covering a period of years interest in the unfair social attitude toward the dependency of mentally and physically handicapped, followed by lectures on Social Economics by Professor Henderson, Chicago University, Jane Adams, Hull House, Julia Lathrop, now of the Children’s Bureau. I took up in 1910 special courses in occupations and educational methods, Chicago School of Civics and Philanthropy, now a part of the University of Chicago, followed by a 6-month study of hospitals, charitable institutions and dependency of mental and physical cases. (Slagle, n.d., p. 1)

For this course of study, Slagle earned a certificate. In April 1912, Slagle was hired as director of occupational therapy by Adolf Meyer of Phipps Psychiatric Clinic, Johns Hopkins Hospital in Baltimore, Maryland. Meyer was instrumental in helping to conceptualize occupational therapy. Indeed, Slagle names Meyer, along with Addams and Lathrop of Hull House, as responsible for sowing the “seed of occupational therapy for mental patients” (Slagle, 1922, p. 11). Because of her background in social welfare, Slagle was interested in the environmental influences on mental illness and joined with Meyer to create and administer a habit-training program at Phipps Clinic. The program was designed for individuals with severe schizophrenia, known at that time as dementia praecox. The habit-training program was based on the assumption that “occupation used remedially serves to overcome some habits, to modify others, and construct new ones to the end that habit reactions will be favorable to the restoration and maintenance of health” (Slagle, 1922, p.14).

After Slagle left Phipps Clinic, she returned to Chicago where, among other activities, she headed a school of occupational therapy named for Chicago physician Henry P. Favill. Slagle then moved to New York and became the director of occupational therapy for the New York Mental Hygiene Department. One of her first acts was to create a habit-training program similar to the one at Phipps Clinic. Although Slagle also supervised the development of other occupational therapy services such as ward activities and occupation centers that ultimately served nearly 70,000 patients in New York’s state hospitals, it was the habit-training programs that held a particular attraction for her. She told training aides, “It takes consecration and genuine love of the human family to
understand the direction and participation in habit training classes among patients who have been in hospitals anywhere from 5 to 20 years” (Slagle, 1922, p. 13).

Slagle (1924) defined the primary goal of occupational therapy as “help[ing] patients to readjust themselves, both socially and industrially, through organized occupations” (p. 98), and she spent her professional life creating and supervising programs that achieved that goal. She also was mindful of the value of validating the effectiveness of occupational therapy and reminded therapists of the “value of accurate notes” (Slagle, 1922, p. 17). She admonished those in charge of conducting research in New York’s Mental Hygiene Department to include the study of the effects of occupational therapy in addition to psychiatry. She said, “Surely it is not too much to expect that equally valuable contributions in the field of occupational therapy would result if the institute undertook research into its underlying principles and its mode of application” (Slagle, 1924, p. 104).

Slagle was heavily influenced by social justice concerns for those who had landed in the “discard of life” to attain a modicum, at least, of self-respect and dignity (Slagle, 1922, p. 13), and she saw occupation as the means to achieve it. She saw scientific research as the means to help establish the value of the occupational therapy profession and ensure its longevity. She dedicated her life to shaping, directing, and promoting the profession, thereby advocating for those not held in high regard by society.

George Edward Barton

George Barton (Figure 3) came to believe in the healing power of occupation through his own personal experience. In 1901, Barton learned he had tuberculosis. In 1912, he developed gangrene on his left foot while doing an environmental survey, and following surgery he developed hysterical paralysis on the left side of his body. Barton was desolate when he sought the spiritual counsel of Rev. Elwood Worcester, rector of the Emmanuel Church in Boston. The good reverend convinced Barton that although he might feel that life might not be worth living for himself alone, “It would be worthwhile to prove for the sake of others that a man in his condition could overcome his disabilities and teach others to do the same” (Licht, 1967, p. 270). Thus Barton’s new vocation in occupational therapy was born.

Barton was an architect by training and interested in the effect that the environment can have on individuals. For a time he worked in London with William Morris, the leader of the Arts and Crafts Movement, who inspired in him a concern for the relationship between the environment and social problems. On his return to the states, Barton served as the first secretary of the Boston Society of Arts and Crafts. As a man sensitive to the environment, he found hospital conditions deplorable. Paramount in Barton’s mind was the need to create an environment that would promote healing.

He purchased a house in Clifton Springs, New York, which he named Consolation House, and remade it to reflect the tenets of William Morris: Your home should contain only what you know to be useful and believe to be beautiful (Boris, 1986). Barton created the opposite of the hospital experience that he had found so debilitating. His wife, Isabelle Newton Barton, describes Consolation House: “Consolation House is merely a little colonial dwelling, with its shop and garden, in a sleepy upstate village, wherein a sick person, who, convalescing, hates the very thought of the hospital, can be far away from all ‘sick’ atmosphere, and at the same time learn something to be of value to him” (Newton, 1917). In other words, it “represented the efforts of a man to get away from institutional life toward one through which he could be happy, get well, and become self-supporting” (Newton, 1917).

George Barton (1922) chose the Phoenix, “which burns itself up with its own fire and is reborn from its own ashes,” as the emblem of Consolation House to represent the “triumph over disability and despair” (p. 308). That engagement in occupation might ultimately result in patients becoming self-supporting was a critical factor for Barton. In part, Barton was operating under a strong social norm at that time. As he wrote, “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” (Barton, 1922, p. 305).

Consolation House provided a healing environment where Barton and others could recover was his solution to the debilitating effects of institutional life. He devised his own self-treatment, primarily using the occupations of carpentry and gardening. As Mrs. Barton describes him, “Starting alone, with no prospect of help, paralyzed on his left side so that he could scarcely do more than stand, and with no motion possible in his left hand and arm, he used his own body as a clinic to work out the problem of re-educating himself. He made a beginning by reclaiming a weed patch” (Newton, 1917).
After he gradually recovered, Barton focused on providing occupational treatment for others. He wrote, “I am going to try to prove that the patient can spend the long enforced hours of convalescence . . . in preparing himself for the life which he has got to lead when that convalescence is ended” (Barton, 1914b, p. 330).

Barton did not have a medical background, and he initially expressed his interest in occupation in terms of a social and educational perspective. He asserted, “I am not a doctor and have no particular interest in medicine, but I may perhaps lay some slight claim to being a socialist however insignificant, and my great aim is to use the hospital as a re-educational institution” (Barton, 1914a). However, Barton’s view changed over time, and by 1917 he was insisting that the word occupational therapy be used instead of re-education because he wanted to have the “health-giving side emphasized” (Barton, 1917b). This change probably reflected Barton’s realization that the profession of occupational therapy would be better accepted and promoted as a therapeutic service that was part of the scientific medical community.

Barton had a close affinity for the engineering sciences, probably because of his technical education as an architect. He was especially taken with the ideas about measurement and efficiency underlying the popular movement of the time known as scientific management. Barton was particularly interested in the time and motion studies of Frank and Lillian Gilbreth. Indeed, he wrote a letter to Frank Gilbreth, offering the services of the NSPOT to contribute to the “Plan to Re-educate Our Men Maimed in the War” (Barton, 1917c). In addition, in a piece he wrote about measuring efficiency, Barton asked, “What is an efficiency expert? An ‘efficiency expert’ . . . is simply an engineer who substitutes accurate measurement for personal opinion . . . and unscientifically derived conclusions” (Barton, n.d., pp. 77–78). Barton then took the idea of devising methods of measurement to address practical problems in scientific management and applied the principles of measurement to occupational therapy. You can understand the appeal to George Barton of a science that could help occupational therapists to measure patients’ movements and match the correct occupation with the corresponding motion. Barton incorporated time and motion studies into his work and developed a form of activity analysis: “Mr. Barton first considers what motions are possible or impossible, desirable or undesirable; then he finds some occupation which involves those possible and desired motions” (Newton, 1917).

Barton died in 1923 and therefore did not live long enough to see many of his ideas implemented. In a letter from Mrs. Barton to Dunton, dated July 12, 1923, she states, His enthusiasm and vision were too energetic for his frail body, and, after a really heroic winter working under great difficulties . . . he collapsed thirteen days before he died on April 27, with a return of his tuberculosis. It, of course, seems very hard to me, but I am happy in possessing the finest sturdiest little 2½ year-old son, who bids fair to possess such a body that he can perhaps accomplish things his father failed in because of his own physical drawbacks. (Newton, 1923)

Through his own journey of self-healing Barton learned the value of occupation. This experience led him to dedicate the rest of his life to helping others achieve the physical, emotional, and financial recovery that he had achieved. Barton was a man of action and ideas. Influenced by the Arts and Crafts and Scientific Management movements, Consolation House represents Barton’s attempts to create an aesthetic, healing environment that also incorporated a scientific approach to treatment.

Barton had a prickly personality; he was easily offended and held strong views. However, I believe that on balance the passion he possessed for occupational therapy compensates for his eccentricities. Consolation House was an extraordinary undertaking in which he tried to put into practice his ideas about occupation and science. In fact, years later, in a keynote address given at the 50th Annual Occupational Therapy Conference, the following question was posed: “Does it sound too visionary to suggest that there be a Consolation House within walking distance of every urban dweller?” (Bockoven, 1971, p. 224).

William Rush Dunton, Jr.

William Rush Dunton, Jr. (Figure 4) is frequently referred to as the “father of occupational therapy” because of his many contributions to the development and promotion of the profession (Quiroga, 1995). He was a strong believer in the value of therapeutic occupation and a tireless promoter of research in occupational therapy. He wrote in his “Credo for Occupational Therapists”:

That occupation is as necessary to life as food and drink

That every human being should have both physical and mental occupation

That all should have occupations which they enjoy.

(Dunton, 1919, p. 10)
Dunton was a man of principle and independent thought. He was a member of a prominent Philadelphia family and a descendent of Benjamin Rush, one of the signers of the Declaration of Independence. After he graduated from medical school at the University of Pennsylvania, it was assumed he would follow in his uncle’s footsteps—his uncle being a prominent physician. However, Dunton broke with his family’s wishes that he marry a woman from an equally privileged background and instead chose Edna Hogan, a nursing superintendent at Children’s Hospital in Philadelphia. This ended his professional relationship with his uncle, forcing Dunton to strike out on his own. He ultimately became a psychiatrist and was appointed supervisor of occupation classes at the Sheppard Asylum (now Sheppard Pratt Hospital) in Maryland.

It was Dunton’s life-long interest in crafts that helped him understand that occupation was a valuable form of therapy for himself and others (1943). He first became interested in crafts as a child. In a tongue-in-cheek autobiographical sketch titled How I Got that Way, he wrote,

Perhaps my parents were to blame. Father was mechanically minded and by precept and example fostered an instinct or craving in me to know how things are put together or why wheels go round [and] we must blame some gene in me which came from my great grandfather, William Rush, who made his living as a wood carver and sculptor [and] Mother was a most accomplished needlewoman, and, being the baby of the family, I was naturally with her a great deal and grew familiar with crocheting . . . and almost all forms of needlework.

(Dunton, 1943, p. 244)

Evidence that Dunton retained a lifelong interest in arts and crafts is provided in his extensive list of publications (Dunton, 1946). It shows several articles on quilts and quilting, gardening, toy making, chintz work, and a study of crafts.

Of course, most of Dunton’s publications are related to promoting occupational therapy. He wrote books and articles to help medical students, physicians, nurses, and occupational therapists understand the use of therapeutic occupation. His perspective was a humanistic one. At the founding meeting, Dunton proposed that the philosophy underlying the moral treatment movement of the mid-1800s was one to which occupational therapy should adhere through its valuing of a humanistic, occupation-based approach to care for the mentally ill (Dunton, 1917). He also was holistic in his view of treatment, arguing in a 1928 article that it was impossible to separate the mental and the physical. He used a quote from Thomas Salmon to highlight the importance of this psychobiological view: “The old, unproductive controversy over what is ‘mental’ and what is ‘physical’ is ending . . . only an approach broad enough to permit . . . the psychobiological point of view throws light upon their nature” (Salmon, as cited in Dunton, 1928b, pp. 9–10).

Although Dunton advocated this enlightened view, he also understood that for many of his fellow physicians, the holistic versus reductionistic and the mind versus body debates were not decided. Thus his 1928 and 1945 editions of the textbook Prescribing Occupational Therapy explained the use of occupations within the context of medical diagnoses.

Dunton’s most important contribution to the promotion of occupational therapy was in his role as publisher, editor, and author. In large part, he was responsible for creating and preserving the written legacy of the profession (McDaniel, 1971). When the NSPOT was formed in 1917, Dunton was editor of the Maryland Psychiatric Quarterly. Dunton made the Quarterly the official journal of the association until 1921, when he inaugurated the profession’s first official journal, the Archives of Occupational Therapy. It was renamed Occupational Therapy and Rehabilitation in 1924. Dunton remained its owner and editor until AOTA took over responsibility for the profession’s journal, and the first issue of the American Journal of Occupational Therapy was published in 1947. Dunton’s editorial contributions totaled more than 25 years, all of which were without remuneration.

One of Dunton’s greatest challenges was obtaining sufficient work of high-enough quality to publish. He worked tirelessly to ensure that sufficient material was available, often prevailing upon his friends, such as Adolf Meyer, Eleanor Clarke Slagle, Susan Tracy, and Herbert Hall, to write. He also wrote many articles himself. Out of desperation he developed one strategy that he described in a letter to a member of the editorial board for an upcoming conference: “By the way, will you arrange with Slagle about the papers which are read? The best plan is to snatch them out of the reader’s hand” (Dunton, 1928a).

Dunton’s challenge was particularly difficult because occupational therapy had not yet established itself as a research-based profession. As a physician, Dunton understood that it was necessary for the profession to conduct scientific research in order to demonstrate its effectiveness within the medical community, and he tried to convince occupational therapists of this necessity. He wrote, “It should be remembered that without a record of the data, the value of the work accomplished may be questioned since it is not available for the use of others unless put in proper written form” (Dunton, 1934, p. 328).
Dunton understood that research and publication were the best ways to promote and justify the profession. He also saw cultivation of a scientific approach as something that would invigorate occupational therapists themselves as well as the profession. He observed, “Unless one has the desire to develop one’s work, to analyze it, to improve it, then it becomes irksome and we are little more than robots. It is this spirit that has advanced occupational therapy so far in the past two decades” (Dunton, 1928c, p. 347).

Part of the challenge for the profession was to articulate the occupation process in a way that would be scientifically persuasive. Dunton understood that it was difficult to convince those who held a scientific view that what appeared to be a seemingly simple process of engagement in occupation was actually quite complex and of considerable scientific merit. He said,

Probably we enthusiasts for occupational therapy are to blame because we have not presented the subject to these doubters in a form in which they could understand it. . . . We have talked too simply of the virtues of occupational therapy and have praised it in one-syllabled [sic] words, whereas we should have used highly technical terms and shown by fractions, tangents, and co-sines the mental effect of making a basket. (Dunton, 1934, p. 325)

Part of the problem of articulating occupational therapy lay in the dearth of research instruments that could measure the full complexity of the individual and his or her successful engagement in occupation. Dunton wrote,

[W]e are unable to present the results of research because the psychologists have not given us formulas for judging the emotional effect of pounding a copper disk into a nut dish or other occupations . . . Nor have the physiological chemists given us a test whereby if we lay a bit of paper on a patient’s tongue we may judge that by its turning a pale pink he is enjoying his weaving to a mild degree, whereas his neighbor shows a crimson when tested because he is having a wonderful time putting a jig saw puzzle together. In other words we lack a quick and snappy means of measuring the emotions. (Dunton, 1934, pp. 325–326)

Thus, Dunton describes in his own inimitable fashion what we continue to struggle with today in terms of providing evidence-based outcomes research.

Dunton believed in both occupation and science. He was humanistic and holistic in his view of the ability of therapeutic occupation to heal both mind and body. He also valued science and understood that scientific research was required in order for the profession to prove its effectiveness to the medical community. Like his fellow found-

ers, Dunton was a man of thought and action. Throughout his long career, he tirelessly promoted the profession through advocacy, publishing, and editing. He almost single-handedly helped to preserve the written legacy of the profession, and he inspired others to write and publish and cultivate an inquiring mind.

To summarize, the founders deeply believed in the benefits of therapeutic occupation and created a profession whose mission was to spread their vision throughout the country. They expressed a vision of occupational therapy that was holistic, humanistic, and scientific. Their goals were as follows:

- To promote occupational therapy as a way to help individuals reclaim dignity and self-respect; to heal the body, mind, and spirit; and to become productive members of society
- To develop a systematic approach to the use of occupation
- To encourage engagement in scientific research in order to demonstrate the effectiveness of occupational therapy and establish its legitimacy within the medical community.

**Centennial Vision: The Profession’s Contemporary View of Occupation and Science**

In 2003, the AOTA Board of Directors initiated a strategic planning process that culminated in the *Centennial Vision*. The process involved close to 2,000 practitioners, educators, and researchers united in developing a “roadmap for the future of the profession” (AOTA, 2007, p. 613). The *Vision* unites all of us in developing and promoting a profession dedicated to meeting society’s occupational needs. The profession is envisioned as “powerful, widely recognized, and science-driven . . . with a globally connected and diverse workforce (p. 613).” In other words, the *Centennial Vision* puts occupation at the heart of what we do, recognizes that scientific research is critical to our survival, and emphasizes our interconnectedness with occupational therapy practice throughout the world.

A major thread that connects the *Founding Vision* with the *Centennial Vision* is a profound belief in the healing nature of occupation. However, the *Centennial Vision* broadens the definition of occupation envisioned by the founders to include “preventing and overcoming obstacles to participation” in valued occupations (AOTA, 2007, p. 613), thus incorporating a social perspective into the view of engagement in occupations.

This incorporation of a social perspective within the *Centennial Vision* reflects the movement within society from a medical illness model to a prevention wellness model exemplified by the World Health Organization’s (WHO’s)
introduction of their 2001 classification system. The *International Classification of Functioning, Disability and Health* promotes a view of health as something that is achieved through the individual working in collaboration with medical and social support systems to break down any environmental barriers in order to achieve a full, productive life (WHO, 2001). Within the occupational therapy profession, a blending of the medical and social perspectives is represented in the *Occupational Therapy Practice Framework, 2nd Edition* (AOTA, 2008), which was introduced in 2002 and revised in 2008 to provide a structure for articulating practice that centers on active participation of the client in a context that promotes engagement in chosen occupations.

The emphasis on science remains strong in both the *Founding* and Centennial visions. One difference is that the profession has gone from aspiration to accomplishment; that is, we no longer simply aspire to do research but are actively engaged in it. The profession’s success in demonstrating effectiveness of therapeutic interventions has improved as more occupational therapists earn PhDs and conduct scientific inquiry. Yet Dunton’s concern—ensuring that the research models and measurements reflect the complexities of engagement in occupation—still remains a challenge today. Although the importance of evidence-based practice is well understood, the need for more research and better instruments is still pressing (Holm, 2000; Coster, 2008).

Finally, the Centennial Vision takes the practice of occupational therapy beyond the United States, linking it to the global community. This represents a realization that to meet society’s occupational needs, the profession of occupational therapy has to serve the world (Kronenberg, Algado, & Pollard, 2005). Each country’s practice and research can—and must—inform and support one another’s practice and research. In comparison, the Founding Vision does not explicitly reflect an international perspective. The founders’ awareness of the importance of international events and community was surely there, however, because the United States was deeply involved in fighting World War I—an event that certainly created an understanding of the interconnectedness of countries and the impact that their actions can have on the rest of the world. With today’s advanced technology and economic interdependency, productive and collaborative international relationships are of paramount importance.

**Achieving the Centennial Vision by Embracing Our History**

We can achieve our Centennial Vision through reclaiming our historical legacy. We can do this if we take the steps outlined below.

1. **Retain the founders’ vision of a humanistic-scientific practice and dedicate ourselves to bridging that divide between the two paradigms.**

The founders believed in a vision of occupational therapy that was holistic and humanistic as well as scientific. But the world has changed since 1917. In 2009, we are living in a world where the scientific medical model has achieved dominance in much of U.S. health care. This creates a conflict of competing values between the holistic, socially oriented humanistic paradigm and the reductionistic, medical-model, scientific paradigm (Kielhofner & Burke, 1977). The challenge that the profession faces is to be scientific in its interventions, documentation, and measurement of outcomes and still hold true to its original humanistic values. Thus it is imperative that today’s occupational therapists bridge the humanistic and scientific paradigms.

In the current practice arena, this is not easy to do if the predominant perspective of the setting is the medical model. Even in school-based and community practices, the medical model is the basis of referral for therapy, and reimbursement agencies expect that practitioners will provide scientific evidence of effectiveness. Thus occupational therapists must blend the scientific and humanistic perspectives in order to achieve occupational therapy’s vision: A vision where occupation is at the heart of our intervention, not a diagnosis.

Leaders within the profession have developed theoretical and research models and frameworks that place client-centered occupation at the core of intervention (Christiansen & Townsend, 2010; Kielhofner, 2008; Law, 1998). Therapists not familiar with these models should become so in order to be able to introduce occupation-centered approaches to evaluation and intervention in their settings. Students and new graduates who have been educated to view occupational therapy practice as occupation and client centered should carry that vision into their various practice arenas and be prepared to fight for this vision when it does not fit with the prevailing treatment approach of the agency.

Adolf Meyer (1922) wrote that there are no “royal roads” to being an occupational therapist (p. 7). By that he meant that no one was going to roll out a red carpet for those promoting this new profession. Occupational therapists would have to face many challenges to help ensure the profession’s success. Like our founders, we must be pioneers and risk-takers to promote our Vision.

2. **We can achieve our Centennial Vision if we emulate the founders as role models of leadership.**

There has been considerable focus on history during the recent U.S. presidential transition and discussion of how the lessons from history could be applied to our troubled times. In particular, Franklin Delano Roosevelt and Abraham Lincoln have been held up as leaders President...
Barack Obama could emulate. Similar to what is happening on the political level, I am suggesting that we in the profession of occupational therapy look to our history and our founders for lessons in leadership.

In this lecture I have tried to provide the biographical essence of three of the founders and discuss the qualities that made them leaders. One quality that stands out in my mind is their personal and professional courage. For example, George Barton developed his own self-cure when the medical community offered him little in the way of treatment. Eleanor Clarke Slagle separated from her husband and established herself as financially self-sufficient and professionally successful at a time when this was relatively rare for a woman to do. William Rush Dunton married a woman outside his accepted social circles, even when it meant being ostracized by his family and having to professionally establish himself without their support.

In addition to courage, creating a profession takes optimism and innovative thinking, and it takes a leap of faith. The founders saw a need and a way to fill it. They were pioneers committed to a vision, and they committed themselves to the hard work that it takes to implement a vision. If it meant working long hours and sometimes doing mundane tasks to be an advocate for the profession, Slagle did it. If it meant snatching the conference papers out of the hands of presenters so the work of occupational therapy could be preserved in written publications, Dunton did it. If it meant overcoming the exhaustion that is part of having a chronic illness to make the dream of Consolation House a reality, George Barton did it.

The founders also had confidence and an unyielding belief in occupational therapy. As Susan Tracy (1921) reminds us, “The real success of the movement often depends upon the faith of the speakers. If occupational therapy be ‘tried’ with a feeling of possible failure, the odds will be against it. There is no success in doubt, there is no success in fear, there is no success in division of purpose. Convince yourself of the value of occupational therapy, and then establish its use” (p. 399).

The founders displayed confidence, courage, hard work, creativity, and a willingness to take risks. These characteristics are what we need to cultivate if we are going to lead our profession in implementing the Centennial Vision. As President Moyers Cleveland reminded us, “Without champions for our Vision, there will not be a Vision” (Moyers, 2007, p. 625).

Call to Action: Now It Is Our Turn to Lead

In conclusion, I would like to issue a call to action to all in this audience. Today I have described the contributions of three of the founders of occupational therapy: Eleanor Clarke Slagle, George Edward Barton, and William Rush Dunton. They were creative risk takers, visionary leaders and tireless advocates for their patients and the profession. You could say that their presence was historical karma—they were the right people at the right time in the right place. Their act of founding the profession—creating a profession that had hitherto not existed—gave them the opportunity to put their many talents and skills to work. It enabled them to live up to their potential and exert an influential role on a fledgling profession.

I would argue that, almost a century later, we are at another pivotal point in our profession. We are at the beginning of the 21st century and we have a vital mission: implementing the Centennial Vision, a Vision that will help us to flourish in this new century. In the United States and around the world, increasing attention is being paid to the rights of all people to participate in society. Like the founders, we are confronted with inequities and disparities in society that affect people’s health, quality of life, and participation. Like the founders, we have a powerful tool—the use of engagement in occupation—as both a means and end to health. What we have that the founders did not is a growing body of evidence to support the efficacy of what we do, and we have the power of numbers. Each of you, through your innovative, evidence-based practice and commitment to participation for all, can enact the social justice values of our founders while creating the powerful, science-driven profession that we envision today.

I would further argue that you are the right people at the right time in the right place. The United States has elected a new president who has pledged to provide health care for all. President Obama’s health policy team is asking everyone for their views on what our health care system should become. Now is the perfect opportunity for occupational therapists to voice our vision.

This lecture should serve to remind you that, like our forefathers and foremothers, we all have the potential to be political activists, risk takers, and confident leaders. Indeed, are you so different from the founders? Are you not tireless promoters of occupational therapy like Slagle? Are you not innovators in your work as was Barton? And are you not all promoters of evidence-based practice like Dunton? If you are not, now is your opportunity to be.

Our founders remind us of what can be done with talent and commitment. And history can strengthen our resolve by helping us to understand that as occupational therapists of today we have a heritage of strong leaders, from the initial founders through succeeding generations of occupational therapists whose innovations in clinical practice, theory, measurement, and research reflect the values

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that the Founding Vision and the Centennial Vision share. Now it is our turn to take up the challenge as we enter a new century of occupational therapy. ▲

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