4-26-2011 12:00 AM

Authentic Occupational Therapy: A genealogy of normative technology in occupational therapy

Daniel K. Molke Mr., *The University of Western Ontario*

Supervisor: Dr. Louis Charland, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

AUTHENTIC OCCUPATIONAL THERAPY: A GENEALOGY OF NORMATIVE TECHNOLOGY IN OCCUPATIONAL THERAPY

Spine Title: Authentic Occupational Therapy
Thesis Format: Monograph

by

Daniel K. Molke

Graduate Program in Health and Rehabilitation Sciences: Occupational Science Field

A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

THE UNIVERSITY OF WESTERN ONTARIO
School of Graduate and Postdoctoral Studies

CERTIFICATE OF EXAMINATION

Supervisor

_____
Dr. Louis Charland

Supervisory Committee

_____
Dr. Thelma Sumsion

_____
Dr. Lilian Magalhaes

Examiners

_____
Dr. Andrew Johnson

_____
Dr. Abraham Rudnick

_____
Dr. Helen Fielding

_____
Dr. Elizabeth Townsend

The thesis by

Daniel Karl Molke

entitled:

Authentic Occupational Therapy: A Genealogy of Normative Technology in Occupational Therapy

is accepted in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

_____
Date

_____
Chair of the Thesis Examination Board

Abstract

Drawing on a Foucauldian genealogical methodology this dissertation critically examines the historical lineage of occupational therapy. During the latter half of the 20th century academics in occupational therapy repeatedly argued that reengagement with the values and beliefs that provided an historical foundation for the profession must occur to ensure that occupational therapy remained relevant and continued to flourish. Critics have also called into question the legitimacy of many of the traditional notions which supported the establishment of occupational therapy at the beginning of the 20th century. In critically examining the moral treatment of the 19th century, occupational therapy practice described as moral treatment in the 20th century, and occupational therapy practice that relates to spirituality, some of the normative assumptions that guide practice in different temporal contexts are explored. Specifically, the genealogical methodology employed helped to outline how particular therapeutic technologies work with normative content. A critical examination of historical and contemporary literature revealed an array of therapeutic techniques that, for better or worse, occupation workers had available to them. Practicing authentically would require occupational therapists to attend to the normative ends of treatment. Concluding arguments highlight the necessity of practice that considers the normative dimensions of occupation and the potential for critical research to help outline limits beyond which occupational therapists risk jeopardizing the wellbeing of clients and communities that seek professional attention.

Key Words

Occupation; Moral Treatment; Values; Norms; Spirituality; Occupational Therapy Practice

Contents

List of Tables

Chapter 1

1 Introduction

> A myth which is understood as a myth, but not removed or replaced, can be called a 'broken myth' … Those who live in an unbroken mythological world feel safe and certain. They resist, often fanatically, any attempt to introduce an element of uncertainty by 'breaking the myth,' namely by making conscious its symbolic character. (Tillich, 1957, pp. 50 & 51)

> It's quite true that I don't feel myself capable of effecting the 'subversion of all codes,' 'dislocation of all orders of knowledge,' 'revolutionary affirmation of violence,' 'overturning of all contemporary culture' … My project is far from being of comparable scope. (Foucault, 1978/1996, p. 283)

In an introduction to an edited volume that considered a variety of perspectives that deal with the relationship between fact and value, Zachar (2008) began with the presentation of a Humean dictum: "one cannot derive an 'ought' from an 'is' or in less poetic terms, one cannot derive a value from a fact" (p. 1). In many ways, this distinction helps to highlight the importance of a particular form of scholarship that is largely missing from scientific literature. As a community of professionals and scholars, occupational therapists need to develop a body of knowledge that aims to uncover and discover the facts, laws, and truths that describe the parameters of human nature as it relates to occupation. In this day and age, the collection of this kind of knowledge must occur using a variety of methods. Indeed the collection of this kind of knowledge using legitimized forms of empirical inquiry will help to ensure that we retain standing in the highly competitive world of health care. However, another kind of scholarship is required particularly if we hope to exist as an autonomous community able to collectively define and redefine the scope and purpose of our expertise. While both kinds of scholarship deal with truth, this second kind of scholarship that I refer to here deals with truth in its broadest sense. After we have collected our facts what will we do with them? What is the aim of occupational therapy practice? For better or worse, what kinds of people will we help to produce with our empirical knowledge? What kind of world do we want to help create? The facts and laws of human nature that we uncover can provide the content through which we effect change. Scholarship into the normative and prescriptive dimensions of practice can center on the purposes that drive practice and the ends that we

hope to reach. This kind of scholarship revolves around the identification, creation, and recreation of our professional myths and beliefs. This form of scholarship concerns the ethos of occupational therapy (see Foucault, 1984/1988b; Peloquin, 2005).

In discussing the scientific method, Tillich (1957) explained that it functions to outline and control reality. He argued that scientific knowledge cannot help us define what should or ought to be. However, as Foucault attempted to demonstrate, all too often, in modernity, "ought is naturalistically reduced to is" (Habermas, 1986, p. 1; see also Townsend, De Laat, Egan, Thibeault & Wright, 1999). Throughout the history of the Western world, reason was a term that helped to define the "source of meaning, of structure, of norms and principles" (Tillich, 1957, p. 75). In modernity, reason, particularly with the health sciences, refers most often to a scientific kind of rationality (see Horkheimer & Adorno, 1972). In adopting the scientific method we are no longer permitted to openly discuss the dimensions of knowledge that work to define the ends to which we aspire as individuals, professionals, and whole communities. We are trapped within a system that demands we push these considerations aside to eliminate bias. Unbeknownst to many of us, this has not helped to eliminate 'bias,' but institutionalize it within closed truth systems. In modernity, we have forgotten that our symbols and myths are symbols and myths. This prevents us from debating their relative validity if not their relative utility. Indeed Foucault (1978/1996c, p.283) believed that norms are codified within the means through which we control and describe existence. Reason works to define the nature of existence and outlines how each of us should structure and direct our lives. With his critical projects, he hoped to "wear away certain self-evidentnesses [sic] and commonplaces about madness, normality, illness," for example. He sought to crack open and explicitly outline the truths that have become implicit assumptions with the routine construction and application of knowledge with modernity. In the past, philosophical work, for example, helped to explicitly outline the norms and principles that structured and ordered existence. In modernity, our scientific methods naively outline the structure of a world according to precepts that, for many, have been forgotten.

To better illustrate, consider the following excerpt from a case example found in an occupational therapy text book published in 1988:

> I'm working on the research proposal for my thesis. Come to think of it, you might be able to help. I want to study the validity of the community readiness activities we use. I think occupational therapists are in a position to exert a lot more influence on the discharge process, but we need to be able to demonstrate better that we can evaluate whether a patient is ready to move out. I'm afraid that community readiness activities in an institutional setting sometimes are a lot different from the real thing outside. I hope that I can tease out ways of identifying the critical elements so we can do a better job. (Tiffany, 1988, p. 379)

This is an example of a common trend that occurred during the tail end of the 20th century. Occupational therapists made valiant efforts to legitimize practice by obtaining advanced degrees and training in the conduct of empirical research. Leaders in the field called on occupational therapists to validate their work using scientific methods. This quote exemplifies those efforts and this call. Occupational therapists worked hard to gain power and influence within health care by induction into the realms of science. However, if one takes a moment and reexamines this statement, one can see much more. The author of this statement identified a tension that exists between what occurs in an institutional setting and the real world which called into question the validity of 'readiness activities' used in that institution. This author sets out to improve things by teasing 'out ways of identifying the critical elements' involved in preparing an individual for discharge. A research project that works to eliminate 'bias' may indentify various factors involved in the concept of 'community readiness.' In the process of conducting this work, however, this researcher may discover that occupational activities are only made meaningful when reflective of occupational norms that exist in the 'real world.' The open inclusion of normative considerations into research and treatment, however, may hamper this occupational therapists ability to have her work taken seriously. This is ironic, in that it may very well be the case that the identification and understanding of the norms that structure occupation may actually constitute the 'critical element' that this occupational therapist is looking for.

One definition found in the Oxford dictionary defines 'norm' as "a standard, a type; what is expected or regarded as normal" (Brown 1993, p. 1939). The norms that structure occupation in a given sociocultural context create expectations about what is acceptable and unacceptable (Jones, 1998; Polatajko et al., 2007b). It has been argued that a fundamental question that often confronts occupational therapists is how they will

deal with established societal expectations when they threaten to delimit what might or could be (Townsend et al., 2007). Consider another concrete example found in an occupational therapy text book published in 1947:

> Restoration of good habits through a program of constructive, normal activities results in the improved social status of the patient by restoring his self-respect and interest in the world of reality. An attempt is made to persuade the patient to make an effort to recover by encouraging him to cope with the social order and by trying to convince him through appeals to his various senses that reality, however difficult, is better than unreality, fantasy and defeat. (Wade, 1947, p. 106)

Here the occupational therapist is directed to identify normal activities that will help to reorient an individual to social reality. The individual will learn to cope with a particular social order through the completion of an occupational therapy program that targets engagement in 'normal' activities. In this particular case, it was a concern with what constituted normal personal hygiene that structured the occupational therapist's intervention. This author wrote further "any remnant of interest or spontaneous expression of normal behavior is used as a basis on which socially acceptable forms of behaviour may be reconstituted." (p. 106). Clearly then occupational therapists have long used the concept of 'normal' when thinking about and outlining interventions with clients. Indeed it seems that conceptions of normality had a strong influence on how practice unfolded in particular temporal contexts.

In reflecting for a moment on my own professional experience in community mental health I can identify instances where I was forced to grapple with normative considerations. For example, working on goals that targeted participation in social occupations and community integration, I might have been required first to enable a client to perform self care activity like laundry. While my client would have been motivated to engage in social occupations, she or he may not have been motivated to perform laundry activities and tasks. Further in performing individual laundry tasks I may have been forced to make normative decisions as to whether to interfere with an individual's task preferences. For example, should I obstruct or support a client's decision to use dish washing liquid rather than laundry detergent when performing laundry? In a moment like this, with one or two words, there is an opportunity to influence how occupation unfolds in relation to particular norms. Here one can see how

normative considerations saturate clinical work of occupational therapists in a variety of ways. However, Iwama argued that little attention has been paid to how norms, for example, are embedded in the practices and knowledge of occupational therapists (Polatajko et al., 2007c). Is it possible for occupational therapists to openly discuss and study the norms that structure their work with clients? Moreover, in today's health care contexts, can occupational therapists openly criticize the norms that structure the communities into which client's are 'discharged'? Finally, how can this be accomplished if we are not able to openly identify, discuss, and criticize the norms that saturate the scientific discourses that constitute our expertise?

In looking at the literature contained within some of occupational therapy's professional journals, one can find examples of both kinds of scholarship discussed above. Academics routinely conduct empirical work that conforms to the scientific method, whether qualitative or quantitative. Academics also routinely outline personal visions for the normative ends to which occupational therapy as a profession should aim. Indeed there have been rigorous attempts to outline the ultimate ends of occupational therapy. For example, along with Janice Burke, in a history of the profession, the late Gary Kielhofner outlined the purposes of occupational therapy practice in different time periods (Kielhofner & Burke, 1983). This work proved that scholarship aimed at uncovering the ends of therapy has value. Well before his untimely passing, Kielhofner (1997) contended that critical exploration of the aims and objectives of occupational therapy must continually be conducted. Indeed many well respected occupational scientists and occupational therapists routinely engage in this kind of historical work (e.g., Alsop, 2006; Bing, 1981; Christiansen, 2007; Driver, 1968; Friedland 2003; Frank, 1996; Hocking, 2008; Peloquin, 1991; Spackman, 1968).

Using historical and philosophical tools and a critical methodology, the following thesis makes a similar but less ingenious attempt to grapple with the ultimate aims of occupation therapy in different periods of time. On review of the historical literature available within occupational therapy, it became clear that moral treatment has been identified repeatedly as a precursor of occupational therapy. This thesis is an example of a rigorous effort to apply a well defined critical methodological perspective.

More specifically, within this thesis I explore the transformation of "moral technology"

(Foucault, 1978/1996c, p. 276) through an exploration of the tools that occupation workers in different time periods have had available to them. In an effort to understand how the technological artifacts of moral treatment relate to present day practices within occupational therapy, the myths that guide and direct practice in both the past and present were questioned and critically positioned. How are technologies used in the routine conduct of professional work relating to occupation loaded with moral and normative content? What ends do these technologies work to actualize?

As other professionals have asserted, the myths of our time are embroiled in power dynamics (Epstein, 1999; Kelly & McFarlane, 2007). The ordering of existence occurs through the deployment and application of particular mythical frameworks that have been transformed into Truth. Castel (1988, p. 7) argued that in order to understand how a profession operates within a web of power, one needs to understand the nature of its 'soft' technological tools. It is the crystallization of particular practices within specific time periods that should be studied in order to understand how particular truth systems function (Foucault, 1978/1996c, 276). New understanding and transformation can begin through critical articulation of the technologies wielded by professional actors' in particular historical contexts. In reference to mental health practice, Castel (1988, p. 9) argued that fighting processes of technological constraint that result from the application of professional knowledge demands "an exact consciousness of the modus operandi of these new 'soft' technologies." The disruption of a particular mythos that has become ridged, fixed, and immobile, might occur through the articulation of the technical frameworks that loosely and collectively administer existence.

We need normative structures to run our lives and therapies both (see Charland, 2009a). We need to be concerned with ultimate ends of life. But our truths need to remain myths and they need to be broken periodically to remind us that our normative and prescriptive systems can never capture an enduring kind of Truth (Tillich, 1957; Foucault, 1978/1996c). The truths that we lay out within the process of conducting professional work are tied to particular needs and ways of viewing the world. Scholarship that works to unearth and outline the ends and purposes of treatment in its most general and widest sense will always be required. Michel Foucault's analytical tools work to dismantle the integrity of modern truth systems. Coupled with the more forgiving outlook

of Paul Tillich, Foucault's critical perspective can also function to re-mythologize our practices and purposes and move forward into the future with renewed confidence (see Friedland & Rais, 2005)[1].

1.1 What this Thesis Contains

In chapter two, I begin with a consideration of two definitions of occupational therapy from different periods of time to help orient readers who may not be familiar with the profession's general mandates and purposes. It should be noted that while I only present two definitions of what occupational therapy entails, many more exist in the literature. Beginning this way also serves to remind readers that the profession has a history that must be considered. Occupational therapy's history places implicit and explicit demands on each practicing therapist that have both positive and detrimental effects on how practice and scholarship unfold in the present. For example, it is often contended that the efforts of occupational therapists' lack direction and unique purpose because the beliefs and mandates that lead to the profession's establishment have been forgotten. In this section, I but begin to explore popularized solutions to this perceived problem. In outlining this problem, its proposed solutions, and critiques offered in reaction to these solutions, I articulate the problem statement that structured the present thesis. Subsequently, I situate this work within a larger program of study that I have been preoccupied with.

In chapter three, I first outline the Foucauldian methodology and methods which were used to structure this research and examine some major concepts that work to organize Foucault's critical ethos, including: 'discourse', 'power', and 'knowledge.' I then relate these to his two historical methods 'archeology' and 'genealogy'; and one unit of analysis: 'the statement.' Then, I outline the various activities involved in genealogical inquiry and indicate how I have performed these activities in relation to the occupational therapy discourse. In this section, I also outline the quality criteria that I used to ensure trustworthiness.

In chapter four, the historical contexts relevant to this research including the establishment of occupational therapy and critical reflection regarding its role in society

[1] See also Clark (2010).

are discussed. This discussion builds and expands on the discussion that occurs in chapter two. Here, the beginnings of occupational science are also outlined in relation to attempts to build a self defined profession that maintains links with occupational therapy's traditional foundations. Attention is then turned to the beginning of the 19th century and moral treatment which is often identified as a precursor of occupational therapy. Subsequently, descriptions of occupational therapy that relate explicitly to moral treatment are reviewed in terms of their changing emphases through time. Within this section readers are encouraged to make links between the aims and purposes of actors operating within these different historical contexts. The seeds of occupational therapy were sown in the early 19th century and the influences of the moral treatment era can easily be identified throughout the history of occupational therapy in the 20th century. However, within this section important differences between the ideas and techniques in operation at different points in time should also become apparent to readers.

A critical reexamination of the moral treatment era and professional work in modernity is undertaken in chapter five. Here, I draw on the work of Foucault in an attempt to understand how particular professional practices have been criticized. Specific attention is paid to the vision of particular moral reformers and the treatment techniques that they employed in the 19th century. Within this chapter, readers will become familiar with how particular treatment technologies correspond to particular visions about what life should necessarily be about. In carefully considering Foucault's critical perspective in relation to the history of madness and moral treatment, readers will become attuned to how power functions through professional work. The perspectives of the professional actors operating in the 19th century can more easily be situated within particular forms of bias that correspond to their historical age. Thus within this chapter, readers will begin to perceive how particular treatment technologies function in conjunction with particular beliefs about existence. This chapter concludes by reconsidering the validity of Foucault's critiques and attempts to rescue the efforts of the great moral reformers from Foucault's relentless and damning perspective.

In chapter six, I endeavor to extend Foucault's critical perspective and apply it to contemporary work. Special attention is paid to practice that occurs in mental health; however, a more focused critique of occupational therapy practice is undertaken in

relation to literature that revolves around spirituality. It is within the literature on spirituality that one can most easily identify the normative content inherent in the technologies at the disposal of occupational therapists. As an adjunct to this analysis, a sampling of perspectives on the values that guide practice is considered to broaden and deepen the critique that is presented. Thus within this section, the end product of occupational therapy and the techniques employed to reach these ends are critically examined.

Finally, chapter seven concludes this thesis and presents the argument that critical work can help to establish the limits of authentic practice (see Foucault 1968/1991a). In the process, I also present personal resolutions to the problems that are identified in chapter two. It should be noted that these resolutions are not meant to be universally applied. Readers are therefore cautioned and encouraged to consider the relative validity of the myths that I deploy against their own understanding of what occupational therapy, and life in general, should necessarily be about. Occupational therapists alone must make decisions about how best to incorporate or reject this knowledge within the context of professional practice.

Very broadly, the notion of 'authenticity' creates a conceptual intersection that can make this work more intelligible. In her Eleanor Clarke Slagle Lecture, Elizabeth Yerxa connected the term to notions of self actualization and a reconnection with the history of occupational therapy. Authenticity in this sense might involve understanding the philosophical heritage that served to structure the classic occupational therapy discourse. An authentic profession would require each of its members to determine their own "authenticity as professionals" and actively define the nature of the profession. Further, Yerxa (1967) explained that "the degree to which we can maintain faith in our profession and still strive to improve it by our acts, the degree to which we can maintain faith in our clients while becoming involved in the process of helping them will determine the future authenticity of our practice" (p. 8-9). On his side, psychiatrist and historian David Healy describes how, for the ancient Greeks, authenticity revolved around a "struggle to heed the call of reason" (1990, p. 29). Indeed, as is indicated above, Paul Tillich (1957, p. 75) connected notions of faith and reason when he asserted that reason in Western culture related to the "source of meaning, of structure, of norms and

principles." Thus, notions that relate to authenticity can provide directionality to life that can work to structure the nature of a profession or a single human being. Louis Charland (2009a) indicated that, in present day psychiatry and psychology, truth and reason often exclude notions that relate to self creation and the regulation of human existence. Both in theory and within the conduct of professional practice these considerations are frequently swept aside. However, Charland (2009a) advances the argument that, in some cases, professional practice may require us to include notions that relate to a deeper notion of what reason entails. Thus, on a more practical level the term "authentic practice" in this work was used to denote practice that is explicitly tied to normative processes and relates to the ultimate ends of existence.

1.2 What This Thesis Does Not Contain

Again, readers of this thesis should not expect to discover a universal Truth to be used to order their own existence, or their own practice. I have not made an attempt here to advance a new system that can be used by all, but to help outline the dimensions of a system that is already in place. In my concluding statements, I also outline personal resolutions and conclusions that have come to motivate and propel me forward (see Yerxa, 1980). Thus there are truths to be found, but no Truths are advanced here.

The 'data' gathered and used to construct this thesis were not collected from research with human participants or institutional locations; rather, data was gathered from the literature identified herein. Within this work, I have made an attempt to examine some of the frameworks and practices that are supported within contexts in which I exist, or have existed (i.e., Canada, The Western world). It should also be noted that within this work I have concerned myself with mental health practice. It should be made clear that this thesis was not intended to criticize specific practices, ideas, or thoughts of particular individuals. While this thesis can be used as a means to question and place limits on particular kinds of practice, it should not be interpreted as an attack on any specific form of practice, or any specific individual. All forms of professional practice and all mythological frameworks have the potential to become problematic. This is good place to extend my gracious appreciation to all those individuals who have taken the time to add to the occupational therapy literature. My criticisms are not aimed at any particular

individual. However, this criticism does depend on the work of others in order to be successful. Again, to the various authors whose work I have cited herein I offer my gratitude. If my comments here prompt others to rethink, revisit, revise, explore new ground, or strengthen their own position, then my efforts have not been wasted.

It should also be pointed out that this work focuses on the practices and value systems that operate within Western world contexts. This should not be understood as a purposeful attempt to ignore the relative validity of the truths that govern existence in alternative geographical locations. This should be interpreted as reflective of my unfamiliarity with alternative contexts; I always enjoy reading other works that outline the technological power dimensions that operate in alternative occupational therapy practice locations and look forward to reading more. Indeed while I used a clearly outlined methodology to structure this work, the resulting analyses still depended heavily on my perceptions which have been influenced by my own personal experiences and filtered through frameworks that have come to structure my understanding of existence. Other works that stem from alternate personal grappling with the issues are needed and will always been needed.

While this thesis has concerned itself with practice, it has done so in an abstract way. One should not read this thesis and expect to find the results of research into the specific practices of particular occupational therapists. In using a Foucauldian methodology, I have concerned myself with ‘discourse.’ Through an exploration of the discursive systems that support and shape practice, I endeavored to outline the material effects of particular discursive systems. Those interested in understanding more about what Foucault, and subsequently Foucauldians, intended with the term discourse are directed to read chapter three and are encouraged to consult the references cited therein. Interested readers should also refer to the limitations section that appears at the end of chapter seven.

Chapter 2

2 Problems and Purpose Statement

Occupational therapists are health professionals that provide intervention to help individuals and whole communities actualize their human potential. In the United States, in 1917, the *National Society for the Promotion of Occupational Therapy* broadly outlined the purposes of the profession as "the advancement of occupation as a therapeutic measure, the study of the effect of occupation on the human being, and the scientific dispensation of this knowledge" (as cited in Nelson, 1996, p. 775). A more recent Canadian visionary document published in 2007 describes occupational therapy as:

> the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life (Townsend & Polatajko, 2007, p. 2).

The growth, development, and transformation of this profession occurred over the course of the 20th century (Hooper, 2006). As will be more clearly explained below, at many points in its history, occupational therapy's survival has been unsure (e.g., Wilcock, 2001a; Yerxa, 1995). While the two statements presented above clearly focus on occupation in their description of the profession, for many decades between the dissemination of these two pieces of text, occupation was forgotten by occupational therapists (Polatajko, et al., 2007a). As a result, leaders in the field worried that a general and widespread understanding of what made occupational therapy different and effective compared to other professions was lacking. Therapists themselves are often unsure what their unique occupational therapy discourse consists of and this can lead to professional identity crises, insecurity, and the loss of professional opportunities (see Yerxa, 1993). Over the last five decades, occupational therapists have made various efforts to reconnect with the profession's historical lineage and bolster the status of occupational therapy (e.g., Kielhofner & Burke, 1983; Mackey, 2007; Reilly 1962; Whiteford, Townsend & Hocking, 2000; Yerxa, 1979). In the 1960s, in an article titled *Authentic Occupational Therapy*, Yerxa (1967) stated that a true profession is characterized by authentic practice. In part, authentic practice required occupational therapists to meet real needs and have

and employ a unique philosophy. Further, practicing authentically seemed to require occupational therapists to reconnect with their occupational heritage. In the 1980s, Kielhofner (1985) explained that the professionalization of occupational therapy required four activities: Systematic clarification of the nature of occupational therapy practice; identification of the basic values that guide the profession; the organization of the profession's knowledge around the unifying concept of occupation; and increased basic and clinical research. It was thought that each of these activities would help to clarify the social role and obligations of the profession and enhance its potential. This in turn would help to secure the profession's long term survival.

Two different problems have been identified in relation to these solutions. First, it is often asserted that the traditional defining features of occupational therapy related to a holistic and optimistic view of people, their capacity for change, and the relation of mundane occupations to health and well being (e.g., do Rozario, 1999). Unfortunately, these features are not always reflected by the dominant health care culture (Kielhofner, 1985; Law, Steinwender & Leclair, 1998; Molineux, 2004; Yerxa, 1979). Secondly, and more recently, members of the profession have also made an attempt to come to grips with an age that contains various disparate perspectives that seem to call into question many of the traditional notions that form the basis of this history (e.g., Dickie, 2004; Hocking & Whiteford, 1995; Iwama, 2004). On the one hand, efforts to reconnect with the beliefs, values, and mandates that originally gave rise to the profession have materialized. On the other, it seems that the legitimacy of these very beliefs, values, and mandates meet both internal and external cultural criticism. This reality creates a number of interrelated problems. Ironically, 'authentic practice' has the potential to become unethical practice because it may not always be accepted as legitimate or proper. Issues of power also become important in regards to this subject as one recognizes how much influence occupational therapists have in relation to the people they see and with whom they work (see Hammell, 2006; Sumsion & Law, 2006). Fleming and Mattingly (1994) discussed these ethical dilemmas in a slightly different way. Some authors contend that when occupational therapists work with their clients using many of the profession's traditional concepts and methods of treatment their work is forced underground. Much of what traditionally provided the rationale for practice is not acceptable within health care

contexts and so, according to Fleming and Mattingly (1994), occupational therapists have had to narrow their recognized professional scope and keep silent about some of the work they do with clients.

In attempting to address these problems and concerns the purpose of this thesis was as follows:

- *This work aims to uncover and make explicit some of the normative assumptions and endpoints that govern contemporary occupational therapy practice, through a critical examination of the various therapeutic technologies that have revolved around occupation since the 19th century.*[2]

In order to understand when and how normative content structures contemporary practice one needs to follow the relevant literature backwards through time (Foucault, 1971/2003a). In examining the origins of occupation therapy one can begin to understand the original meanings and therapeutic ends that supported practice. In tracing the transformations of these meanings and purposes through time to the present one can begin to uncover how normative content continues to structure professional work (see Charland 2008). Without a clear understanding of the normative structure on which contemporary practice rests implicit power conflicts will continue to occur (see Castel 1988). Indeed if occupational therapists cannot properly articulate what it is they do, or even fully understand what it is they do, various dangers follow. Practitioners will remain unaware of what it is that is actually accomplished with professional work (see Castel 1988). There is no way to police practice to ensure that clients receive the best possible care (see Hammell, 2006). Also, if open communication regarding the profession's beliefs, techniques and traditions does not occur, a rigorous description of practice cannot fully come into view. This hampers the conduct of scientific investigation that may help to legitimize 'authentic practice' or lead to new discoveries regarding the skills needed to effect change (see Kielhofner, 1985; Mocellin, 1995, 1996). Moreover, therapists may rush to address particular social problems without reflecting on how this will impact on the role of the occupational therapist in detrimental ways (Molineux, 2004). New opportunities may endanger the profession by negatively impacting on its values and mandates. Conversely, without a clear understanding of the classic discourse on which

[2] See Castel (1988), Charland (2008), & Clark et al., (1991)

occupational therapy practice rests one can never be sure when broad changes might be necessary (see Kinsella, 2001; Mocellin, 1995, 1996). The social contexts within which occupational therapists operate are continually changing (see Wilcock, 2002). The social needs that occupational therapists address and might potentially address change over time (Wilcock, 2002). Do the foundations that have traditionally informed practice remain useful, relevant and culturally safe (see Gray & McPherson, 2005; Iwama, 2006; Mocellin, 1995, 1996)? A continual and recurring effort must be made to uncover the beliefs, rules, values, and expectations implicit in professional work that revolves around occupation (Kielhofner, 1997). It should be made explicitly clear that this kind of work is not intended to erase or eliminate the inclusion of normative content in the routine application of occupational therapy services; rather this, kind of work is intended to raise consciousness and promote dialogue (e.g., Castel, 1988; Charland, 2008; Townsend & Wilcock, 2004).

In this way I have attempted to make sense of the professional heritage that preceded me. As a result many of the observations, realizations, and conclusions outlined herein are not new. It must also be acknowledged that similar work guided by different questions and concerns will likely uncover different materials, answers, and conclusions (for example see Sellar, 2010). The articulation of the ends and purposes of occupational therapy throughout different time periods must continue to occur. In this thesis I hope to have made a new and unique contribution to current analyses and discussions of the present role and history of the concept of 'occupation' in contemporary occupational therapy. For example, this work has been worthwhile in that it has helped to identify a need for further research on the authentic dimensions of occupation and occupational therapy practice. This thesis also makes new and more detailed links between the moral treatment of the 19th century, occupational therapy described as moral treatment, and occupational therapy relating to spirituality in the 20th century. In addition, I have helped to refine and describe activities and procedures involved in conducting Foucauldian genealogical projects and provided an example for others wishing to conduct this kind of scholarship.

This research project must also be contextualized. In previous work done with others, I have traced the development of occupational science and its relationship to

occupational therapy, outlined some of the practices of occupational therapists in community mental health, worked to understand how knowledge about occupation is deployed within particular contexts with unexpected consequences, and described how history and progress have been conceptualized by some members of the occupational therapy community (i.e., Molke, Laliberte Rudman & Polatajko, 2004; COTA Health, 2006; Molke & Laliberte Rudman 2009; Molke 2009b). This current work builds on this and, like this previous work, can be situated somewhere and somewhat between occupational science and occupational therapy. Others working within these communities have at times positioned themselves similarly for a variety of reasons (e.g., Clark, Jackson & Carlson, 2004; Molineux, 2004; Pierce, 2003; Wicks, 2005; Wood, 1996).

Chapter 3

3 Considerations of Method: Discourse, Power, and Genealogical Investigation

Foucault's work has inspired my own. Here, I outline some important concepts that relate to his historical methodology. To enhance comprehension and quality of the proposed analysis, descriptions of some important terms have been pieced together. These appear in Table 1. Readers are encouraged to familiarize themselves with important terms before reading further. Discussion related to these terms also appears in the paragraphs that follow.

Foucault's methods allow one to question the present in the hope of promoting change (Dean 1994; Gastaldo & Holmes, 2002; Hacking, 1986b; Molke, 2009b). This kind critical work poses dangers for those engaged in analysis (see Kincheloe, & McLaren, 2000). To effectively and safely conduct these works researchers must ground or anchor their work in a particular epistemological tradition (see Hook, 2001). As Hook explains, the analyst needs to appeal to "stable reference points outside of the text" (p. 539). As Paré (2001) explains, the analyst needs to find a place to stand. As Bing (1986) suggested the foundation of thought and action requires sold ground on which to rest.

I am an occupational scientist, an occupational therapist, white, male, Canadian, and graduate student. I exist in a western context and am the product of a western context. English is my first and only language. Currently, I situate myself within the professional tradition within which I was, and am, being educated. The knowledge, struggles, and customs that make up this community concern me. My faith in this epistemological tradition remains doubtful (see Tillich, 1957).

Table 1: Methodological Terms of Some Importance

Term	Description
Discourse	A group of statements that belongs to a single limited system of formation (e.g., economic discourse, clinical discourse, psychiatric discourse, the discourse of natural history) (Foucault, 1969/2005a, p. 121). A discourse is delineated by boundaries and rules that in turn determine their conditions of existence (Foucault 1968/1991a, p. 61). Discourses actively produce the objects, subjects and practices of knowledge (Hall, 2007) and provide the building blocks that individuals use to construct their very beings (Dean, 1994). They relate to "patterned forms of thought and action that include both compatible and contradictory elements" (Major-Poetzl, 1983, p. 25).

Power-Knowledge	"There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (Foucault 1975/1995, p. 27). "We are judged, condemned, forced to perform tasks, and destined to live and die in certain ways by discourses that are true, and which bring with them specific power-effects" (Foucault, 1976/2003c, p. 25). Power "traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (Foucault 1977/1980c, p., 119). "Relations of power-knowledge are not static forms of distribution, they are matrices of transformations" (Foucault, 1976/1990, p. 99).
Archeology	An archeology is a discourse about discourses, an analysis of fields or systems of knowledge production. The archeologist works to uncover how knowledge comes to be created at a particular point in time through a careful study of the rules structuring discursive formations. (Foucault, 1969/2005a; Major-Poetzl, 1983).
Genealogy	A genealogy is a study of the tactics and strategies of power inherent in discourse and their constitution of knowledge and the subject (Dean, 1984; Foucault, 1976/1980a) that also brings to attention disqualified and illegitimate discourses (Foucault, 1977/1980b, p. 83). Genealogy is the disclosure of differences, the establishment of a countermemory or an anti-science (Major-Poetzl, 1983).
The Statement	A single sign or a number of signs (Foucault, 1969/2005a, p. 95) with a material existence, a place and a date (Foucault, 1969/2005a. pp. 112-113). A statement is more than a series of marks; it is endowed with repeatable material effects (Foucault 1969/2005a, p. 120). A statement is a function that cuts across structures and unities and has the potential to reveal their configurations in space and time (Foucault, 1969/2005a, p. 98).

3.1 Discourse, Power, and the Subject

Many associate Foucault's methods with what is commonly known as 'discourse analysis.' However, Foucault did not create discourse analysis methods (Hook, 2001). Still, Foucault was concerned with *discourse*. Hook argued that a broad definition of discourse is needed along with a broader "analytic scope than one limited basically to the analysis of *texts*" (p. 532). For Foucault, discourse was an expansive term that he employed in different ways in an effort to understand 'the order of things' and help to establish a new kind of present (Hacking, 1986b). Within his conception of discourse, Foucault collapsed the distinction between text and action and created a "blurring between the textual and material, the 'discursive' and the 'extra-discursive" (Hook, 2001,

p. 538). As we will see below, the study of discursive formations and practices gives us an understanding of how particular kinds of knowledge and particular contexts are ordered and organized. Discourses actively produce the objects, subjects, practices of knowledge (Hall, 2007), and provide the building blocks that individuals use to construct their very beings (Dean, 1994). Discourses are multiple, contradictory, and constantly transforming (Foucault, 1969/2005a; Molke, 2009b). Thus discourses exist both within and beyond text, are multiple and contradictory, outline the limits, rules, and structures that order existence, and have material effects.

Foucault's notion of discourse was intimately tied to his understanding of the mechanisms and functions of power relations that have an impact on modern subjects (Foucault, 1976/2003c). For Foucault, power was not to be understood as a resource; rather, it operates and circulates between things. It functions. Power is not only something that denies or excludes access to freedom. Power places demands on modern subjects, it produces things, creates knowledge, and generates discourse (Foucault, 1975/1995). In other words, power "needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression" (Foucault 1977/1980c, p., 119). In order to understand the operations of power one needs to become aware of how different kinds of knowledge struggle and battle over access to the human body in modernity (Foucault 1975/1995; Foucault, 1976/2003c). In modernity, knowledge and truth are not inevitable manifestations of what is, but organized and disparate configurations of what has come to be. *Power-knowledge* relations have real effects on our bodies in that they determine what it is we can do, think, and feel. Knowledge and truth are intimately tied to the operations of power. Different truths about what it means to be human, about the ideals that we should aspire to as human beings, for example, place expectations on us that have real effects on our bodies, our thoughts, and our actions (Foucault, 1975/1995; Foucault, 1976/2003c). In historicizing truth, Foucault highlighted how knowledge and power are joined and must be analyzed together in terms of their effects and consequences. In part, knowledge-power configurations operate through discourse (Hall, 2007). It was through systematic investigation into multiple fields of discourse that Foucault sought to understand how knowledge and power were joined in modernity. He worked to

understand how particular 'regimes of truth' structure discourses (Dean, 1994). As Foucault argued:

> Truth isn't outside power, or lacking in power … truth isn't the reward of free spirits, the child of protracted solitude, nor the privilege of those who have succeeded in liberating themselves. Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its 'general politics of truth': that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements (Foucault 1977/1980c p. 131)

In contextualizing truth and denying its transcendent character, Foucault highlighted the transient nature of particular power-knowledge formations. Relations of power-knowledge, like discursive fields and practices, are not to be understood as static and unchanging. Foucault's methods of historical investigation hinge on the expectation that power-knowledge formations will be constantly changing and in flux (Foucault, 1976/1990, p. 99) and work to form the subjects and objects of modernity (Dean, 1994).

3.2 Archeology, Genealogy, and Ethics

Foucault's methodologies are a blending and bending of philosophical, historical, and sociological thought that can be used to "uncover and outline the historical contingencies that shape what we can be, think and do" (Foucault, 1978/2003b, p. 56). While Foucault's work can be called historical, he made an attempt to differentiate his work from other notions of what historical research entails (Foucault, 1969/2005a). In this dissertation, I do not make an attempt to compare and contrast various historical methods as they relate to occupational therapy. In order to proceed with a comparison like that it is necessary to have a comprehensive understanding of different historical methods that relate to occupational therapy. The application of Foucault's historical methods to the history of occupational therapy has not yet been comprehensively and adequately addressed. Accordingly, this is one of the main tasks I have set for myself in this dissertation. However, I do consider some important points of divergence between Foucault's historical methods in relation to the role of moral treatment in the history of occupational therapy and later and alternate historical interpretations of those same

developments. But this is not by any means a formal methodological comparison between two historical methods.

Foucault used the terms *archeology* and *genealogy* to describe his methods (Scheurich & McKenzie, 2005). Archeology is the analysis of fields or systems of knowledge production and self formation. Archeological works uncover *how* knowledge comes to be created at a particular point in time through discursive formations (Foucault, 1969/2005a; Major-Poetzl, 1983). Genealogy, on the other hand, uncovers the consequences of the application of dominant discursive systems; that is, a genealogy relates particular discursive formations to the operations of knowledge-power in particular contextual locations. A genealogy records the justifications of power (Major-Poetzl, 1983, p. 38). A genealogy problematizes particular discourses, their truth effects, and as a result creates opportunities for alternative discourses that have been subjugated or undermined (Foucault 1976/2003c; Dean, 1994). Foucault explained "what it [genealogy] really does is to entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchies [sic] and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects" (Foucault, 1977/1980b p. 83). Contrasted with an understanding of the order of discourse that archeology provides, a genealogy strategically positions what has been forgotten, remained hidden, or cut away in an attempt to reorder and reshape existence. An archeology is a kind of incorporeal historical analysis; but, when combined with genealogy, and its broader and more tactical conception of discursive power and practice, it becomes a project invested in the present (Hook, 2001; Dean, 1994).

Near the end of his life, Foucault subsumed all of his projects under the aegis of genealogy. His various historical works became different components, or axes, of his genealogical project (Foucault 1983/2003d). We have seen above how truth and power are important methodological touchstones for Foucault. In his final genealogical works, an ethical dimension takes center stage. Ethics, for Foucault, relates to an individual's relation to themselves as a moral subject. The ethical dimension of Foucault's work concentrated on how "the individual is supposed to constitute himself as a moral subject of his own actions" at different times in history (Foucault, 1983/2003d, p. 111). Foucault

explained that all three dimensions – truth, power, and ethics – had been part of his work from the beginning (Foucault 1983/2003d). In retrospect, Foucault defined his projects as historical ontologies of the self:

> Three domains of genealogy are possible. First, a historical ontology of ourselves in relation to truth through which we constitute ourselves as subjects of knowledge; second, a historical ontology of ourselves in relation to a field of power through which we constitute ourselves as subjects acting on others; third, a historical ontology in relation to ethics through which we constitute ourselves as moral agents. (Foucault, 1983/2003d, p. 110)

Foucault made it quite clear that his concern with discourse (and truth, power, and ethics) was a concern that revolved around the formation of subjects. Through his genealogical investigations Foucault attempted to understand how the self had been subjugated in different ways through history.

It is important to note that a genealogical project does not free truth from power. As we have seen above, for Foucault, truth and power were inevitably interrelated. Foucault's projects worked and continue to work to "detach the power of truth from the forms of hegemony, social, economic and cultural, within which it operates at the present time" (Foucault, 1977/1980c, p. 133). As Major-Poetzl (1983, p. 36) explained, genealogy is the "disclosure of difference" and has the potential to become a kind of "dangerous countermemory that threatens the present." In studying history, Foucault did not attempt to unearth forgotten secrets to be used to construct our ethical experience in the present, for example; rather, Foucault attempted to demonstrate that the truth about existence has been and will be problematized in different ways (Foucault, 1983/2003d). His critical histories de-familiarize the taken-for-granted enabling us to better historicize and understand present day tensions providing an opportunity for change (Fraser & Gordon, 1994; Molke, 2009b). Thus within this work I am interested in both Archeology and Genealogy. It must be made clear, however, that unlike some, I am interested in 'therapy' and not only critique (see Charland, 2002; Hacking, 1991). Specifically, with this work, I am interested in helping to ensure that the futures of occupational therapy and occupational science remain secure.

3.3 The Statement

Any research requires materials for analysis. Archaeologies and genealogies are no exception. While it has been argued that genealogy should not be associated with popular discourse analysis methods (see Hook, 2001), genealogy *is* a 'documentary' science (Kearins & Hooper, 2002). Foucault's histories, like many forms of historical investigation, relied on books, letters, papers, and records, for example, to patiently outline the conditions of reality that have ordered existence in his present and in times past (Foucault, 1969/2005a; Foucault 1971/2003a). The basic units of these analyses are statements (Foucault, 1969/2005a). In his book *The Archeology of Knowledge,* Foucault used a great deal of space defining the functions and forms that statements take. He explained that "there is a statement whenever a number of signs are juxtaposed – or even, perhaps – when there is a single sign" (Foucault 1969/2005a, p. 95). Statements are the atoms of discourse (Major-Poetzl, 1983; Foucault, 1969/2005a). They, like the discourses that they constitute, exist both within and outside of the texts in which they appear. Statements have both a material existence and a material effect (see Hook, 2001). Statements exist in time, place, and are supported by specific contexts that include and extend beyond the document in which they are situated (Foucault, 1969/2005a). Foucault went to great lengths to define what statements are or can be, but refused to definitively explain what form they *must* take. This is because statements themselves do not have a universal structure; rather, the statements that constitute a particular discourse function to create the conditions of existence that provide structure. In Foucault's own words:

> One should not be surprised, then, if one has failed to find structural criteria of unity for the statement; this is because it is not in itself a unit, but a function that cuts across a domain of structures and possible unities, and which reveals them, with concrete contents, in time and space. (Foucault, 1969/2005a, p. 98)

In conducting a genealogy one looks for the "regularity of statements within discursive formations" (Dean, 1994, p. 31) that taken together form a contextualized discursive totality which in turn delimit the kinds of statements can be made and are given to reflect truth.

In order to make this more intelligible in practical terms, I will provide examples from previous work I conducted with others. In attempting to trace the effects of

occupational discourse in international contexts (Molke & Laliberte Rudman, 2009), statements connected to occupation and how it was thought to function in relation to human life were collected. For example, I scrutinized a document that was published in the late 1970s and found the following statement that defined doing as: "purposeful action that enables the nascent human to become humanized" (Fidler & Fidler, 1978, p. 305). I attempted to identify how this and other statements worked to create contextualized discourses that have real material effects on what constitutes occupation, human reality, their ideal forms, and the work that occupational therapists may do with their clients. In another paper (Molke, 2009b), statements were collected that related to how history and progress have been conceptualized within occupational science and therapy. For example: "occupational science and occupational therapy are offshoots from the same root" (Segworth, Sittler, & Wilson, 2006, p. 25). The intent here was to demonstrate how historical statements found in occupational therapy and science could be connected with philosophical discourse related to the functioning of History and the process of transformation and change. Through an examination of statements like these, an attempt was made to outline the effects of discourse in terms of its consequences and dangers for the development of occupational science and therapy and the individuals associated with each. Within this thesis, an attempt was made to strategically position statements taken from texts that predated occupational therapy with statements that have been deployed in more recent times. This was accomplished to create a space of dispersion. This space of dispersion helps to make present practices seem strange and arbitrary in an attempt to create room for difference and change (see Eakin, Robertson, Poland, Coburn, & Edwards, 1996; Hooker, n.d.; Rabinow & Rose, 2003). In this way, a critical genealogy of occupational therapy worked to mythologize practice in the present and began to highlight the limits beyond which occupational therapy practice might work to do more harm than good (see Foucault 1968/1991a).

3.4 The Specifics of Method

Up until this point, for the most part, I have discussed Foucault's methods in terms of his methodology. This is because genealogy is predominantly a methodologically driven enterprise. Foucault, and subsequently Foucauldians, have not

outlined in great detail precise principles or procedures (Kearins & Hooper, 2002). However, there have been some attempts to outline the specifics of method that are associated with these kinds of critical historical projects. In consulting the literature and in reflecting on previous work, I have outlined nine genealogical activities. These activities are listed in Table 2. The original inspiration for these steps and the accompanying table came from Carabine (2001). I have liberally adapted, added, and rearranged based on other literature and previous work. Please note that some steps are ongoing or are revisited repeatedly (e.g., b & d). Steps are provided in linear sequence here to depict the general flow of the genealogical inquiry that was conducted.

3.4.1 Select topic – access documents.

Like all research, genealogy begins with a research problem. Indeed, Foucault's histories were "genealogies of problems" (Foucault, 1983/2003d, p. 104). In order to conduct a 'genealogy of problems' one first needs a particular topic area. As we have seen above, Foucault's broad overarching focus related to the formation of subjects (Foucault, 1983/2003d). With each history he targeted different subjectivities and different ways in which people have been subjugated through history. Madness, medical knowledge, and discipline, for example, became topics of inquiry. Data collection (and analysis) must begin at a particular point.

Table 2: Steps for Genealogy

a) Select topic – Access documents
b) Know your data – Read and reread
c) Historically contextualize topic
d) Identify themes, categories and objects of discourse
e) Identify questions for document interrogation
   - Identify the rules ordering discourse and subjugation
   - Identify material effects of discourse and associated dangers
f) Collect Statements
g) Contextualize the material in relation to the present
h) Construct a space of dispersion making room for difference

i) Be aware of limitations of data, sources and analysis

Note. Adapted from Carabine, 2001; Foucault, 1968/1991a, 1969/2005a, 1980/1991b, 1983/2003d; Hook, 2001; Molke, 2009a; Molke, 2009b

For example, in his essay *Governmentality* Foucault selected Machiavelli's *The Prince* as a starting point from which he was able to examine the descent and transformation of discourse related to government through the 16th to the 18th centuries (Foucault, 1978/1991c). In order to better understand the classic foundations of occupational therapy practice, its place within society, and where ethical tensions in practice may exist in the present, a particular problem needs to be identified. *This work aims to uncover and make explicit some of the normative assumptions and end points that govern contemporary occupational therapy practice, through a critical examination of the various therapeutic technologies that have revolved around occupation since the 19th century*.[3]The beginnings of occupation work are often connected to the development of moral treatment in the 19th century (Bing, 1981). As such, I selected the following classic moral treatment texts to organize my analysis:

- Philippe Pinel's Medico-Philosophical Treatise on Mental Alienation (2nd ed.)
- Samuel Tuke's Description of The Retreat: An institution near York, for insane persons of the Society of Friends.

Philippe Pinel and Samuel Tuke are popularized and celebrated historical figures whose names have become synonymous with the moral treatment reform movement (see for example, Bing 1981; Dickinson, 1990; Licht, 1948/1983; Peloquin, 1989). This is why these two particular texts were chosen for analysis. The various and changing concepts related to 'moral treatment' and 'occupation' worked to organize the substantive focus of this research project. This critical reflection, on how moral treatment and occupation were used therapeutically, helped to outline the profession of occupational therapy's shifting role. The problematization of moral treatment and occupation in the past and the present served as a focal point through which I was able to begin to understand the effects and significance of occupational therapy and its effects in different time periods. In attempting to understand how different contexts in time gave rise to different problems,

[3] See Castel (1988), Charland (2008), & Clark et al., (1991)

occupational solutions, and ideals, I began to historicize present problems that confront occupational therapists. As an occupational therapist who was educated and worked in Canada, I am also concerned with professional frameworks that govern practice in Canada. In examining different versions of the Canadian Model, striking similarities between the moral treatments of the 19th century became apparent. In particular, the Canadian Model's focus on spirituality creates opportunities for normative content to play a role in practice in ways reminiscent of the moral treatment period (see for example, Charland 2007; Egan and Delatt 1994). Subsequently, it was thought that examining literature that focuses on spirituality in occupational therapy would allow for an articulation of how occupational therapy technologies are loaded with normative content.[4] An effort was made to collect documents related to spirituality in the occupational therapy literature. The literature related to spirituality within occupational therapy outlines a variety of techniques that therapists have available to them to work on the subjectivities of the individuals who receive professional attention. Some attempt was also made to outline the values and norms that govern treatment as it relates to spirituality to broaden and contextualize this analysis. Literature was collected from American, Australian, British, and Canadian Journals and books. Literature was identified using electronic databases and subsequently through review of reference lists in work that had been obtained. With any attempt to collect literature on a particular topic practical concerns place limits on what literature can be obtained. It is acknowledged that literature may have been missed in the process of conducting this literature search. As well, work on spirituality continues to appear in the occupational therapy literature. As such future analysis will likely produce different 'results' and different conclusions.

3.4.2 Know your data – read and reread.

I continually read and reread chosen texts while engaged in this project.

[4] It should also be noted that I have maintained a long standing interest in spirituality that predates my interest and participation in occupational therapy. As well, during my education as an undergraduate and graduate student I have had many opportunities to deepen and explore this interest.

3.4.3 Historically contextualize topic.

Alternative analyses and commentary on these texts and the institutions associated with them were used to enrich the analysis and relate it to the broader historical movements that characterized the period. Foucault's work, in particular, was used to help make this analysis critical in nature. The work of other historians (e.g., Bockoven, 1971; Castel, 1988; Digby, 1985; Goldberg, 1999; Ignatieff, 1983; Rothman, 1990; Scull, 1993; Wilcock, 2001b) was also used to broaden the historical depiction of moral treatment that is presented by Foucault. In addition, the work of other philosophers was used to provide an alternate philosophical depiction of the period and pertinent issues (e.g., Charland, 2002; Hacking, 1991). Occupational therapy histories were sought out to help contextualize the beginnings, growth, development, and transformation of the profession; however, it should be noted that there is a great deal more historical work regarding the moral treatment period than on the history of occupational therapy.

3.4.4 Identify themes, categories, and objects of discourse.

Foucault's work provided the historical framework that sensitized me to pertinent critical concepts. This work highlighted particular themes, categories, and objects of discourse (e.g., fear, freedom). The work of Louis Charland and Anne Digby, in particular, provided a counter point to Foucault's critical philosophical and historical analysis of the period. This particular step was placed in this particular sequence to emphasize the fact that analysis begins early, is ongoing, and always changing based on what is uncovered in the relevant discourses examined.

3.4.5 Identify questions for document interrogation.

General questions were identified based on previous work conducted with others (e.g., Molke, Laliberte Rudman, & Polatajko, 2004; Molke & Laliberte Rudman 2009; Molke 2009b). These were refined through consultation with Foucault's methodological discussions (Foucault 1983/2003d; Foucault, 1968/1991a; Foucault, 1975/1995). The following overarching questions were chosen to organize the analysis:

- What constitutes the true or ideal self?
- What techniques are used to create or reform the selves of others?

- What techniques are used for self creation or reformation?

This was supplemented with the critical question:

- What dangers might answers to these questions pose?

For those wishing to conduct similar work, examples of more detailed 'sub-questions' are provided in Appendix A. These questions were used to structure my critical perspective and were reflected on repeatedly to refocus my wandering attention and narrow the scope of this analysis.

3.4.6 Collect statements.

Statements functioned to interrogate Foucault's analysis of classic moral treatment texts. As well, analysis of more contemporary occupational therapy literature related to spirituality in particular provided some understanding of how particular discourses and their associated material techniques structure and work to shape particular kinds of individuals that relate to the historical lineage of occupational therapy as it is captured in classic moral treatment texts. This last related to the following step.

3.4.7 Contextualize material in relation to the present.

The resulting analysis was then compared to documents discussing practice conducted in the present broadly and more specifically to practice within occupational therapy that relates to spirituality. Once again in relation to the literature on spirituality, themes, categories, and popular and reoccurring objects of discourse were identified. These were grouped critically presented and compared to the historical material and critique uncovered in relation to moral treatment.

3.4.8 Construct a space of dispersion making room for difference.

In contextualizing truth and knowledge in relation to occupation work and moral treatment within particular social contexts (i.e., contexts described within classic moral treatment texts), and demonstrating how they are linked to power and occupational therapy practice in the present, a "space of dispersion" was created (see Foucault, 1969/2005a, p. 11). An attempt was made to highlight the discontinuous and arbitrary nature of discourse (Foucault, 1968/1991a). An analysis like this does not work to outline an enduring causal framework that will make ineligible the overall significance of

something. Instead this analysis sought to uncover statements deployed in occupational therapy that might be imported from moral treatment discourses; what within them was retained; how they have been reconstituted, transformed and; the changing roles to they have played through time (Foucault, 1968/1991a). This was not undertaken to highlight an enduring truth, but to emphasize arbitrariness "divisions, limits, differences of level, shifts, chronological specificities" (Foucault, 1969/2005a, p. 11). No single meaning, purpose, or idea can account for the history that is presented. The aim is to create a dispersion that will in turn create room for difference, allow occupational therapists to become more aware of the normative effects of particular kinds of practices, and help to outline the limits beyond which occupational therapists risk jeopardizing the wellbeing of those that seek professional attention (see Dean, 1994; Eakin, Robertson, Poland, Coburn, & Edwards, 1996; Foucault 1968/1991a; Molke 2009b).

3.4.9 Be aware of limitations

The limitations of this project are many, not the least of which was my inability to read many pertinent texts in their original language. As well, access to archival records from the sites of moral treatment identified would have enhanced this work. I did not have this access. Future research might be geared in this direction. Finally, as with all research, time and capacity are limiting factors. Every work has its limit based on how much time and natural capacity the individual conducting the work possesses. What has been accomplished here can only be thought of as a beginning. See also the limitations section that appears in chapter seven.

3.5 Trustworthiness Criteria

Lincoln & Guba (1985) explained that, put most simply, trustworthiness relates to one's ability to convince others that any particular inquiry is worth paying attention to and taking account of. The trustworthiness of any piece of scholarship relates to the criteria one uses to judge and measure its value. For a Foucauldian theorist attempting to maintain standing within the contexts of health care and academia it becomes critically important to carefully explain how these kinds of inquiries are legitimate. This is because Foucault's histories, methods, and purposes have often met with criticism in relation to

more traditional measures of rigor or validity in various disciplines (e.g., Rousseau, 1973). However, these criticisms must be taken into account and responded to if these kinds of work are to be taken seriously.

An often used method of ensuring credibility is *triangulation* (e.g., Lincoln & Guba, 1985; Morrow, 2005). Through the use of multiple and different sources one enhances the credibility of one's findings. Differently, Hook (2001, p. 31) explained that a Foucauldian approach demands that "we follow a polymorphism of analysis" (see also Foucault, 1978/1991b). Through the incorporation of an ever expanding polymorphism of data sources the analyst progressively and more effectively reveals the nature of a discourse in question and the "motives and operations of power-interests" (p. 531) that intersect with it. Related to this is the criticism that Foucault's work lacks a particular kind of depth and detail. However, a Foucauldian analyst strives for breadth over depth (Hook, 2001). To achieve *triangulation* and obtain a *polymorphic* quality, various histories of the period and concepts in question were consulted. An effort was made to locate similar, alternative, and contradictory interpretations of the concepts and periods I explored.

Another important often used method of ensuring credibility is *peer debriefing.* As one conducts research work a peer or colleague examines the processes and products involved in the research (Lincoln & Guba, 1985). The processes involved in thesis committee meetings functioned in a more effective way than peer debriefing ever could.

Morrow (2005) stated that critical qualitative research requires different criteria. This assertion seems to correspond well to the purposes of Foucauldian work as is outlined above. The two critical criteria that I selected were *consequential* and *catalytic* validity. Research guided by these considerations of quality works to increase consciousness regarding issues of power by drawing attention to those who have or what has been silenced, disempowered, or overlooked and creates new avenues for action and/or change (Morrow, 2005).

Chapter 4

4 Historical Contexts

In the previous chapter, the methodology that was used to conduct this research was outlined. In the present chapter, I begin to outline the historical contexts to be compared. This relates to step 'c' listed in the specifics of method. First, I explore the history of occupational therapy in the 20th century. Occupational therapy has not always existed. In this chapter, I outline some of the factors that lead to its establishment, pay specific attention to professional crises that have changed how occupational therapists conceptualize their role in relation to society, and the development and promotion of the profession. The lineage of occupational therapy is then traced back to reform movements that occurred in the 19th century related to moral treatment. Drawing on historical literature, various different conceptions and manifestations of moral treatment are also discussed. Subsequently, I explore occupational therapy that continues to be explicitly described as moral treatment. Work extending throughout the 20th century is examined to outline the different ways in which occupational therapy, conceptualized as moral treatment, has been discussed by academics working in occupational therapy. The historical depiction presented in this chapter will function as a basis for the work presented in subsequent chapters.

4.1 Emergence of Occupational Therapy in the 20th Century

Although it is common for supporters of the profession and its mandates to tie its establishment to medical, social, philosophical, and political movements that predate its appearance (e.g., Bing 1981; Busuttil 1992; Driver 1968; Dunton 1947; Friedland, 2003; Hocking 2008; Wilcock 2001b; 2002), most agree that the profession of occupational therapy was first formally established at the beginning of the 20th century. In the early years of the 20th century, various institutions in different geographical locations in the UK, the USA, and Canada identified the value of occupation, organized, and provided training for the provision of occupation work in tuberculosis sanatoriums, mental hospitals, and institutions for the physically disabled (Dunton 1947; Friedland, Robinson & Cardwell 2001; Wilcock 2002).

The First World War is often identified as the 'turning point' when occupational therapy as a distinct profession began to be formally established (e.g., Friedland & Davids-Brumer 2007; Wilcock, 2002; Woodside, 1971). 'Reconstruction Aides' or 'Ward Aides' were trained to do reconditioning work with wounded soldiers through the use of occupations during their convalescence to combat psychological problems and ensure their reintegration into society and the labor force (Friedland 2003; Jones 1988; Wilcock 2002). As Colman (1990) explained, occupation therapy work was in high demand and gained popular recognition at this time due to its professed potential to "reactivate soldiers for both the military and the civilian labor force" (p. 743). During this time, George Barton, an architect, is often credited with naming the profession 'occupational therapy' (Bing, 2005; Dunton, 1947). Barton, having personally battled disability and infirmity in his own life, grew to value the health promoting effects of occupation. In the interim between the two World Wars, many of the training programs that had been established during the First World War persisted, but some were discontinued (Alsop, 2006; Robinson 1981; Woodside 1971). However, those that believed that occupation based treatment had potential worked hard to ensure the survival and expansion of the profession. As well, due to its perceived value to social wellbeing and the efforts of members, the profession received attention in newspapers (Colman, 1990). Formal associations and education programs were created, educational standards were developed, and occupational therapy departments in institutions were established (Rerek, 1971; Robinson, 1981; Wilcock, 2002). Subsequently, the Second World War created an increased demand for occupational therapists that would again be required to work with soldiers wounded in the conflict. As Wilcock (2002) remarked, "to say this phase of the profession's history was important to its development is almost to understate the matter. It was a time that enabled the newly committed groups of individuals to make their identity know to the world at large" (p. 181).

The creation of occupational therapy as a distinct entity had been successful. With its emergence as a profession in its own right, discussions about its role and the techniques it would use to achieve its ends became more plentiful. As a result, historians have had ample material to outline the scope and mission of the profession as it was described in those early years in detail. For example, in an analysis of British

occupational therapy literature written between the years 1938 – 1951, Hocking (2007) outlined the purposes of the profession and its member's efforts to engage their patients in occupation treatment. Hocking highlights occupation's perceived potential to restore mental and physical capacities. Occupation was used as a means to restore order, or prevent the onset of disorder in the thought patterns of individuals with mental difficulties and convalescents with tuberculosis, or physical ailments. Occupation was used to ready the patient for discharge, or further and more intensive restorative therapy that targeted particular functional abilities, or vocational skills. Subsequently, occupation intervention was used to remediate the functions of the mind and the body by targeting specific habits, in the case of those with mental health issues or physical injuries, for amelioration.

Kielhofner and Burke (1983) examined a range of predominantly American literature written in the first four decades of the 20th century. These authors claimed that during these years a coherent perspective predominated that served to organize the efforts of occupational therapists which they call the 'the paradigm of occupation.' A single unified paradigm was said to direct the emerging profession as its members worked with individuals suffering from mental illness and physical disability. Human beings were seen to have an occupational nature that worked to organize and structure the habits of living that led to a personally satisfying and socially useful existence. Unhealthy occupational habit rhythms were targeted and replaced with healthy ones to address dysfunction and restore balance. In the case of mental illness, faulty occupational habit patterns developed in the course of living lead to disorder. For those battling physical disability, periods of convalescence, or losses of physical ability resulted in the deterioration of healthy occupational routines. Engagement in a balance of occupations served to gradually restore, or develop an individual's abilities and skills, and restructure, or reinstate healthy habit rhythms preparing them for successful reintegration into social life. This paradigm, these authors argued, was the reapplication of earlier perspectives and procedures rooted in the humanistic philosophy of the 18th and 19th centuries called moral treatment. More will be said about moral treatment and how it has been deployed differently throughout occupational therapy's history in subsequent sections. For now, it

is just important to note that historians concerned with occupational therapy often trace its beginnings to the moral treatment era and the techniques associated with it.

4.2 Critical Reflection on Professional Foundations

While the creation of occupational therapy as a distinct profession in the United States, the United Kingdom, and Canada was successful, its diversification and efforts to adhere to transforming epistemic realities led to debate and critical engagement with the theoretical foundations on which it rested (Driver, 1968; Dunning, 1973; Reed & Peters, 2008; Trider, 1972; Yerxa, 1967; Wilcock, 2002). As Wilcock pointed out, this questioning of professional values and concerns reflected the cultures in which the profession was situated. The 1960s and 1970s gave rise to a culture preoccupied with change, revolution, and experimentation, which in turn, had an impact on those working within the profession (e.g., Shimeld, 1971). Occupational therapy leaders came to believe that true professionalism would not be possible until occupational therapy was able to construct its own knowledge and define its role independently. During the 1960s, Driver (1968) contended that it was necessary for occupational therapy to reflect the focus of the period in which it was situated but warned "in keeping with our age, some introspection is in order and an element of danger exists here. Over-indulgence in introspection can result in paralyzing confusion … If, as a result of deep searching thought, we merely state our pains and take no action, then we are allowing introspection to become paralyzing pessimism" (p. 58). Despite these and other similar warnings, or perhaps because of them, in the years and decades that followed, leaders in occupational therapy spent a great deal of time and effort in consideration of questions that related to the identity of the profession. At the same time, there was an increased focus on activities that served to bolster the status of the profession and ensure its survival (e.g., Christiansen, 1991; Cockburn, 2001a; 2001b; Diasio, 1971; 1985; Fidler, 1981; Ilott, 2002a; 2002b; Llorens, 1970; Reed & Peters, 2008; Shannon, 1977; Sumsion & MacKinnon, 2008; Trentham, 2001; Wilcock 2002). Many felt that occupational therapy had lost its way because its original focus on occupation had been forgotten. Shannon (1977; 2005), like many others, believed that occupational therapy's mission had been forgotten and called for a return to the values and beliefs that provided a foundation for the profession's

establishment in the first half of the 20th century. Some also point out that occupational therapists lacked a well articulated scientific basis (e.g., Christensen 1987; 1991; Hunter, 1976; Reed & Peters, 2008; Yerxa 1987).

4.3 Constructing a Humanistic Science of Occupation

For example, as part of this effort, a new scientific discipline labeled 'occupational science' was created in the late 1980s (Wilcock 2006). It was promised that this new discipline would help to provide a scientific foundation for occupational therapy through the development of a body of knowledge regarding occupation that reflected the values of occupational therapy (see Molke, Laliberte Rudman & Polatajko, 2004). As Glover (2009) argued, the roots of occupational science reside in occupational therapy. Leaders in the field intended to strengthen and expand the value of the profession by promoting an 'occupational renaissance' that identified occupation as a fundamental human need (Polatajko, et al., 2007a; Whiteford, Townsend, & Hocking 2000; Wilcock 2006). Occupation would serve as the central construct through which particular values would be preserved and new scientific knowledge would be generated (Molineux, 2000). In other words, study of occupation would ensure that the profession would progress through scientific activity but remain tied to the humanistic sentiment that lead to the profession's establishment in the early part of the 20th century (Molineux & Whiteford, 2006; Wilcock 2006; Yerxa, 1991; 1992).

Occupational science was promoted as a discipline that would allow occupational therapy to retain a role in society while preserving its core identity as it was articulated by the early founders of the profession (Clark et al., 1991). It was to be a "rigorous and systematic study of human being's interaction with occupation, particularly in relation to health" (Wilcock, 1991, p. 299). One author indicated that this inquiry should revolve around the core question: "What is the relationship between human engagement in a daily round of activity (such as work, play, rest and sleep) and the quality of life people experience including their healthfulness" (Yerxa, 1993, p. 3)? Yerxa (1993) believed that occupational science should focus on issues related to enabling persons with disability to reconnect with the 'elemental routines' that were proper within a particular culture. Clark and her colleagues argued that "in generating theory about occupation we must examine

the rules, moral convictions, symbolic meanings, emotional responses, and sociocultural and historical contexts that influence one's decision about whether to invest one's energy in particular occupations" (p. 302). However, as efforts to construct this science continued, questions related to which kinds of scientific knowledge would be best to pursue emerged (Carlson & Clark, 1991).

Molineux and Whiteford (2006) explained that tensions exist between the philosophical tenets of the science and the basis of professional practice. They claimed that occupational therapy and the new discipline occupational science were founded on humanistic principles. Questions about the appropriateness of the sciences and associated knowledge that are used in the application of health care services arise when confronted with a science that is so explicitly based on values (see Murray, Holmes, Perron & Geneviève, 2007). While occupational science provides practitioners with an opportunity to "interject its humanistic values and optimistic view of human nature into the health care system," this interjection is not always seen as appropriate or desired by that system (Yerxa, 1992, p. 82).

Molineux and Whiteford (2006) explained that this tension is linked to the conceptual inconsistencies between the biomedical and human and social science paradigms. The creation of a science of occupation allowed for the development of knowledge that was ethically and epistemologically consistent with the profession's early history, but not necessarily with the roles and demands that the profession and its members fulfilled in the societies in which they practiced. While academics work to reclaim the profession's distinct identity and value system as articulated by its founders through a science of occupation, the knowledge that has currency within the health care system is reductionistic, value neutral, concentrated on the elucidation of physical laws, and justified with economic reasoning (see Wilcock 2006; Yerxa, 1991; 1992). Practitioners have available to them a growing body of knowledge that revolves around the construct of occupation; however, it is knowledge that is not necessarily respected or accepted in practice milieus. To better understand how this science has the potential to support, enhance and expand the missions and mandates of occupational therapy the historical soil that fuels its growth and development needs to be examined more carefully. In answering the criticisms of academia and healthcare which threaten to eliminate the

normative dimensions of occupational science and therapy, these dimensions and the reasoning that gave rise to them need to be more clearly articulated. Next, I attempt to contextualize the historical context that gave rise to many of the therapeutic ideas that revolve around occupation.

4.4 Moral Treatment

Occupation's ameliorative potential was identified and cultivated by moral treatment reformers in the 18th and 19th centuries (Wilcock, 2001b). Moral treatment models are only one of many different influences that have structured the work of occupational therapists (see Friedland, 2003). However, as is indicated above, moral treatment, perhaps more than any other set of ideas and practices, has been discussed and touted as providing the major foundation for the creation of occupational therapy (e.g., Bing, 1981; Bockoven, 1971; Busuttil, 1992; Diasio Serrett, 1985; Dickinson, 1990; Driver, 1968; Engelhardt, 1977; Kielhofner & Burke, 1983; Paterson, 1997; Peloquin, 1989; Wilcock 2001b).

Moral treatment was used as a strategy to treat mental illness in the late 18th and 19th centuries. It is difficult to understand what moral treatment consisted of due to the different ways in which the term 'moral' has been used through time. In the 1970s, in an attempt to reassure social relativists, Bockoven (1972) related the 19th century use of the term 'moral' to 'emotional' or 'psychological' aspects of human experience. For example, Bockoven (1972) explained that previously psychological stressors were understood as 'moral causes' of stress. Charland (2008) broke down the etymology of the term in more detail. He too explained that at the end of the 18th century medical writers used the term moral to refer to mental or psychological as opposed to physical phenomena. However, the psychological material that the term moral was concerned with could include notions related to values and morality. For example, Charland (2008) demonstrated how the famous moral treatment of Philippe Pinel included ethical as opposed to just psychological dimensions. While the term 'moral' did refer to material aspects of psychology, moral treatment processes also worked to identify and sought to evoke 'healthy', or 'good' psychological experiences and states of being that can be connected to normative considerations. For example, according to Pinel, Medicine,

through the application of moral treatment, would demonstrate how instances of individual and social immorality could lead to insanity (Charland, 2008). In establishments that were more explicitly connected to a religious community, like the York Retreat in England, moral treatment did include immersion into a faith community. Indeed, in this case, routine religious worship was part of moral treatment (see Tuke, 1813). Treatment was explicitly based on an effort to reconnect individuals with a Quaker ethical sensibility (Charland, 2007; Digby, 1985). The ethical quality of moral treatment becomes clearer when different diagnoses available during the period in question are carefully examined. Among the various diagnoses that were available at the time 'moral insanity,' above all, immediately suggests that there was an ethical dimension to the meaning of the word moral (see Digby, 1985). Digby quoted Dr. Prichard, a physician writing in 1835:

> In cases of this description the moral and active principles of the mind are strangely perverted and depraved; the power of self-government is lost or greatly impaired; and the individual is found to be incapable … of conducting himself with decency and propriety in the business of life. (as cited in Digby, 1985, p. 93)

Digby (1985) reviewed the case notes of 18 Quaker patients given a diagnosis of moral insanity at the Retreat and found clear indications that normative expectations and their deviations were what marked these individuals as 'morally' insane. For example, Digby summarized a list of specific character criticisms that justified this diagnosis: self-willed, irritable, idle, unsuitable sexual behaviour, abusive, deceitful, violent, dirty, intemperate, and sullen. One individual given this diagnosis was described as "very self-willed and obstinate – indisposed to follow medical or other advice" (Digby, 1985, p. 96). Digby (1985, p. 96) explained that he was "put on a plain diet and sponged vigorously with cold water every morning" as treatment for this supposed 'illness'. While the term moral did refer to psychological dimensions of human experience, it also related to ethical dimensions of human experience. The distinction between psychological states and ethical considerations were not clearly delineated, nor was it thought necessary to do so (Charland, 2009b).

In attempting to understand what moral treatment consisted of, it is helpful to understand why institutions were established that provided this form of treatment. In his

book *Description of The Retreat* published in 1813, Samuel Tuke, an English Quaker, described the events that lead to the establishment of the York Retreat in England, often identified as one of the birth places of moral treatment. In 1791 Quaker communities in England were distressed that one of their own, a woman named Hannah Mills, had died at the York Asylum after family had been denied the right to visit her (Digby, 1985; Tuke, 1813). This event provoked reflection on the treatment of mental illness and on potential improvements that could be made. As Tuke (1813, pp 22-23) explains it was thought that:

> A milder and more appropriate system of treatment, than that usually practiced might be adopted; and where, during lucid intervals, or the state of convalescence, the patient might enjoy the society of those who were of similar habits and opinions. It was thought, very justly, that the indiscriminate mixture, which must occur in large public establishments, of persons of opposite religious sentiments and practices; of the profligate and virtuous; the profane and the serious; was calculated to check the progress of returning reason, and to fix, still deeper, the melancholy and misanthropic train of ideas, which, in some descriptions of insanity, impress the mind. It was believed also, that the general treatment of insane persons was, too frequently, calculated to depress and degrade, rather than to awaken the slumbering reason, or correct its wild hallucinations.

What made the practice of moral treatment at the Retreat innovative at the time is further captured through a description of the process through which George Jepson, the Retreat's superintendent appointed in 1797, is said to have come to understand his role:

> Following steadily but cautiously the guidance of his judgment and his feelings, he was soon led by observation and experience to abandon the system of terror, and to adopt that which presumed the patient to be generally capable of influence through the kindly affection of the heart, and also in a considerable degree through the medium of the understanding. (Yorkshire Herald, 1892 as cited in Wilcock 2001b, p. 317)

In 1841, in an introduction to a manual focusing on the construction and management of hospitals for the insane Samuel Tuke was invited to describe the character that one conducting this work ought to have:

> A ready sympathy with man, and a habit of conscientious control of the selfish feelings and the passions, ought ever to be sought as carefully as medical skill … he should be one who knows experimentally the religion of the heart; who can condescend to the weak and the ignorant, and who in the best sense of the phrase, can become all things to all men. (as cited in Digby, 1985, p. 27)

Through the 16th and 18th Centuries in England and Europe, the solution to the problem of madness and other states of social deviance had increasingly become incarceration (Castel, 1988; Digby, 1985; Foucault, 1961/2009; Scull, 1993; Wilcock, 2001b). The institutionalization of mental illness served to remove the mad (along with others who threatened social life) from the community at large. Depictions of the period which preceded the moral treatment era simultaneously portray a British and European solution to the problem of mental illness as barbarous in nature. Scull (1993) identified Bethlem Hospital in London as the quintessential monument to this historical tale. A punitive ethic rather than one of care is often said to have dominated:

> Cloathing was 'coarse and uncomfortable', the diet meager and inadequate to maintain health, idleness and inactivity the norm, the reliance on chains and other form of restraint widespread and routine, the patients vulnerable to both physical and sexual abuse and subjected to what Carkesse termed 'Mad Physick': 'drenching with medicine which was at once 'uncomfortable, painful and debilitating, producing voiding from both stomach and bowels, scarification, sores and bruises. (Andrews 1991 as referenced in Skull 1993, p. 56)

Generally, the typical response to madness changed over the course of the 18th and 19th centuries (Scull, 1993). Insanity was created as a distinct category of social deviance deserving scientific attention and came to be treated within an institutional setting under the control of lay healers and eventually professional medical men (Castel, 1988; Digby, 1985; Scull, 1993; Rothman, 1990). Industrialization, The Enlightenment, and revolutionary thinking altered how humans were to be understood and common responses to madness and its management (Castel, 1988; Digby, 1985; Foucault, 1961/2009; Scull, 1993; Wilcock, 2001b). The transformation of an old mentality that conceptualized people with mental illness as brutes or animals devoid of reason into a new mentality that understood them as human beings who's outlook and experience had become clouded or confused but not completely lost to reason occurred (Digby, 1985; Foucault, 1961/2009; Scull, 1993). This change in sentiment had real effects in terms of how people with mental illness where treated and what kinds of technologies were used in that treatment. Digby (1985) explained that this change was understandable. When those thought to be mentally ill are believed to share attributes with humanity then rehabilitation or socialization is likely. When those thought to be mad are seen as animals then coercion

and discipline prevails. Complete submission and subjugation of the insane was replaced by efforts that sought to reawaken normal sentiment and a self determining capacity (Bockoven, 1972; Digby, 1985; Scull, 1993).

Generally speaking, moral treatment was driven by optimism; optimistic in terms of a belief in the possibility of cure for insanity and in the nature of human beings themselves (Digby, 1985; Scull, 1993). For Samuel Tuke (1813, p. 139), moral treatment consisted of "assisting the patient to control himself." At its most basic level, the various moral treatment technologies worked to cultivate the individual's ability to control and manage their own liberty (Tuke, 1813). By employing a benevolent attitude asylum superintendents and handlers worked to enhance the mentally ill's ability to restrain, monitor, and control their own behavior (Digby, 1985, Pinel, 1809/2008; Scull, 1993; Tuke, 1813). Occupation in particular was used to divert the attention and regulate the mind and body to better achieve these ends (Digby, 1985, Pinel, 1809/2008; Scull, 1993; Tuke, 1813). Manual labor and amusements were the occupations employed most often (Pinel, 1809/2008; Tuke, 1813). Much stock was placed in the power of a charismatic patriarch and matriarch (Pinel, 1809/2008; Tuke, 1813). As Pinel (1809/2008, p. xxix) explained, a superintendent must embody a "compassionate firmness" (p. xxix) creating "a single centre of authority … always present in their [patient's] imagination for them to learn to control themselves" (xxii). Much emphasis was put on placing patients in a pleasing and well ordered environment. This lead to a detailed discussion about the form and structure that moral treatment institutions should necessarily take and how space could be used therapeutically (Pinel, 1809/2008; Tuke, 1813). For example, Tuke (1813) noted that bars were purposely left off windows to prevent the Retreat from resembling "a place of confinement" (p. 94). Generally, the Retreat was thought to "combine nearly all the circumstances, which are usually considered favorable to longevity and the almost uniform health of the family [the inhabitants of the Retreat]" (Tuke, 1813, p. 94). The Retreat was surrounded by courtyards, gardens, farmland, and walkways all to be used in treatment. Pinel (1809/2008, p xxiii) also dreamt of a time when all asylums in France would be specially designed to deliver this kind of treatment:

> The internal lay-out and amenities of the premises are of such great importance in a psychiatric hospice that we must hope to see one day the inauguration of a new kind of establishment especially designed for this purpose and worthy of a

> powerful and enlightened nation. But will the architect yet again model his buildings on the places where ferocious animals are confined? Does the mentally ill patient not also need clean and healthy air to breathe?

For some, moral treatment embodied the scientific approach. For example, Pinel's (1809/2008) work is clearly a naturalist's attempt to systematically document the forms that mental illness could take. Moral treatment was thought to represent the happy marriage of humanistic sentiment and scientific understanding (Healy, Charland, Hickish, 2008). As we have seen, this union is preserved within the occupational therapy and occupational science discourse.

Moral treatment was not a coherent and unified movement or set of principles and techniques (Scull, 1993). Rather, it is a term that identifies a variety of different treatment programs that existed in a variety of different places and times. Wilcock (2001b) offered a quote from a lecture given by W.A.F. Browne, a psychiatrist, during the first half of the 19th century in Scotland: "All recent writers on insanity have spoken loudly in praise of moral treatment … Each of them attaches a different meaning to the word. Employment is the panacea of one, amusement is the specific of another, classification is advocated by a third" (Wilcock, 2001b, p. 454).

Digby (1985) briefly alluded to the conflict that occurred between the various advocates of moral treatment when she quotes Philippe Pinel, the French moral treatment advocate, discussing the Italian advocate Vincenzo Chiarugi's work: "it was Chiarugi's lot to follow the beaten track" (p. 31). Digby (1985) also differentiated Pinel's moral treatment from that conducted at the Retreat. Pinel believed that religious activities should be restricted due to their potential to exacerbate particular kinds of illness, while at the Retreat, religious worship was fundamental to treatment. Indeed Charland (2007) underlined the fact that historians contend that moral treatment at the Retreat dealt more with the establishment of a moral sense whereas moral treatment for Pinel focused more on the proper conditioning of the emotions. Digby (1985, p. 32) also explained that the Retreat's lay therapists were more involved in the day-to-day lives of a few patients, while Pinel worked in a larger institution and was more of an "aloof investigator." "Pinel," Digby (1985, p. 32) argued, "adopted a systematic approach to study the symptomatic states of his patients and construct a scientific nosology of mental diseases.

The Retreat's lay therapists were more pragmatic in working out their treatments and more selective in recording their cases." Charland (2008) also identified disagreement between more scientific minded medical professionals during this era. He differentiated the work of Pinel and Alexander Crichton the Scottish physician. While each emphasized the importance of the emotions, they could not agree on the role that values and ethics played in their regulation. Rothman (1990) described the unique circumstances that led to the birth of the asylum in America. The asylum solution was adhered to later than in England and Europe. In America, moral treatment did not begin with the dramatic freeing of the insane and removal of chains but the building of new institutions. Prior to the 1820s systematic construction of large specialized institutions for the insane did not take place and the treatment of the insane had not taken on the same brutal qualities that it had in Europe (Rothman, 1990). As in Europe, because of notions that American life had become more fluid, open, and chaotic it was thought that those with mental illness had become "casualties of the system" (Rothman, 1990, p. 133). The ties and values that traditionally held society together were thought to be unraveling. While this hypothesis has been employed to explain changes in England and Europe (e.g., Foucault, 1961/2009), in America, the unique quality of its social organization was thought to hold its own special dangers: "To this end it [the asylum] had to isolate itself and its members from chaotic conditions. Behind the asylum walls medical superintendents would create and administer a calm, steady, and rehabilitative routine" (Rothman, 1990, p. 138).

Even within specific locations, the practice of moral treatment changed over the course of the 19th century. For example, Digby (1985) described the difference between emphases on moral treatment and moral management which she believed predominated at different times at the Retreat in England.[5] Contrast the following quote with the quote appearing at the beginning of this section in regards to Jepson the first superintendent of the retreat. The following quote was written by J.C. Bucknill and Daniel H. Tuke, the great grandson of William Tuke, the founder of the retreat, and the son of Samuel Tuke, the author of the *Description of The Retreat*, and relates to the desirable character of a superintendent:

[5] Occupational therapy historians do not seem to differentiate between 'moral treatment' and 'moral management' in the literature (but see Bing, 1981).

> A faculty of seeing that which is passing in the minds of men is the first requisite of moral power and discipline, whether in asylums, schools, parishes or elsewhere. Add to this a firm will, the faculty of self-control, a sympathizing distress at moral pain, a strong desire to remove it, and that fascinating biologising power is elicited, which enables men to domineer for good purposes over the minds of others (Bucknill & Tuke, 1858 as cited in Digby, 1985, p. 61).

Over the course of the 19th century, Digby (1985) pointed out that there was a growing preference for the term 'moral management' to 'moral treatment.' Digby (1985, p. 61) attempted to demonstrate that this change could be associated with the establishment of a "more systematic organization … and a more pervasive authority" over patients. Over the course of the 19th century, treatment became more systematically imposed on patients through institutional routinization (Digby, 1985). At the Retreat, what had in the first half of the century been a therapy openly structured by the values inherent in a Quaker familial way of life became a more implicit system of institutional controls. Moral treatment had transformed into moral management. Overt treatment according to shared values became "pervasive but concealed techniques of social management" (Digby, 1985, p. 86). Digby (1985) believed that over the course of the century the moral treatment techniques used may not have been all that different; rather, they became more organized and came to completely saturate Asylum life. For example, seclusion, classification, and the granting and withholding of privileges worked to systematically create a system of behavioral control that was inescapable. In discussing this change, Digby (1985, p. 86) quoted a patient who was at the Retreat in the 1870s: "I told him [the superintendent] one day that I believed what he meant by 'better' was a nearer approach to that subdued and helpless condition below the power of complaint, which I saw in many of those around me."

The change at the York Retreat, which Digby (1985) described as a change from moral treatment to moral management, reflected general trends that eventually lead to the decline and demise of the moral treatment era. Scull (1993) documented this process of decline in England in detail. The unbounded optimism that lead to reforms at the beginning of the 19th century had waned as it became clear that moral treatment, while effective, did not live up to expectations. Early advocates imagined that properly regulated moral treatment would result in "60, 70, or 80 per cent" cure rates (Scull, 1993,

p. 272). It became clear that many would remain chronically ill and continue to struggle with mental illness. Asylums began to accumulate these chromic cases. Scull (1983, p. 272) wrote:

> An overwhelming and growing proportion of the asylum population quickly came to be composed of chronic, long-stay patients. And it was this specter of chronicity, this horde of the hopeless, which was to haunt the popular imagination, to constitute the public identity of the asylums, and to dominate Victorian psychiatric theorizing and practice.

In presenting data gathered from the Annual Reports of the Commissioners in Lunacy, Scull (1993) established that cure rates continued to drop over the course of the second half of the 19th century in England. Even at the York Retreat, which some argue was the gold standard of care, recovery rates fell from 45 % to 32 % between 1796 and 1892 (Digby, 1985). National estimates in England were lower, as Scull (1993) demonstrated, and depending on the type of asylum ranged from 16 % to 7 % between 1860 and 1890. The result was that chronic cases accumulated and the unrestrained optimism characteristic of early reformers slowly eroded. Asylums became much larger, patient crowding became an issue, and public pressure to economize appeared (Scull, 1993). Management took precedence over treatment and the asylum took on a custodial role. Near the end of the period in England, in some cases, Asylums housed over 1000 patients (Scull, 1993). Compare this to the York Retreat which began with three patients in 1796 and in 1834 had 102 patients and the differences become glaringly apparent (see Digby, 1985; Tuke 1813). In order to cope with the growing numbers, routinization became necessary. For example, whereas early moral treatment techniques had required individual attention and individualized treatment plans, over the course of the 19th century, this became impossible. Scull (1993, p. 285) quotes various stakeholders writing in the second half of the 19th century:

> ‘It is totally impossible to do more than know [the inmates] by name.’
> ‘Individual interest in the patients is all but dead’ … ‘their number renders the inmates mere automations, acted on in this or that fashion according to the rules governing the great machine.’

For example, early moral reformers believed that well chosen occupation was important and had curative properties (see Tuke, 1813, Pinel 1809/2008). Scull (1993, p. 285) demonstrated that as the 19th century progressed even occupation became

something that was doled out in a systematic way and was "shaped to fit the asylum's timetable and routine." Amusement and employment were still used therapeutically, but were chosen with an eye more to the needs of the institution than the needs of individual patients and some were "not given any task, however trivial. Many patients were simply left to rot" (Scull, 1993, p. 289). Some have also pointed to the influx of patients from various divergent ethnic and economic backgrounds (Digby, 1985; Rothman, 1990; Scull, 1983). As we have seen, in some places in particular, there was an ethical component to moral treatment which rested on assumptions about how best to live life reflecting a particular cultural heritage. Faced with new patients whose cultural beliefs and assumptions were not familiar or tolerated, it is possible that pragmatism and prejudice prevented attempts to cater to their unique cultural needs leading to treatment failures (see also Bing 1981; Bockoven, 1972; Goldberg, 1999). By the end of the 19th century, the optimism of the early 19th had all but disappeared; so had all but the most general superfluities of moral treatment.

4.5 Moral Treatment & Occupational Therapy

In the previous section I examined the history of moral treatment in the 19th century. In this section descriptions of 20th century occupational therapy practice that are explicitly described as moral treatment are explored. Readers are thus given an opportunity to recognize links between practices described as moral treatment in both time periods. Along with historians, occupational therapists interested in moral treatment often explain that on seeing and being dissatisfied with the poor conditions in which mental patients were held in hospitals in England and France at the turn of the 18th into the 19th century, reformers like William Tuke and Philippe Pinel introduced humanitarian reforms (e.g., Bracegirdle, 1991). Occupational therapy researchers have indicated that it was optimistically believed that humane treatment would lead to recovery from mental illness. Moral reformers made an "effort to re-educate the insane in habits of industry, self-control, moderation, and perseverance" involving "the provision of education, training, recreation and work thought suitable" (Bracegirdle, 1991, p. 231).

For example, writing at the close of the First World War, Dunton (1919) expressed the belief that occupation therapy was not something newly invented at the

beginning of the 20th century. Rather, he reported that it was something that had gone out of fashion, been discarded, and forgotten for a time. Dunton (1919) argued that Philippe Pinel was "one of the earliest advocates of occupation as a means of treatment of the mentally sick" (p. 19). He also quoted, at length, comments made by a Sir James Connolly in 1813 in relation to the York Retreat:

> The substitution of sympathy for gross unkindness severity and stripes; the diversion of the mind from its excitements and griefs by various occupations, and a wise confidence in the patients when they promised to control themselves led to the prevalence of order and neatness, and nearly banished furious mania from this wisely devised place of recovery (Dunton, 1919, p. 21)

In highlighting particular aspects of moral treatment as discussed in texts written over the course of the 19th century, Dunton (1919) emphasized which of its aspects he believed were important in organizing and conducting occupational therapy portrayed as 'reconstruction work'. While moral treatment was used in the 18th and 19th centuries predominately with people who were identified as mentally ill, Dunton (1919) emphasized the potential for occupation therapy to help the physically ill as well: "It has been proved that reconstruction therapy can be used to restore both the physically and mentally sick to their normal or perhaps above it, and make them once more useful units in a community" (p. 11). Notwithstanding Dunton's (1919, p. 43) claim that occupation relates to anything that diverts the attention, at this time, occupation seemed to refer most often to work, especially manual labour (see also Friedland, 2001). Indeed a great deal of space is spent highlighting the importance of the 'work cure.' Dunton (1919) did highlight the importance of providing a variety of amusing activities for patients. For example, while the first sentence of a credo etched into the front pages of Dunton's (1919) book is often cited in the occupational therapy literature – "occupation is as necessary to life as food and drink" – the following sentences advocating a range of occupation and hobby, both physical and mentally stimulating, makes it clear that Dunton believed that labour alone was not enough to restore 'normality' or prevent the onset of illness. Still, the importance of physical labour in both moral treatment and reconstruction therapy is made clear by the following quote Dunton (1919, p. 22) included from Jean-Étienne Esquirol, the student and close colleague of Philippe Pinel:

> This valuable resource of work is missed in the treatment of the wealthier class of men and woman. Its place is not entirely filled by supplying walks, music, lectures and social events. The habit of idleness in the homes of the well-to-do counterbalances other advantages which this class possesses for recovery.

Elsewhere, Dunton (1918, p. 14) again emphasized the importance of work by quoting Dr. Robert Chase who described features of the York Retreat over the previous century:

> No feature in the treatment of the insane is more highly valued than occupation, systematically applied and judiciously carried out. Work is a law of our nature which demands expression … It may be seen that from the beginning Friends' Asylum made intelligent and continuous effort to give the patients the benefit that comes from employment and rational diversion.

The reasoning behind this emphasis on work in moral and occupation treatment becomes clearer when the larger social context is considered within which these early books were written. In the preface to their book '*The work of our hands,'* Hall and Buck (1915) lamented over the burden placed on the various governments and communities caused by men incapacitated by the war. This was also a time when the needs of industry were paramount. "The really well to do community or the really prosperous man must be constantly at work, adding to the world's store of valuable things. The moment industries stop there is waste and desolation" (p. ix). Hall and Buck (1915) appealed to their readers by asking them to imagine themselves in the place of a man unable to work because of crippling illness: "Imagine the despair and the final degeneration that must sap at last all that is brave and good in life" (p. viii). Hall and Buck (1915, p. x) lauded programs in hospitals that required interned patients to take responsibility for the day-to-day institutional needs:

> The patients participate in all the household work, especially in the laundry and in the kitchen. They are also employed in the manufacture of clothing, shoes, and furniture. They are making and remaking mattresses, and, best of all, they are employed very largely upon the farms in the raising of crops for the use of the institutions.

Without reading too deeply into these texts, one can readily see that a mix of graded activities (mental and physical; productive and leisurely), tact, kindness, patience, praise and a genuine trust in individuals' ability to control and direct their own behavior were thought to be important aspects of occupational therapy at the end of the second decade of the 20th century. One can thus identify clear similarities between the moral treatment

of the 19th century and occupational therapy described as a kind of moral treatment in the 20th century.

Near the end of the 1940s after the Second World War had ended, Licht (1948/1983) again cited the first edition of Philippe Pinel's *Medical Philosophical Treatise on Mental Alienation* and linked occupational therapy to the claim that "rigorously executed manual labor is the best method of securing good morale and discipline." (p. 75). He then described the spread of the moral treatment for people with mental illness through Europe, the United Kingdom, and North America and its decline and resurgence in the early 20th century. Once again, the claim is made that Pinel used occupational therapy with mental patients. In the 1940s, Licht (1948/1983) described occupational therapy as 'moral treatment,' 'activity therapy,' 'work treatment,' 'work therapy,' or 'ergotherapy' and outlines a method of treatment with which "people could be retrained or readjusted to gainful living" (p. 86).

Bockoven (1971), an American physician who wrote various books on moral treatment and community psychiatry in the 1960s and 1970s, also became an advocate for occupational therapy and argued that "the history of moral treatment in America is not only synonymous with, but is the history of occupational therapy" (p. 223). In an article published in the *American Journal of Occupational Therapy*, Bockoven (1971) argued that moral treatment philosophy was based "on the law of love and on the capacity of caretakers of the mentally ill to appropriate the troubled feelings of a fellow human being as their own" (p. 223). A 'regimen of daily life' consisting of creative activities conducted alongside others would help those individuals "drifting about in a state of social disorientation" find "their own values and find their way out of demoralization" (p. 224). Engelhardt (1977) explored the development of occupation therapy in the 19th and 20th century and linked the profession to concepts that he claimed characterize the moral therapy of the 19th century. Occupational therapy, explained Engelhardt, "offers a meaning of therapy that accents the process of human adaptation through involvement in recreation and in physical and mental activities generally … humans adapt and thrive in their environments by structuring their time in tasks that lead to recreation and pleasure" (p. 672). Drawing on the work of Bockoven, he described various means through which moral treatment might adapt individuals "to the general mores or values of their culture."

(p. 668). Moral treatment would consist of lectures in the arts and sciences, religious worship, engagement in manual labor, and the establishment of regular habits of self control. He described occupational therapy as a 'humanistic art' and professional intervention as a means to "enrich the breadth of human life" (p. 671).

Peloquin (1989) examined a range of American literature on moral treatment published both within and outside of occupational therapy from the early 19th Century and the 1960s, 1970s, and 1980s. She summarized the image of moral treatment she found within these texts as the treatment of the mentally ill within institutions that included "humane treatment, a routine of work and recreation, an appeal to reason, and the development of desirable moral traits" (p. 538). Habits of self control would be developed and an understanding of right and wrong would be established through immersion in a "total therapeutic community" (p. 538). In conclusion, Peloquin explained: "In the face of changing trends, therapists must continually redefine and rearticulate the value of a humane practice that transcends scientific validation and bureaucratic understanding" (Peloquin, 1989, p. 544).

Paterson (1997) traced the development of moral treatment through an exploration of early texts published by pioneers operating, for the most part, in the 19th century in Europe and the UK. She emphasized the importance of the relationship formed between the therapist and their patients. "Kindness, patience, interest and encouragement" were the tools used to treat mental illness. Her article is interesting in light of this discussion for two additional reasons. First, her focus once again seems to highlight moral treatment's potential to help people with mental health problems "obtain gainful employment … and to become useful members of society" (Paterson, 1997, p. 182). Secondly, in her concluding words she linked moral treatment to occupational therapy work done at the time and cautions therapists with the following words: "However, they need to be mindful of the fate of the alienists, who tried to cloak their humane and pragmatic approach to the management of their patients in scientific somatic-pathological terms, and only succeeded in losing their rationale for meeting the environmental, occupational and psychosocial needs of their patients" (p. 182).

A number of interesting issues present themselves when these different descriptions of moral treatment are examined. Although the various techniques seem

simple (e.g., application of: work, creative activities, recreation, kindness, patience, encouragement, the routinization of time, emersion in a therapeutic community, religious worship), the promised effects on the individual to be treated are enormous and potentially cause for alarm. The individual receiving moral treatment will adhere to the values of a particular culture, obtain habits of self control, moderation, perseverance and industry, and return to gainful living. Changing emphases of moral treatment work within occupational therapy become apparent as one compares statements made over the different decades. For example, after both World Wars emphasis was on manual labor, discipline and a return to gainful living. In the 1970s, Bockoven (1971) and Engelhardt (1977) emphasize empathy, self discovery, self control, engagement in pleasurable activities, manual labor, and the attainment of an enriched existence. Indeed Wilcock (2002) linked changes in occupational therapy treatment to the changing sociohistorical contexts in which the profession operated. During and after the First World War, the rise of industry, Taylorism, the need to reconstruct society, and those damaged in the conflict created a focus on work and reemployment (Wilcock, 2002). In the 1940s and continuing into the 1950s post war reconstruction efforts in occupational therapy moral treatment again focused on 'return to work'(Wilcock, 2002). As is also pointed out above, the 1960s and 1970s were a time of experimentation that emphasized critical reflection, self examination, and personal expansion. Thus we begin to see how occupation intervention might be tied to different social and cultural movements and their underlying values and needs. This means that far from being focused on the needs of individual clients, occupational therapy described as moral treatment seems to be attached to the needs of particular social systems. Interesting links between the foci of moral treatment perspectives within occupational therapy and the identified goals of occupational science are also apparent. For example, occupational science goals target investigation into the proper 'elemental routines' that lead to health and quality existence. Occupational therapy described as a kind of moral treatment is intended to train the individual to adhere to these routines. One can also identify difficulties faced by both occupational science and occupational therapy, described as a kind of moral treatment, in terms of tensions that exist between the values that provide a theoretical and philosophical foundation and demands for justification within a particular kind of scientific reasoning.

Chapter 5

5 Contexts Reexamined: Listening to Foucault

In the previous chapter, I explored the historical contexts related to the establishment of moral treatment and occupational therapy. In addition, literature that compared occupational therapy to moral treatment, or identified occupational therapy as moral treatment was examined. The changing emphases of moral treatment were also related to different sociocultural pressures in operation at different periods in the history of moral treatment and occupational therapy. In order to better understand how knowledge and its application are influenced by normative factors, I explore the role of 'bias' in the development of knowledge in the following paragraphs. For some, power and knowledge are always intimately related. For others, the articulation of truth requires the inclusion of value considerations. This discussion is meant to prime readers for and situate the critiques of Michel Foucault. This section is related to steps 'd' and 'h' outlined in chapter three. Here readers are encouraged to become familiar with many of the themes that interested Foucault. In doing so, readers will become sensitive to some of his critical thought and revalue the effects of moral treatment techniques. Later, in chapter six, I will extend Foucault's critical style to contemporary literature in occupational therapy that relates to spirituality.

Knowledge is routinely produced and organized through scientific enterprise and put to use through professional application. It is often assumed that neutral knowledge wielded by health care professional's works to improve life's quality in rational, beneficial, and unbiased ways (see Murray, Holmes, Perron et al. 2007). However, as indicated above in relation to occupational therapy, what is considered rational changes and what constitutes Truth relates to changing beliefs and their associated sociocultural contexts (see also Foucault, 1977/1980c; Kuhn, 1977). We have also seen that what was typical of moral treatment in the 19th century and occupational therapy described as moral treatment in the 20th century changed across space and time in relation to particular contextual pressures. It is now time to consider more carefully how truth and power are joined within the conduct of moral treatment. This analysis necessitates a more thorough

consideration of how norms play a part in the routine deployment of therapeutic technology and the conduct of scientific investigation.

While I have explored Foucault's notions related to how truth and power are joined, other less critically damning theorists have outlined how truth, values, and the conduct of science may be related (Klemke, Hollinger, Rudge & Kline, 1998; Zachar, 2008). In the conduct of professional work that is founded on the 'discoveries' of science, 'bias' may be unavoidable. Many argue that the work of scientists and professionals is controlled and steeped in value judgments in a number of different ways (Klemke, Hollinger, Rudge & Kline, 1998; Kuhn, 1977; Zachar, 2008). For example, the theories that scientists use to understand the world, the values that determine what constitutes 'good science' within a particular context, and the way in which scientists chose the 'problems' that they will pursue all depend, some argue, on particular ways of valuing (Klemke, Hollinger, Rudge & Kline, 1998; Kuhn, 1977; Zachar, 2008). McMullan (1998) explained that some believe that the fundamental assumptions on which the scientific enterprise rests begins with the valuing of Truth. The pursuit of Truth provides a goal creating a kind of transcendental context within which scientists can conduct their work. The argument here is that this, in and of itself, constitutes a kind of a priori valuing of particular kinds of knowledge at the expense of other kinds of knowledge based on different kinds of values. In times past, truth had nothing to do with fact and related more to what one did or ought to do rather than what one knew (Healy, 1990). In the present day, veneration of fact as Truth requires one to make an epistemological commitment which determines what kind of knowledge becomes important (Kuhn, 1977).

A more specific example, which can be more easily related to health professional practice, relates to the science of psychopathology. Charland (2008) explained that it is generally assumed that in pursuing 'facts' about mental illness the science of psychopathology should avoid questions of value. Charland (2008) contended that, in the present, it is commonly believed that a science of psychopathology should not incorporate questions that relate to morality and professionals should not pass moral judgments on the goals and activities of their clients. However, Charland provided historical evidence which highlights where efforts to construct a strict scientific study of affectivity and mental illness might be forced to grapple with questions of value.

Charland (2008) traced different construals of how concepts like value, morality, science, affectivity, and mental illness have been portrayed by various thinkers in the 18th and 19th centuries. This author found that, far from demarcating a clear distinction between what can be known as opposed to what is valued, the historical foundations of the science of psychopathology of emotion are mired in questions that entangle fact and value. As a result Charland (2008) concluded that we cannot assume that we can differentiate fact and value in affectivity and study facts alone. The pursuit of Truth in the conduct of science requires a careful consideration of value (see also Bing, 1986). And yet, scientific discussion revolving around psychopathological states as defined by diagnostic systems like the American Psychiatric Association's (APA) fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) shy away from discussions that relate to values and morals (Charland, 2006). For example, it is commonly believed that the DSM-IV is a-theoretical in that it does not reflect ideas about etiology but simply reveals and expresses empirical facts about psychopathology (Cooper, 2004; Lopez et al., 2006). DSM –IV categories of mental disorder are intended to be descriptive depictions of disordered states that individual human beings attempt to cope with in their day to day life (APA, 2000). Various authors have criticized this claim pointing to the biological etiological explanatory foundations on which this diagnostic system rests (Cooper, 2004; Lopez et al., 2006). In seeking to uncover the terms and notions explicitly and implicitly tied to specific psychiatric disorders defined in the DSM – IV (i.e., narcissistic, antisocial, histrionic, and borderline) and reflecting on their associated presuppositions and meanings, Charland (2006) revealed the normative assumptions concealed in the language of the DSM – IV system.

This inevitable relation of value bias to professional and scientific work becomes troubling when one considers how much influence health professionals and scientists have over the lives of the individuals in their charge. Occupational therapists do not provide diagnoses, but they do make judgments that depend on particular normative values. Indeed occupational science is often described as an academic discipline concerned with the human as an 'occupational being' and occupational therapists are regularly in a position to influence how individuals and communities come to understand and engage in occupational life (see Hammell 2006; Molke & Laliberte Rudman, 2009).

Taken together, it becomes clear how a science devoted to the study of 'occupational beings' and a profession that uses the knowledge produced to influence how occupational engagement occurs can come to influence how life should unfold in accordance with particular norms (see Molke & Laliberte Rudman, 2009). We have seen in chapter four how occupational therapy described as a kind of moral treatment emphasized different depictions of what constitutes an idealized existence. At some times, work was emphasized, at others personal expansion was important. How particular historical contexts recognize what constitutes occupation, or a balanced occupational engagement will change how practice is structured. The facts that are deployed regarding occupation in different times will demarcate different expectations about how life should necessarily unfold (Molke & Laliberte Rudman, 2009). Understood in this way, a science of occupation does more than simply describe, it is also prescriptive. Responsible practice necessitates that members of these communities carefully consider how their work is fundamentally related to questions of value (see Lilleleht, 2002a).

Reflection on how values play a part in the construction and application of knowledge can take on different forms. Some more orthodox thinkers advocate a kind of objective analysis and weighting of the values that underpin knowledge, practice, and individual experience, to preserve the goals of science and the work of professionals in the present (Rudner, 1998). As we have seen above, with the work of Foucault, other more provocative thinkers have attempted to use the tension between truth and value to challenge and undermine the validity of the aims and objectives of scientific discovery (Klemke, Hollinger, Rudge & Kline, 1998). Questions of value that relate to culture, ethnicity, and gender, for example, seem to undermine claims to objective Truth and demonstrate that even an objective study of value through the construction of a 'science of ethics' will carry with it moral consequences that require us to make choices about how best to feel, think, live, and act in the present potentially excluding, alienating, and pathologizing particular individuals that are different. This situation has created what some have called the 'science wars' (Klemke, Hollinger, Rudge & Kline, 1998).

How are these notions about how life should be lived transformed into practice? What kinds of practical technologies are used to actualize these visions? What dangers do these visions and associated technologies pose? These critical questions are powerful, but

they are also potentially paralyzing ones that can disrupt action. In some ways, those that feel compelled to act in the present through professional work have become casualties of the science wars. For example, as the radical critiques of Michel Foucault were published and taken notice of by those operating in modernity, Foucault hoped that certain actors in particular contexts would "no longer know what to do" (1980/2003e, p. 256). Occupational therapists must examine their efforts in light of more radical criticisms, but this effort need not work towards the complete demolition of its histories and traditional practices. The issues presented here revolve around the problem of how members of professional communities might engage in critical reflection without stalling or destroying efforts to do good in the present (see Charland, 2002; Driver 1968). One must open oneself to radical critical thought in an effort to understand how and why particular ways of thinking and particular modes of practice potentially propagate injustice and do more harm than good. And yet, one cannot let criticism disable or dissuade practical work in the present. Certainly, one of the most radical and challenging thinkers of the modern era has been Michel Foucault.

In writing about psychiatric care in the present, Lilleleht (2002a) called for an increased mindfulness among professionals and social scientists. Lilleleht's (2002b) work gives us a clear understanding of how historical work fueled by Michel Foucault's critiques can help open critical spaces where serious dialogue can occur. In the particular quotes that she made use of to introduce her commentary, Lilleleht (2002b) also reminded her readers that, all too often, the process of critique only serves to reinstitute troubling practice measures that serve to control rather than 'cure.' While the notion of cure should be foreign to occupational therapists and occupational scientists, the documented history of the profession clearly demonstrates that unwitting surrender into dominant knowledge regimes is familiar. In using critical work to harvest new insights for the science of occupation, one runs the risk that this kind of work will only propagate the injustices that were to be avoided. In "listening to Foucault" (Bracken, 2002, p.187) we should neither avoid action nor feel compelled to participate in kinds of action that are intolerable to us (see Charland 2002; Lilleleht 2002a, 2002b). In engaging in this kind of 'listening' we walk an extremely thin line and risk that in the end we will have no ground

on which to act (see Molke 2009b). Yet, if 'progress' is to occur, these kind of works are terribly important.

In the sections that follow, I work to highlight and explore various Foucauldian concepts that are important for those in occupational therapy and occupational science to consider. In the sections that precede this one, I have already explored some of the history of occupational therapy, moral treatment, and moral treatment within occupational therapy. I have introduced many different concepts and issues. In the sections that follow, I draw on Foucault and begin to articulate a kind of "countermemory" (Major-Poetzl, 1983, p. 36). In this section, I attempt to de-familiarize the taken-for-granted in order to create a space of dispersion in which different kinds of action can unfold in the present (Fraser & Gordon, 1994; Molke, 2009b). In subsequent chapters, I extend Foucault's critical perspective and attempt to create a counter memory that will begin to demarcate limits for occupational therapists who work with normative content in the present (Foucault 1968/1991a). This subsequent critical depiction focuses on occupational therapy literature discussing spirituality.

I start broadly and review various concepts in Foucault's body of work that relate very generally to the control of the citizenry in modernity through the development of its institutions and professionals. I focus on the professionalization of expertise in modernity and the formation of the modern subject. I tie professional knowledge to the concept of normality and the government of individuals. Within this discussion, the concept of power creates a foundation that supports a critical understanding of the professional role. This section provides a theoretical background that can be used to understand a process of professionalization which led to the creation of occupational therapy and the creation of occupational science. Within this interpretation, for better or worse, the occupational therapist empowered with the knowledge that occupational science 'discovers,' becomes a judge of normalcy in modern times.

Afterwards, I narrow my focus to look more specifically at Foucault's history of 'madness' and the mental health professional. This section functions to further and more specifically articulate how the professionalization of knowledge about madness worked, not to liberate, but to dominate particular individuals. The 'clinical gaze' outlined specialized knowledge of the abnormal and worked to create pathological subject

categories. This section begins to describe how the clinical gaze penetrated day to day life and outlined the limits between normal and abnormal and provides a foundation for the concepts and techniques discussed in the following sections (see Foucault 1968/1991a). An attempt is made to demonstrate how fact and value and knowledge and power were, and are, intertwined in the process of professionalization. Expert knowledge of mental illness worked to construct an ambiguous liberty that tied the freedom of individuals to particular ethical prerequisites.

I then more carefully examine two contexts in which moral treatment occurred. I begin by articulating the particular Truths that governed moral treatment at The York Retreat and the institutions over which Philippe Pinel presided. Afterwards, I attempt to catalogue the various therapeutic technologies that were used in both locations. Because Foucault's work has often been criticized in terms of its historical accuracy, these sections also work to test his theories through a reexamination of the texts in question. Appropriate examples have been added and other historical opinions have been consulted. The final subsection in this chapter examines what Foucault had to say in relation to occupation in the process of his critical examination of moral treatment.

Finally, this chapter ends with a discussion of the limits of Foucault's critique. It places limits on Foucault's critical thought, attempts to rescue the heroes of the moral treatment movement, and begins to work towards an integration of Foucault's insights into a way forward in the present.

5.1 Professional Discourse, Discipline, and Government in Modernity

At the end of his book *Discipline and Punish,* Foucault (1975/1995, p. 308) wrote: "I end a book that must serve as a historical background to various studies of the power of normalization and the formation of knowledge in modern society." With this particular work Foucault traced the development of the modern penal system, in part, to demonstrate how knowledge and power operate within modern historical contexts. As explained in the preceding methodology sections, Foucault's work was intended to reveal how human subjects are formed within modern times. This particular history, in this sense, is not so much about penal systems in Europe and North America. It is a work that reveals how the power of norms came to dominate social life in modernity. This history

was intended to highlight how prisoners, soldiers, school children, and workers, for example, are created and controlled within modern societies. In other words, this work articulated how the routine structure of everyday life functions like a prison to discipline, shape, rehabilitate, and control individual citizens in modernity. With *Discipline and Punish*, Foucault demonstrated how the advance of a particular discourse in the 18th and 19th centuries and the values associated with this logic contributed to the creation, domination, and control of the individual. He sought to demonstrate how scientific and professional discourses work to invest bodies and subjugate them through various "material elements and techniques" (Foucault, 1975/1995, p. 28; Hook, 2001). The individual's mind and body are disciplined and dominated by particular values that are supported by knowledge. These 'politics of the body,' as Foucault called them, are invested with the normative values that circulate within a particular space. Foucault's book *Discipline and Punish* can be conceptualized as an attempt to understand the interplay between the macro and micro power-knowledge relations that circulate through the institutions of modernity. It is within specific fields of operation that power and knowledge are joined through discourse. Foucault traced conflicting scientific discourses and associated material techniques documenting the "ceaseless struggles and confrontations" that battle over access to the human body in modern times (Foucault, 1976/1990, p. 92).

For example, Foucault explained how disciplinary techniques, like application of routine, work to individualize the subject. Factories, workshops, hospitals, schools, and prisons produce individuals that adhered to particular norms through the control of activity. The time table, for instance, was used to "establish rhythms, impose particular occupations, [and] regulate the cycles of repetition" (Foucault, 1975/1995, p. 149). An 'exhaustive use of time' eliminated idleness and helped to create the 'docile body:'

> One must seek to intensify the use of the slightest moment, as if time, in its very fragmentation, were inexhaustible or as if, at least by an ever more detailed internal arrangement, one could tend towards an ideal point at which one maintained maximum speed and efficiency. (Foucault, 1975/1995, p. 154)

At the end of the 18th century the individual body became something that could be molded like clay, it was a machine that could be manipulated, trained, shaped, constructed, improved, transformed, corrected, and mastered; turning it "silently into the

automatism of habit" (Foucault, 1975/1995, p. 135). The processes that were used in attempts to shape and control the citizens of modernity were created within institutional settings. Technologies were developed in houses of confinement, insane asylums, prisons, work houses, schools, and poor houses (Castel, 1988; Foucault, 1961/2009, 1995/1975; Ignatieff, 1983; Rothman, 1990; Scull, 1993). However, over the course of modernity these institutional technologies and the mandates that supported them became invested in the character of professionals themselves (Castel, 1988; Digby, 1985; Foucault, 1961/2009).

For example, Digby (1985) discussed the process whereby the physician moved into a position of ascendancy within York Retreat during the 19th century. As is typical of his histories, in his book on madness, Foucault pushed the meaning of this development to its absolute critical limit. In outlining Tuke's and Pinel's discussion of the role of the medical personage within the asylum, Foucault (1965/1988a, pp. 271-2) argued:

> It is thought that Tuke and Pinel opened up the asylum to medical knowledge. They did not introduce science, but a personality, whose powers borrowed from science only their disguise, or at most their justification. These powers, by their nature, were of a moral and social order.

As Haskell (1984) explained, in modern times, the "deference to experts is woven into even the homeliest routines of everyday life" (p. ix). Haskell notes that the term 'expert' in its noun form did not come into popular usage until the middle of the 19th century. However, according to Foucault, the professional embodies more than expert knowledge. Their expertise rests on a kind of moral supremacy that mirrors the power differential that exists between adults and children. Foucault (1965/1988a, p. 273) argued:

> To such a degree was it true that the medical personage according to Pinel, had to act not as the result of an objective definition of the disease or a specific classifying diagnosis, but by relying upon that prestige which envelops the secrets of the Family, of Authority, of Punishment and of Love; it is by bringing such powers into play, by wearing the mask of Father and Judge, that the physician, by one of those abrupt short cuts that leave aside mere medical competence, became the almost magic perpetrator of the cure and assumed the aspect of a Thaumaturge [a miracle worker].

Castel (1983) believed that this situation is often thought to be a result of practice rushing ahead of viable scientific explanations or justifications. A "therapeutic eclecticism" materialized born of sentiments that could not be matched by scientific knowledge

(Castel, 1983, p. 252).[6] As a result of this eclecticism professional practice frameworks were permeable to non-medical norms. These were the:

> Dominant social values, the guiding ideas of the politico-moral ideology of the time: order, discipline, sanctification of family ties, the cult of work as source of all moralization, respect for hierarchies, acceptance of one's allotted place in the social system. (Castel, 1983, p. 252)

Conversely, for Foucault (1961/2009), the process of knowledge development and scientific discovery worked in conjunction and gave rise to the norms that imbued therapeutic practice frameworks. The professional-patient divide was magnified and created the boundary between order and disorder, morality and immorality, reason and non-reason, sane and insane, and normal and abnormal (Foucault, 1961/2009). Within the Asylum, for example, the physician became a judge and an example that helped to order life according to particular socioethical mandates. The moral regulation of insanity came to reflect the moral ordering of social space as a whole through the embodiment of social order in the professional. Foucault argued that as demands for a particular breed of objectivity took hold it became necessary to completely disguise the nature of the professional-patient relationship in the logic of scientific reasoning. Subsequently, Foucault (1965/1988a, p. 274) explained that the meaning of the ethical practice that took place within this couplet soon escaped even medical professionals as the process of treatment became "enclosed in the norms of positivism." According to this critical interpretation, the objectivity that allowed physicians and scientists to uncover the truth about madness was delusional:

> If we wanted to analyze the profound structures of objectivity in the knowledge and practice of nineteenth century psychiatry from Pinel to Freud, we should have to show in fact that such objectivity was from the start a reification of a magical nature, which could only be accomplished with the complicity of the patient himself, and beginning from the transparent and clear moral practice, gradually forgotten as positivism imposed its myths of scientific objectivity; a practice forgotten in its origins and its meaning, but always used and always present. What we call psychiatric practice is a certain moral tactic contemporary with the end of eighteenth century, preserved in the rites of asylum life, and overlaid by the myths of positivism. (Foucault, 1965/1988a, p. 276)

[6] See Friedland & Renwick (1993) for a discussion of 'eclecticism' in relation to occupational therapy practice (see also COTA, 2006; COTO 2010; Mosey, 1970).

In the present, various sciences, professions, and associated technologies have been developed that ensure that the ordering of modernity occurs in an efficient and rigorous manner (Foucault, 1975/1995; Rabinbach, 1992). Drawing on Foucault, I have argued above that knowledge is inevitably tied to particular discourses and that 'truth' itself is representative of a particular kind of contextualized historical system. The values and associated truths that predominate and circulate at a particular point in time are historically contingent and work to construct and hold together particular social systems and power interests (see also Castel, 1988). As indicated above, Charland (2006) demonstrated that even modern psychiatric frameworks developed within a strict scientific structure contain implicit notions about morality and proper living. The discourses found in particular spaces contain both explicit and implicit assumptions and relate to particular norms. Norms are not always neutral or biological in nature but are tied to particular cultural value judgments that relate to a particular social order (Hacking, 1991). As professional expertise and the power of norms worked to subjugate social life in modernity the concept of deviance became important (Jones, 1998). In modernity, professional experts, like occupational therapists, and the sciences associated with them, like occupational science, help to rehabilitate deviant individuals according to the norms that govern existence in a particular society (see also Hammell, 2006).

This discussion of professional expertise and the function of professional relationships relates in many ways to Foucault's work on the 'art of government.' The art and practice of governing and its relation to what Foucault calls 'governmentality' revolve around the techniques in which the conduct of individuals is guided and formed (Gordon, 1991). In thinking about government as it relates to this perspective, one reflects on the relations that exist between the self and the self and the self and others in both public and private spheres; relations of the self that work to create, mold and control individuals and their conduct (Gordon, 1991). The professions of modernity form a critical part of how government occurs in modernity (Castel, 1988; Johnson, 1993). The expert deployment of particular truths and norms across social space makes social, economic and occupational life amenable to governing (Johnson, 1993). Work within occupational science has demonstrated how power and knowledge join through occupational discourses to create and mold individuals in particular ways according to

particular cultural norms and associated political goals and ideals (see Molke & Laliberte Rudman, 2009; Wilcock, 2002). Thus experts in modernity can be conceptualized as political tools which productively intervene and order life in accordance with particular dreams and expectations about what is good and desirable for the state (Castel, 1988).

In his book on the development of the modern medical consciousness, Foucault (1963/2005b) described this process further. Physicians developed a 'political consciousness' and became involved in the governance of the state and the regulation of 'healthy' and 'normal' conduct (see also Castel, 1988). "Medicine," explained Foucault, "must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of *healthy man*, that is, a study of *non-sick man* and a definition of the *model man"* (1963/2005b, emphasis in original, p. 40). That is to say, physicians no longer confined themselves to the study and remediation of illness but expanded their role to define the nature of healthy and virtuous living. As the quote that follows is intended to demonstrate, this focus on health was intimately tied to the health of the state:

> It fell to medicine to punctuate work with festivals, to exalt calm emotions, to watch over what was read in books and seen in theatres to see that marriages were made not out of self-interest or because of a passing infatuation, but were based on the only lasting condition of happiness, namely, their benefit to the state. (Foucault, 1963/2005b, p. 39)

Through this process the professional's role was enlarged to define and dictate the norms and standards by which individuals should exist in relation to themselves and society. With the creation of occupational science too, it was intended that a body of knowledge that revolved around occupation would expand beyond concepts related to disability and include considerations of healthy and normal occupational engagement (Yerxa et al., 1990). One begins to see how scientists and professionals work to identify both political and individual problems and target them for intervention (Rose & Miller, 1992). Over the course of modernity the scientific and medical problems identified were intimately tied to how one ought to live a normal life that would be of benefit and contribute to a particular social order (Castel, 1988). As medicine developed a 'political consciousness' its powers over life expanded. This development of a sociopolitical consciousness ensured that professionals would become part and extensions of society's governing apparatus.

However, as we have seen above, the ordering of life functions in an implicit way through discourse through which scientists and professionals are also dominated (see Johnson 1993).

The application of professional knowledge works to discipline, shape, and control the citizenry of modernity. This form of governance begins through the domination of the professional actors who deploy their expertise (see also, Jones & Stewart, 1998). Expectations about what constitutes health and normal living are contained and reproduced in the professional and scientific discourses that professional actors employ and produce. Thus the means through which these expectations are deployed should also be contained in this discourse. Professionals become the embodied form of expertise within late modernity. Put this way, governance no longer occurs solely through the institutions of modernity, but is embodied in the professionals who themselves have been disciplined, who have been professionalized (see Johnson, 1993). Professionals act both within and outside of the major institutions established in modernity (e.g., factories, hospitals, schools) (see Lilleleht, 2002a). They are politicized beings that carry with them the expertise capable of disciplining the modern subject in accordance with a particular socioethical framework that fits the needs of a particular society; they became the 'judges of modernity' whose role was to discipline and order life in multiple ways. As Foucault (1975/1995, p. 304) argued:

> The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the 'social worker' – judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements.

To this list of social actors we must also add the occupational therapist-judge as occupational therapists are also professionals that operate in the modern age.

5.2 Liberty, Virtue, and Professional Observation

The nature of the role of the professional in modernity and the objective knowledge that they wield becomes more easily understood when one examines the historical process that led to the creation of 'insanity' as a distinct social category. In the

previous section, I described the process of professionalization generally. In this section, I focus more specifically on psychiatric treatment and moral treatment.

While moral treatment reform movements are often portrayed as liberating, according to Foucault (1961/2009, p. 515), this 'liberation' came at a cost: "What the late eighteenth century witnessed was not a liberation of the mad but an objectification of the concept of their liberty." According to Foucault (1961/2009, p. 514), while the work of reformers occurred within a "constant horizon" of liberty, it was an ambiguous liberty that worked to constrain and form the human within a particular truth system (see also Castel, 1988). Through the provision of different liberties, reformers, like Pinel, made an effort to place madness in an objective structure. "The very essence of madness," Foucault (1961/2009, p. 524) explained, "was to turn men into objects." A science of madness developed through a process of recognition. In the spaces of confinement the mad were recognized as such and differentiated from other forms of social deviance. As madness became more subtly defined, different categories of insanity appeared. The mad were not only differentiated from others who could not fit into society, but his or her specific variety of madness had to be identified, differentiating her or him from others who were identified as mad. As we have seen above, medical thought came dominate this process in the asylum. At the same time, old justifications for confinement that had sufficed previously were no longer sufficient.

As Foucault explained, over the course of the 17th and 18th centuries those thought to be insane were believed to have lost a particular relation to truth and/or a balance of the proper sentiments. "Madness begins where the relations of man to truth is disturbed and darkened" (Foucault 1965/1988a, p. 104). A loss of relation to "moral truth" created "madness of character, or conduct, and of the passions" (Foucault, 1965/1988a, p. 105 see also Charland, 2010). According to Foucault (1965/1988a), in Europe, a bourgeois socioethical framework structured expectations about how one might lead a virtuous and useful existence of benefit to society. "It is not immaterial that madmen were included in the proscription of idleness …" wrote Foucault, "in the workshops in which they were interned, they distinguished themselves by their inability to work and follow the rhythms of collective life" (pp. 57-58). Madmen were identified as a social problem to be remedied; as individuals who could not integrate into the social group in a 'normal' way

and adhere to the principles of 'proper' and 'virtuous' living. The social control of deviance was of primary importance.

By the end of the 18th century the individual became a basic unit of economic and political analysis (Foucault, 1961/2009). The concept of individual freedom had to be dealt with when justifying confinement of the individual within asylums. While the growth of a mercantile economic thinking could partially account for this sentiment, according to Foucault (1961/2009, p. 430), "freedom did not simply have a market value, it had a moral value too, and was also to be acquired through virtue" (p. 430). Madness, seen as a social problem in the late 18th Century, was not to be dealt with only from the point of view of social order, but from the point of view of the individual who had rights, from the point of view of all individuals who had rights. Foucault quotes Pierre Jean George Cabanis, a French physician and philosopher writing in the middle and end of the 18th century:

> When men enjoy the full power of their rational faculties, i.e. whenever these powers are not so altered as to compromise the safety and tranquility of others, or expose men to genuine danger no one, not even society as a whole, has the right to raise a hand against their independence. (Canbanis cited in Foucault 1961/2009, p. 438)

The mad had not become completely lost to truth and reason, they had become alienated from it. Into the 19th century, according to Foucault, the mad had abandoned or been alienated from their own truth: "To talk of a madman in the nineteenth century was to single out a man who had abandoned the ground of his own immediate truth, and had lost himself" (Foucault, 1961/2009, p. 380). The mad had become alienated not only from society but their own truth. The individual's truth had been covered, muted, or forgotten, but not completely destroyed. As a result the individual lost his or her freedom; however, this freedom, like her or his truth, was not completely lost. Moral treatment worked to help the mad recapture a sense of who she or he truly was. It focused on reconnecting the self with its true self through various means. As we have seen the key to this formula revolved around providing opportunities for individuals to take responsibility for their own liberty and to immediately identify moments where there was a failure to do so. The simultaneous creation of a science of mental illness within the institutions that deployed this therapeutic formula worked to differentiate the different ways in which man could be

alienated from him or herself, virtue, reason, and truth. As Foucault indicated: "the quest was for the morbid forms of madness, and all that was found were deformations in morality" (1961/2009, p. 196). Freedom was acquired through truth and virtue and the reestablishment of an individual's reason. The various ways in which an individual could be lost to truth and virtue were described in escalating detail and obscurity. According to Foucault, this process enabled the development of a kind of medicine that would treat moral deficiency but hide "its moral accusations behind the objectivity of observation" (Foucault, 1961/2009, p.523).

This was how, Foucault (1961/2009, p. 443-4) argued, that madness was made accessible to the 'gaze':

> The mad and the non-mad were to meet face to face. The only distance between them was the one immediately measured by the gaze … Under the gaze that now enveloped it, madness shed all the prestige that had made it until recently a figure banished on sight; it became an object of investigation, a thing invested with language, a known reality: it became in short an object … While it became purified for knowledge, and was freed of its ancient complicities, it also found itself engaged in a series of questions that morality began to ask itself: it penetrated everyday life, affecting everyday choices and elementary decisions.

For a moment in the 18th and 19th centuries the powers that operated over madness were made explicit. The division between reason and madness was tied explicitly to norms that dictated what good life should consist of. Freedom came with the requirement that the individual lead a virtuous life that did not disturb or threaten society. When this requirement was met, the madman would be set free. In this moment of freedom, madness would remain hidden and would be controlled. The madman would adhere to the dictates of a particular ethical morality. Within the asylum all the ways that madness could express itself were caught, classified, and catalogued by the gaze of the natural scientist. A 'professional gaze' in the asylum worked tirelessly to ensure that virtue and mental health were entwined in a causal relationship.

For example, Charland (2010) carefully outlined some of the components involved in Pinel's moral treatment. In identifying which data Pinel deemed to be important to collect in relation to his patients,' Charland (2010) gives us a sense of how virtue was thought to be connected to health even in the work of scientifically minded medical reformers like Pinel. The norms associated with a particular truth

system help to guarantee a healthy life. Truth and morality were more than just intertwined; one defined the other. Truth is not just something to be discovered at the Asylum; rather, a particular Truth discourse is constructed that works to subtly define the limits of healthy morality and normality. For instance, Charland (2010, p. 31) identified a variety of instances where Pinel points to particular kinds of vice as the cause of mental alienation: "sexual excesses, drunkenness, gluttony." Further, Charland (2010) identifies where particular passions or virtues receive special attention due to their ability to interfere with the authority of the superintendent of the asylum. Pride and vanity, for example, are passions that were to be avoided to ensure the effectiveness of moral treatment and the smooth running of the asylum.

5.3 A Critical Examination of Moral Treatment Technology

As a more detailed language worked to order and classify madness and normality, so did more complex therapeutic technologies that promised cures. Madness was closely observed by medical men and "suffering and knowledge were to adjust to each other in the unity of common experience" (Foucault 1961/2009, p. 307). The asylums became social laboratories within which close observation and experimentation lead to the therapeutic ideas which could be tested immediately (Castel, 1988). A constant relation between theory and practice was made possible. In typical fashion, Foucault critically outlined the parameters of the cures and their subtle differences within this new arrangement. Each therapeutic regimen worked to establish the constraints of the particular ethical code that dominated a particular institution. For example, at the Retreat, a "patriarchal calm" dominated, but in Pinel's institutions it was a "lucid firmness" that took charge (Foucault, 1961/2009, p. 464). It is to Foucault's descriptions of these two institutions that I now turn.

5.3.1 A Quaker morality.

As we have already seen, operated by and for Quaker's, the Retreat recreated all the structures of a Quaker family. Madness erupted in the individual as she or he strayed from the path that nature had set for him or her (Charland 2007; Foucault, 1961/2009). Placement in a strictly controlled Quaker community that adhered to the

dictates of nature would reawaken a natural reason lost but not destroyed (Foucault, 2009/1961). Tuke (1813, p. 173) quotes the following poem which helps to outline the character of the belief system that operated at the retreat. Under the influence of mental illness, the conduct of the individual is "most opposite to his character and natural dispositions":

> Bound in Necessity's iron chain,
> Reluctant Nature strives in vain;
> Impure, unholy thoughts succeed,
> A dark'ning o'er his bosom roll;
> Whilst madness prompts ruthless deed,
> Tyrant of the misguided soul

Foucault (1961/2009, p. 474) explained: "It [The Retreat] aimed to be a great fraternal community of patients and helpers, under the authority of the directors and the administration. It was a rigorous family, without weakness or complacency, but fair, in accordance with the great image of the biblical family." Patients became infantilized within an idealized familial setting guided by the dictates of a natural Quaker religion. Samuel Tuke (1813, p. 161) explained: "To encourage the influence of religious principles over the mind of the insane, is considered of great consequence, as a means of cure." Freedom within the asylum, recovery, and eventual release depended on an individual's ability to conform to the dictates of a Quaker morality (Charland, 2007). Moral treatment here was guided by a longing for an idealized past and the restoration of a pure and natural morality. The founders of the Retreat attempted to reestablish the ethical constraints and controls that existed in a pure idealized state which had been lost and within which it was believed a variety of forms of mental alienation could be cured (Foucault 1961/2009).

5.3.2 Pinel and the new secular society.

At the Bicêtre and the Salpêtrière in France, Pinel worked to reestablish a different kind of order. According to Foucault, Pinel's treatment worked to liberate the mad person's mind from harmful effects of religious sentiment, but more firmly imposed the strictures demanded by a particular social order (Foucault, 1961/2009). Each individual was pressured to assume their proper role within the social structure.

Order was obtained through a proper recognition of one's social responsibilities. As Foucault (1961/2009, p. 478) argued:

> So the chains came off and the mad were free. And at that moment, they recovered their reason. Or rather, they did not: it was not so much that reason reappeared in and for itself, but rather fully-fledged social species that had slept for so long in madness were suddenly awakened, and stood up straight, in perfect conformity with all that they represented … As though the madman, freed from the animality to which his chains confined him, could only rejoin humanity as a recognized social type … His health was only restored in the social values that were both its sign and its concrete presence.

In the midst of revolution these would be institutions that eliminated the ill effects of war, religion, and vice, to reestablish a stable social order within which the individual would fit. According to Foucault, liberation of the mad person was an attempt to impose the dictates of an idealized, but secular social ethic. Freedom depended on how well one conformed to this ethical code without the supports and punishments employed in the asylum. This was to be a social microcosm that revealed and established the limits that freedom could take. Moral treatment in this context was guided by a longing for an idealized future in which social perfection had been attained. It was an attempt to create the foundations for a perfect social order that had yet to be established and within which a variety of forms of mental alienation could be cured (Foucault 1961/2009).

5.3.3 Treatment technologies.

While I have outlined the ideas and principles that guided treatment, I have yet to discuss the specific techniques that were used to effect change. At the Retreat and in the Asylums over which Pinel presided, the most obvious symbols of confinement and punishment were removed. In the place of chains a more delicate system of constraints and freedoms was installed designed to mold the behavior of the mad person. Foucault (1961/2009, p. 439) identified the most obvious symbols of this change in the material tools that were used to control the behavior of the patients interned in these institutions:

> The most concrete form of this justice, its most visible symbol, was no longer to be the chain – an absolute, punitive restriction that 'invariably wounds the flesh it rubs against' – but the new, soon-to-be-famous straitjacket … designed to

> progressively hinder movements as their violence increased. The straitjacket should not be seen as the humanisation of chains, or as progress towards 'self-restraint.' A process of continual deduction leads to the straitjacket, showing that in madness, the experience was no longer of an absolute conflict between reason and unreason, but rather a play – always relative, always mobile – between freedom and its limits.

Scull (1993, pp. 69-76) provides descriptions and illustrations of various kinds of technology that were used in the routine treatment of the insane. For example, Scull (1993, p. 73) quotes a letter authored by Benjamin Rush in which he describes a device he calls a 'Tranquillizer':

> I have contrived a chair and introduced it to our [Pennsylvania] Hospital to assist in curing madness. It binds and confines every part of the body … Its effects have been truly delightful to me. It acts as a sedative to the tongue and temper as well as to the blood vessels. In 24, 12, six, and in some cases in four hours, the most refractory patients have been composed. I have called it a Tranquillizer.

In digging through the correspondence between various superintendents working at different asylums, Digby (1985) outlined a developing professional network that shared techniques and tools to be used to control patients. The retreat was famous for developing special straps and buckles to restrain individuals to varying degrees, or techniques that could be used to force feed patients reluctant to take sustenance. For example, Tuke (1813) described an apparatus that could restrain the suicidal melancholic in bed but allow him or her enough freedom of movement to change her or his position.

These are some of the more obvious and, strictly speaking, mechanical technologies that were used. According to Foucault, there were other more subtle social and psychological technologies at work. Foucault (1961/2009) outlines the specific methods that were used to mold the subjectivities of patients in the idealized societies created within the Asylum. Technologies were employed to tie man to a social Truth which had been lost or had yet to be attained. The term technology used in this sense must be defined. It is fairly easy to see how a strait jacket might be considered as a kind of technology. It is, perhaps, more difficult to understand how a social milieu, for example, can be understood in this way. It may be even more difficult, for some, to understand how physical labour might be understood as a technology that can be used to treat mental illness. In discussing 'technology' in this section, I focus on the meaning of

the word in its widest sense. With his genealogical projects Foucault (1983/2003d) sought to catalogue how human beings have been turned into objects that can be operated on in modernity. It is in this sense that I use the word technology (see also Molke & Laliberte Rudman, 2009). Charland (2009a) points out that technologies work to accomplish something using knowledge, processes, or methods. The technologies that I discuss here refer to the processes, methods, and knowledge that act on human kinds (see also Hacking, 1995). Once objectified according to a particular taxonomic truth system, for example, the human being can be cured according to the laws of cause and effect which correspond to that particular truth system. 'Cure' in a Foucauldian sense would relate to the formation of a subjectivity that corresponds to the dictates of morality that govern existence in a particular sociohistorical context.

5.3.4 Fear, the desire for esteem, and conscience at the Retreat.

As we have seen, at the Retreat it was an old morality biblical in nature that governed social life. Before the advent of moral treatment fear was already used as a means to counteract or cure certain kinds of mental illness. Francis Willis, an English physician working at the end of the 18th century and who treated George III, employed force and fear routinely. Scull (1993, pp. 69-70) briefly describes Willis' beliefs in relation to fear using comments he made to a visitor:

> The emotion of fear is the first and often the only one by which they can be governed. By working on it one removes their thoughts from the phantasms occupying them and brings them back to reality, even if this entails inflicting pain and suffering. It is fear too which teaches them to judge their actions rightly and learn the consequences. By such means is their attention brought back to their surroundings.

Foucault discussed the various ways in which fear was used during the 18th and into the 19th century. Disordered emotional states were sometimes countered by inducing an opposing emotional state. "The dream was," Foucault (1961/2009, p. 324) wrote, "of a conditioning whereby each fit of anger in a maniac would be immediately accompanied and compensated by a reaction of fear." Foucault (1961/2009, p. 324), quotes the Scottish physician Alexander Crichton:

> It is by strength that we triumph over the frenzy of the maniac; and it is by opposing fear to anger that anger can be tamed. If the terror of a punishment

> and public shaming become associated in the mind with fits of anger, the one will not manifest itself without the other: The poison and the antidote will become inseparable.

Given the state in which the insane were kept prior to the changes brought about by the moral treatment reforms that occurred at the end of the 18th and into the 19th centuries, it is easy to believe that individuals who were identified as insane were treated differently. It has been argued that moral reformers sought to eliminate the use of fear from the routine of care of the mad in favor of a kinder benevolence (Charland 2007). Tuke (1813, pp. 140-141) exemplifies this change when he argued:

> The idea seems to have arisen, that madness, in all its forms, is capable of entire control, by a sufficient excitement of the principle of fear. This speculative opinion, though every day's experience decidedly contradicts it, is the best apology which can be made for the barbarous practices that have often prevailed in the treatment of the insane.

The use of a system of free terror was abandoned; however, Foucault (1961/2009) contended that fear continued to be used. Its use in the routine treatment of the insane became less overt and took on a more covert character. During the era of confinement that preceded moral treatment, fear was employed without regret. In the 19th century at the Retreat, for example, its use took on subtler quality. Changing conceptions of madness and the importance of individual liberty meant that any use of fear be reflected on carefully. Fear could no longer be employed indiscriminately and so, as a treatment technology, it took on more intricate dimensions. A careful consideration of how fear was employed functioned not to eliminate its use but to train the budding professional in its subtle uses and complexities (see also Castel, 1988). In his book, Tuke (1813, p. 141), immediately after condemning the use of fear, went on to argue:

> The principle of fear, which is rarely decreased by insanity, is considered as of great importance in the management of the patients. But it is not allowed to be excited, beyond the degree which naturally arises from the necessary regulations of the family. Neither chains nor corporal punishments are tolerated, on any pretext, in this establishment.

Indeed, as Foucault (1961/2009, p. 483) argued, prior to the advent of moral treatment, fear was a "surface phenomenon, Fear at the Retreat was a much deeper affair." Developing professionals would have to reflect on their use of fear as a

technique. They would have to gauge its severity and decide if its use would be seen as acceptable in a familial context. It was only to be used in so far as it served a therapeutic purpose as opposed to a punitive one. It was only used in so far as it could bring the individual closer in line with, and by, the Truths that dominated the context into which he or she had been thrown. In Tuke's (1813, p. 142) words:

> There cannot be a doubt that the principle of fear, in the human mind, when moderately and judiciously excited, as it is by the operation of just and equal laws, has a salutary effect on society. It is a principle also of great use in the education of children, whose imperfect knowledge and judgment, occasion them to be les influenced by other motives. But where fear is too much excited, and where it becomes the chief motive action, it certainly tends to contract the understanding, to weaken the benevolent affections, and to debase the mind.

Charland (2009b), in discussing Pinel's moral treatment, argued that using fear and operating within a commitment to gentleness and respect were not seen as incongruent during the 19th century. Foucault chose his moment in time very carefully. During this era, what was to become hidden was openly apparent. The delicacies of the technologies of fear were just beginning to be worked out. In looking backward at this seeming contradiction we begin to understand how the present might be more complex and filled with more ambiguity than we regularly imagine. The use of fear was prescribed with care and in cases of melancholia, for example, even counter-indicated (Tuke, 1813). This brand of 'mild treatment' involved the superintendant calmly explaining the rules and behavior required of the patient. Further, rather than quickly resorting to punishment or restraint, the superintendant gave the mad a taste of the freedoms and comforts available while describing the conditions on which these depended. Tuke (1813, p. 146) outlined this procedure as it was employed with a new admittance to the Retreat:

> He had been afflicted several times before; and so constantly, during the present attack, had he been kept chained … [the chains were] taken off, when he entered the Retreat, and he was ushered into the apartment, where the superintendants were supping. He was calm; his attention appeared to be arrested by his new situation. He was desired to join in the repast, during which he behaved with tolerable propriety. After it was concluded, the superintendant conducted him to his apartment, and told him it was his anxious wish to make every inhabitant in the house as comfortable as

> possible; and that he sincerely hoped the patient's conduct would render it unnecessary for him to have recourse to coercion.

And so, the use of fear did persist in a 'mild' way that saturated the mechanisms at play in all parts of the institution.

In the 19th century the mad person's keepers used a constellation of coercive technologies to capitalize on this power of fear. We have already discussed how the madman was turned into an object subjugated by the professional gaze; this produced a knowledge of insanity, but also functioned to control and shape the behavior of the madman by imbuing the observing professional with authority. The 'judges of normality,' as Foucault called them, classified, but they also worked tirelessly to catch each moment the norms of a particular morality were violated. Asylums were built to allow for easy observation of all the individuals contained within its walls (Tuke, 1813). This set up a system of constant "surveillance and judgment" (Foucault, 1961/2009, p. 488) at the centre of which was the superintendant of the institution:

> What Tuke instituted was a mediating element between guardians and patients, between reason and madness. The space reserved by society for alienation was now haunted by figures 'from the other side,' representing both the prestige of the authority that confined, and the rigours of the reason that judged. The superintendent intervened unarmed, with no instruments of constraint at his disposal other than the gaze and language … And yet it was not as a concrete person that he confronted madness, but rather as the incarnation of reason, bearing the full force of the authority invested in him by the fact of his not being mad.

Punishments and rewards were doled out as quickly as possible to reinforce authority, ensure a rapid conditioning process, and highlight the fact that patients were constantly observed. Digby (1985, p. 244) quotes a pamphlet which Samuel Tuke contributed to in 1815. The pamphlet outlined several practical hints that could be used in the construction and running of asylums. Tuke describes the routine espionage that was to take place in this environment. This historical evidence suggests that it was not only the patients that were watched closely for signs of abnormality, but the staff as well. This scheme worked its way through the entire

asylum system to ensure that everyone, patient and attendant alike, was watched carefully:

> The regulations of an asylum should establish a species of espionage, terminating in the PUBLIC: this cannot be effected in an ill-constructed building. One servant and one officer should be so placed as to watch over another. All should be vigilantly observed by well-selected and interested visitors.

Even the superintendents were watched carefully by politicians, the public, and, in some cases, themselves (Digby, 1985; Pinel, 1809/2008; Scull 1993).

Surveillance and fear of authority were only the beginning. The system was subtler still and hinged on the assumption that the cooperation of individuals could be ensured by capitalizing on his or her desire for esteem, or the fear of its loss. Fear of punishment was far too base a motivator; fear of lost esteem was much more sophisticated and, at the Retreat, effectively helped to bring inhabitants back in line with a particular moral truth. Tuke (1813, p. 157) points to the importance of esteem in the Retreat system:

> Though we allowed fear a considerable place in the production of that restraint, which the patient generally exerts on his entrance into a new situation; yet the *desire of esteem* is considered, at the Retreat, as operating, in general, still more powerfully.

In order to stimulate and awaken the mind, inhabitants of the retreat were given an opportunity to demonstrate their expertise. Tuke (1813, p. 158) described the process whereby the superintendant would engage in conversation with patients in such a way that allowed them to take pleasure in their own knowledge. The aim was to reawaken the desire for esteem:

> He introduces such topics as he knows will most interest them; and which, at the same time, allows them to display their knowledge to the greatest advantage. If the patient is an agriculturalist, he asks him questions relative to his art; and frequently consults him upon any occasion in which his knowledge may be useful.

Once this desire had been awakened, or reawakened, inhabitants would work hard to retain the esteem they had acquired or reacquired. Retreat patients feeling themselves of consequence would further support and adhere to the dictates of the Quaker morality by “restraining those dispositions, which, if indulged, would lessen the

respectful treatment he receives; or lower his character in the eyes of his companions and attendants" (Tuke 1813, p. 159). The gaze had established norms and the desire for esteem slowly ensured that the patient would struggle to "confine their deviations, within such bounds, as do not make them obnoxious to the family" (Tuke 1813, p. 157). This whole process was thought to strengthen the individual's mind and develop habits of self restraint.

In Foucault's mind, this process marked fear's progression into conscience. Developing habits of self control was the final step in the therapeutic process employed at the Retreat. Patients' desire for esteem in their own eyes functioned more effectively to control the symptoms of insanity than a desire for esteem in the eyes of those that surrounded the patient. Within Foucault's analysis, the final phase of moral treatment involved the installation of a particular kind of conscience. Guilt would function to ensure that the norms inherent in the Quaker religious system would be adhered to. When the conduct of the insane individual could be controlled internally within a self that had been shaped and molded by technologies of fear; they could finally be released. As Foucault (1961/2009, p. 487) explained, the freedom of the madman would then be "constantly threatened by an acknowledgement of guilt." This was a kind of conditioning that worked to eliminate particular behaviors or aspects of being seen as unacceptable in the mad. It was also a process that worked to construct new behavior patterns, strengthen a weak character, and actively construct a personality out of the void that was thought to be madness. Madness was turned into an object that could be dominated and subjugated within the confines of normalcy and guilt. What informed this impulse at the Retreat were Quaker attitudes concerning the importance of self discipline and autonomy (Charland 2007; Digby, 1985). It was a benevolent attitude at work, but one that depended on a particular belief system geared toward the installation of a particular kind of ethical consciousness (Charland 2007). As Foucault (1961/2009, p. 487) explained:

> What at first glance seemed to be a simple negative operation that loosened bonds and freed the profound nature of madness turned out to be a positive operation that enclosed madness in a system of rewards and punishments, including it into the movement of moral consciousness.

5.3.5 Science, virtue, & society.

Pinel is often credited as a pioneer in psychiatry due to his relentless attempt to classify and categorize the causes and flora and fauna of madness (Charland, 2010). In reading his philosophical treatise and comparing it to Tuke's description of the Retreat, it becomes clear that effects of his moral treatment were more systematically documented, and while there are similarities between the two collections of techniques, there are also differences. Many of these differences relate to the level of detail provided, but they also relate to the quality and complexity of thought on which these techniques are based. At the Retreat, a Quaker morality dominated. This was an asylum created for and run by lay men who were Quakers. At the Retreat, while medicine was to become of growing importance in the provision of moral treatment, tension between medical men and Quaker community leaders were apparent, particularly in the early years (Digby, 1985). At the Salpêtrière, the Bicêtre, and in the mind of Pinel, medical thought reigned supreme. "Religion was not to be a moral substratum of life in the asylum," Foucault (1961/2009, p. 491) argued, "but purely and simply an object of medicine." Pinel was a trained professional who believed that the success of medicine required "observation and experience" (Pinel, 1809/2008, p. xxi). He was a natural historian who dedicated himself to the "science of facts" (p. xxiii) and considered himself his own harshest critic. In Pinel's (1809/2008, p. 4) own words: "here I am speaking as a doctor, not a theologian." The level of detail accessible to Pinel's (1809/2008, p. xxii) professional gaze not only helped him to outline the nature of mental illness, but dictated how the establishments in his charge were run:

> The way to avoid mistakes is simple especially if he is in charge of a big establishment. This is to make inventories of the patients, month by month and year by year, and to see after a fixed time, what the results are of treatment which, even though wise, should still give him some doubts. He finds out what the ratio is between the total number of patients treated and the number of cures obtained ... Doctors who do not approve of my treatment method are free to apply the same analysis to that which they have adopted, and a simple comparison will show which is the better.

The basis of cure and the evidence of that cure reveal how Pinel's moral treatment, while veiled in a kind of scientific objectivity, remained a kind of ethical indoctrination. His gaze worked tirelessly to classify all the ways in which the individual could offend the sensibilities of society. As Foucault (1961/2009, p 494) argued, "the asylum was to reduce difference, repress vice, and eliminate irregularity. It denounced anything that was opposed to the essential virtues of society."

Foucault's observation is partially born out through a careful examination of Pinel's work. In the following statement, Pinel (1809/2008, p. 45) identified some of the moral failings that he believed could lead to mental illness: "Indulgence in vice, as in drunkenness, unlimited and unselective womanizing, disorderly conduct or apathetic lack of concern can gradually degrade reason and result in a certified alienation, as numerous examples seen in the hospices show." However, Pinel (1809/2008, p. 45-46) also seemed to argue that mental alienation itself could cause the individual to develop vices frowned on by society:

> In the asylums devoted to psychiatric patients people of either sex are seen who are commendable for their sober and industrious lives, completely irreproachable manners and most delicate sentiments, but who sink through some recognized physical or mental cause into a complete loss of reason. They develop vices which constitute a striking contrast with their basic character during the course of their alienation, before finally returning, when they are better, to their normal happy disposition.

Mental alienation and vice, and health and virtue, related directly to each other and were dichotomized with their opposites. There is no clear causal directionality in Pinel's writing. A lapse of reason could be caused by vice but it could also lead to vice. The only certainty seems to be that he believed that mental alienation and vice were linked. Based on this certainty, the professional working with mental illness was directed to provide support to the weak willed so that they had the opportunity to regain their reason. At times, even the great Pinel (1809/2008, p. 188) seemed to be overwhelmed by the prospect of handling this task:

> All monstrous excesses of vice, the apathetic torpor of indolence, the habit of drunkenness and unbridled abandon to sexual pleasures are as likely to lead to mental alienation as to foment it. Can the most enlightened doctor dispel the effects of the most pressing inclinations which seem to have absorbed or overwhelmed all the mental faculties?

Pinel (1809/2008, p. 188) recognized the magnitude of the mission he had set for himself when he asks the question: "Does the whole of society not continually show the same contrast of vices and virtues?" To properly cure mental illness would require that a solid understanding of normalcy or a universal ethic be outlined and deployed. Foucault (1961/2009) argued that what Pinel worked to accomplish in this characterization of mental illness was the defense of society through the establishment of a universal ethic by means of scientific investigation. Indeed, in his text, Pinel (1809/2008, p. 110) spoke of a "true elementary knowledge of universal timeless and ubiquitous morality" that would function to bring the people in his charge back from the "void." Part of what Pinel (1809/2008, p. 188) proposes to accomplish is the establishment of this universal ethic through scientific investigation; however, he believed that his mission would not be a popular one:

> Practice of a universal morality of all peoples does not constitute the dominant taste of the present century, whereas all the other sciences have made great progress … Whatever answers one gives to these deep questions, one cannot deny medicine the benefit of working powerfully towards the return of a sound morality, giving an account of the evils which result from its neglect, and especially in publishing a series of corroborating facts.

This mission of discovery set the stage on which Pinel's moral treatment would take place. His systematic method of observation functioned both as context and content of a therapeutic process. Debauchery offended social sensibilities, but Pinel would also show that it inevitably led to mental alienation and vice versa. Like at the Retreat, Pinel's hospices would 'cure' mental alienation by appealing to the "inalienable virtue" within each individual. However, for Pinel, 'virtue' rested on a social and scientific basis which, according to Foucault, was, for Pinel, "both the truth and the resolution of madness" (494). Thus moral treatment in Pinel's hospices was:

> To do the moral work of religion, ignoring the fantastical text and concentrating on the levels of virtue, work and social life. The asylum was thus a religious domain stripped of religion, a domain of pure morality and ethical uniformity. (Foucault, 1961/2009, p. 493)

Fear operated here like at the Retreat, but in Pinel's institutions its operation had become more complex. According to Foucault (1961/2009), to achieve an ethical

uniformity, or moral synthesis, three principle technological means were used: *Silence, Recognition in a Mirror*, and *Perpetual Judgment*[7]. Each will be discussed in the paragraphs that follow.

The Retreat set up a system of surveillance that extended into its architectural design. There the mad were judged according to the dictates of a Quaker morality. On Pinel's wards the keen gaze of a professional gave expression to a more detailed description of normality and deviance of a secular nature. Once this knowledge was established it was coupled with treatment. According to Foucault (1961/2009, p. 500), this process gave rise to a "ceremony of justice" (p. 500) which turned medical treatments into punishments. The mad were enveloped in a judicial space where they were forced to recognize all that was in them that offended society. Yet, as we have seen already, the age in which Pinel operated was changing and the individual and his freedoms had to be accounted for (see also Castel, 1988). In the statement that follows, Pinel (1809/2008, p. 121) explained that while favorable effects might be obtained by using fear, the unique sensibilities of the French, keenly attuned to abuses of power, had to be respected:

> But should the favourable effects generally to be expected from fear in the curing of insanity, and the acute sensitivity of the Frenchman and his violent reaction against any offensive abuse of power whilst any flicker of reason remains, not call for the gentlest disciplinary measures?

'Punishments' became 'treatments' for aberrant behavior. Again, while the chains had been removed, the means of restraint became more pervasive and saturated the routines of treatment. Foucault (1961/2009) used the example of cold showers to make his point. While cold water was thought to shock the system and interrupt obsessive trains of thought, it also became a naked form of punishment requiring no further therapeutic rationale: "With Pinel, the use of the cold shower became openly judicial, and a shower was the usual punishment meted out by the simple police tribunal that permanently sat in the asylums" (Foucault, 1961/2009, p. 501). Pinel (1809/2008, p. 120) used his punishments to eradicate "inflexible obstinacy" and "dominant ideas." For example, in the following passage, Pinel (1809/2008, p. 79)

[7] Castel (1988) described slightly different techniques. These are *Isolation, The Asylum Regime,* and *The Power Relationship.*

described how showers and baths were used to punish patients who were unwilling to work or obey other hospice rules:

> Showers, considered as a means of restraint, are [used] often enough to lead a patient who is capable of it to obey the general rule of performing manual work, to overcome obstinate food refusal and to bring patients driven by a kind of turbulent but reasoned mood under control. The bath is made use of then. We can benefit from such occasions to refocus attention on the fault committed. Through the tap a stream of cold water is squirted onto the head, disconcerting the patient or dispelling a prevailing idea with a harsh and sudden sensation. If she persists in being obstinate this shower is repeated, carefully avoiding harshness of tone and shocking language likely to outrage. She is made to understand that, on the contrary, it is only for her own benefit, and with regret, that these harsh measures have been resorted to; and a few jokes are sometimes thrown in.

Pinel (1809/2008, p. 78 italics in original) described another case of a young woman who refused to work during convalescence:

> The superintendent, to punish her, one day had her taken to the lower courtyard amongst the idiots. However she appeared to enjoy this kind of suppression and just cavorted and danced and ridiculed everything. So a corset with straps was applied, pulling her shoulders moderately backwards. The young girl seemed to stiffen and put up with this ordeal for a whole day, but the constraint she suffered made her ask for pardon and she no longer refused to do the sewing. If she became slack in her work she was laughingly reminded about the *velvet waistcoat* and she immediately became obedient.

Here, like at the Retreat, punishment was to be swift and was thought most effective immediately following the behavior that was to be corrected. Here too, the process was not complete until the mad had repented and acknowledged guilt. Fear was to be used, punishment was to be swift, and a respect of authority would inevitably lead to remorse. It was thought to be important that the patient understand that his or her punishment depended, not on the whims of the superintendent, but on bad behaviour. Pinel (1809/2008, p. 121) wrote:

> Does the most constant experience not show that to make the effects of fear lasting and sound, this sensation must be associated with that of respect as reason is regained? This implies that any discipline should not have been undertaken out of anger or arbitrary harshness, that only force proportionate to the degree of resistance was used to overcome the patient's exuberance, and that one was solely driven by the desire to restore him to his old self, as shown by a frank and friendly explanation immediately upon his repentance.

According to Foucault (1965/1988a, p. 269), this is the process whereby the individual identified as being mentally ill became encased in an endless trial:

> whereby any transgression in life, by a virtue proper to life in the asylum, becomes a social crime, observed, condemned, and punished; a trial which has no outcome but in a perpetual recommencement in the internalized form of remorse … The asylum of the age of positivism, which it is Pinel's glory to have founded in not a free realm of observation, diagnosis, and therapeutics; it is a judicial space where one is accused, judged , and condemned, and from which one is never released except by the version of this trial in psychological depth – that is, by remorse.

In Pinel's institutions the individual would be broken, subdued, and made docile. He or she would be invested with a universal ethic that corresponded to a particular brand of reasoning. She or he would abandon faulty reasoning, learn to accept his or her faults, express remorse, and only then receive treatment kindly in nature. At these institutions, kind treatment was only forthcoming if the patient was 'good'; if the patient had succumbed to the pressures and Truth that surrounded them. It was a kind of coercion that would not end until the patient convinced his or her attendants that she or he was cured:

> At the Salpêtrière, rigour and firmness are only used to subdue the patient, return her to order and make her docile. As soon as she is subdued and resigned, and her reason begins to come back and make her accept her faults, then everything changes for her and she has nothing but gentle and kindly manners awaiting her. (Pinel 1809/2009, p. 128)

If this system was confronted by 'deluded' versions of Truth that prevented a confession of guilt and the operation of remorse then the individual would be condemned to endure a kind of reorienting silence. Society would be denied to her or him. The mad person would not be chastised; he or she was to be ignored and abandoned. The individual would be trapped in a relation to the self intended to amplify the effects of abandonment, guilt, and shame. Pinel's prescription of silence prevented the deluded madman from becoming a martyr in her or his own eyes:

> The faces of the enemy disappeared, and he [the madman] no longer experienced their presence as a gaze, but rather as a refusal to pay any attention to him, a gaze averted; for him others were now nothing but a limit that constantly retreated as he advanced … Before, he felt himself to be punished, and saw there the signs of his innocence; now free of any physical punishment, he had no option but to consider himself guilty. His torture had

> been his glory: his deliverance was his humiliation. (Foucault 1961/2009, p. 497)

The development of this technology, according to Foucault (1961/2009), marked a movement in history where madness was silenced and was forced to attend to the monologue of reason and order. The social Truth that Pinel helped to uncover in this age would become an incessant drone that dominated in the deafening silence that surrounded the mad and in which the voice of madness was lost. To rejoin the social order and be heard the mad would have no choice but to adopt the discourse of 'reason.'

Within this silence the mad might also be confronted by a mirror and forced to recognize their mental illness. The insane were called on to examine their reflection in the behaviors of their peers. This technology ensured that the gaze not only functioned from without, but also functioned within and between the mad. According to Foucault (1961/2009), the object of this particular technology was not to demonstrate to the mad person the error of his or her thinking, but to highlight their arrogance. In the space of Pinel's institutions the mad were not only watched they were in a space that afforded them the opportunity to watch each other. This opportunity was not only used to help police aberrance, but to amplify and make clear the delusionary nature of the beliefs of the mad. Perhaps the mad could not recognize their own sin in relation to society, but they would be able to recognize this sin in those around them. "Realization, or gaining consciousness," Foucault (1961/2009, p. 501) argued, "was now linked to the shame of being identical to that other, compromised in him and scorned by oneself even before reaching recognition and knowledge of oneself." Pinel (1809/2008, p. 96) outlined an example of this technology at play when he documented a reorienting series of monologues the superintendent delivered to an individual who thought he was king:

> 'If you are the sovereign,' he said, 'why do you stay mixed up with all kinds of deranged patients?' He went back again the following day to talk like this with him, in a kindly friendly tone. He gradually got him to see the absurdity of his exaggerated claims, and showed him another patient who had also been convinced for a long time that he was invested in supreme power.

5.3.4 Occupation therapy in moral treatment.

As indicated in previous chapters, one part of moral treatment involved the provision of occupation. While Foucault did not discuss occupational therapy in his history of madness, like other important aspects of moral treatment, Foucault's (1961/2009) perspective scrutinized the merits and effects of the routine use of occupation. With his historical method, he traced the changing ideas that provided a foundation for the use of occupation in treatment in the 17th, 18th, and 19th centuries. In previous chapters, I have already discussed some of Foucault's critical thought in relation to the use of occupation in modernity. For example, with the rise of industrialization and the professional, the individual was forced to conform to schedules that worked on the rhythms of the body. Foucault identifies different techniques that were used in the 17th and 18th centuries that are reminiscent of both the ways in which occupation was used during the moral treatment era and how it began to be employed in the 20th century by occupational therapists.

Foucault (1961/2009) explained that *regulation and movement* were thought to be important methods in the treatment of mental illness. Wilcock (2001b) described 'rules of health' that were disseminated during the middle-ages. Within these prescriptions, motion was thought to help keep the body and mind in a state of balanced health. Disordered fibers of the body could lead to disordered minds, thoughts, and madness. Ideas that were similar but relied on changing causal explanations persisted into the 17th, 18th, and 19th centuries. For example, Foucault (1961/2009) quoted Thomas Sydenham, an English physician, writing at the very end of the middle ages in the 17th century on the therapeutic value of horseback riding:

> What disorder of the functions, or other natural impotence of the organs, can be imagin'd so great, as not to be helped by the frequent jolting of the horse, and then too in the open air, whose innate heat is so extinguished, that it cannot be stirr'd up by this motion and ferment afresh? … Moreover, the blood being perpetually exagitated by this motion, and thoroughly mix'd, is as it were, renewed, and grows vigorous again. (pp. 318-319)

Fresh air, jolting movement, and exciting the blood threw an immobile body into action and stirred up stagnating humours and fixed ideas. Motion and mobility were important for the health of the body and the soul. It was not a senseless shock to the

system that was called for, but stimulation that would somehow match the harmony of nature. The cure would be obtained by achieving motion that was real, regular, and which obeyed the rules of movement in the world (Foucault 1961/2009).

According to Foucault, in the 18th century, the effects of travel were also celebrated. Movement here took the form of a journey. This journey would distract the attention of the melancholic from their painful brooding, for example. Foucault (1961/2009, p. 319) quoted Le Camus, a French physician writing in the 18th century, who prescribed: "walks, journeys of all descriptions, horse riding, exercise in the open air, dance, theatrical spectacles, light-hearted reading, and any occupation to distract the mind from its central preoccupation." Obviously the 'travel' that was prescribed could entail engagement in and diversion through a variety of different occupations. What was sought was a distancing from the present and a reinsertion into the rhythms of the world. In Foucault's (1961/2009, p. 320) own words:

> The therapy was both a forcing of the mind 'back into step' and a conversion, as movement prescribed rhythm, and also constituted in its novelty and variety a constant appeal to the spirit to emerge from its own preoccupations and re-engage with the world … here the call was for the mind to return to wisdom by accepting its place in the general order, thereby forgetting madness, which was the moment of pure subjectivity.

Madness was the mind giving into itself at the expense of worldly wisdom. This depiction seems to relate to a kind of abandonment of the world and its natural laws in an effort to indulge in one's own subjective world.

Foucault critically discusses the importance of occupation at the Quaker Retreat and his depiction can be related to ideas which existed in the 17th and 18th centuries. As outlined in previous sections of this chapter, at the Retreat, there was an attempt to usher the individual back onto the path that nature had set for him or her. It involved reconnecting the individual with their natural selves' core. In some cases the evils of 19th century society had alienated the individual from themselves. Life at the Retreat would be a return to a simpler existence in the country side where "excellent air and water," a "wooded, fertile plain," gardens, "shrubs and flowers," and animals could be found, the last of which was thought to "awaken the social and benevolent feelings" in some patients (Tuke 1813, p. 42; 93; 95; 96). It would be a return to the

natural movements of nature, a combination of "diet, air, and exercise" that would cure mental illness (Tuke, 1813, p. 123). Close attention was paid to the patient's "animal spirits" so as to ensure they were not too "excited or depressed" (Tuke, 1813, p. 123). Paying attention to the following poetic 'truth' Tuke (1813, p. 130) lauds the work of the professional who: "Gives melancholy up to Nature's care, And sends the patient into purer air." As well, one can see a connection to beliefs of the past when Tuke (1813, p. 130) speaks of the powerful effect of journey on those who have had to travel to the Retreat to seek out care: "Several instances have occurred, in which melancholy patients, have been very much improved by their journey to the Retreat." Simple occupations were used, like gardening, which mirrored the rhythms of the natural world and would help to cure mental illness. Foucault (1961/2009, p. 473) wrote:

> The seasons and the days, the great plain of York and the wisdom of gardens, where nature coincides with the order of men, were to recall reason and awaken it from its momentary slumber. Inside this life of tending the vegetable patch that was imposed on patients at the Retreat, under the sole guidance of an unshakeable confidence, a magical operation was concealed, where nature helped nature triumph by a process of resemblance, rapprochement and mysterious penetration, while the anti-nature that society had infused into man was simultaneously exercised.

The operations that were believed to underlay the same treatments from centuries before had changed slightly. The mad where not exposed to the natural movements of nature to take on natural qualities, but to reawaken their latent selves. These were not techniques designed to layover and eliminate error, but to reestablish a connection with an inner Truth that had been lost or forgotten. It was a reawakening, or a remembering, that was thought to occur; it was nature reaching out to itself. Tuke (1813, p. 133) believed that the patients "intellectual, active, and moral powers, were usually rather perverted than obliterated" and proper treatment could reawaken "respect and obedience" (Tuke 1813, p. 135). However, Tuke quotes Francis Bacon and alludes to the means through which an individual's will was to be pushed towards the acquisition of good habits: "order, pursuit, sequence, and interchange of application, which is mighty in nature; which although it require more exact

knowledge in prescribing, and more precise obedience in observing, yet is recompensed with the magnitude of effects."

Occupation within this world was also tied to a Quaker morality in terms of beliefs of the importance of work where "God blessed men with signs of their prosperity" (Foucault 1961/2009, p. 485). Tuke (1813, p. 180-181) wrote: "As indolence has a natural tendency to weaken the mind, and to induce ennui and discontent, every kind of rational and innocent employment is encouraged." Work was valued in this moral system in and of itself. It was also valued due to its ability to constrain and fix patients in "a system of responsibility" that would repress both bad behavior and aberrant thoughts and imaginings; liberty unchecked by the wholesome rhythms of work lead to disaster and mental alienation. In Foucault's (1961/2009, p. 486) analysis, work functioned more effectively than physical restraint in its ability to control patients:

> It was only imposed as a moral rule. It was a limitation of liberty, submission to order, an engagement to responsibility, of which the only goal was the tethering of a spirit that roamed too freely in the excess of a liberty which physical constraints only limited in appearance.

Physical bonds were limited to the control of the physical body. Work had the power to constrain both the physical and moral domains. It is clear that, for Foucault, moral here referred both to the psychological and the ethical. It was a technology that served to replace chains and simultaneously train the patient in how to effectively manage liberty in Quaker fashion. Work was diversionary, but it also served to train the patient. It functioned to construct and mold an individual along the lines of an ethical pattern that dictated what a virtuous Quaker existence should consist of. Work helped to make a Quaker what he or she ought to be in an ideal sense. Tuke (1813, p. 156) stated:

> Of all the modes by which the patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious; and those kinds of employment are doubtless to be preferred, both on a moral and physical account, which are accompanied by considerable bodily action.

Active, exciting, or sedentary occupations were prescribed depending on the class of insanity and interest of the patient. Occupations that the patient preferred were in

some cases denied when it was thought that they would exacerbate illness. When not referring to manual labour, like gardening, Tuke (1813) specifically mentions chess, ball games, drafts, drawing, writing and composition, books, and study in mathematics and natural science. In some cases, occupations were specifically chosen to train the individual's capacities, as in the case of one patient who studied mathematics to develop his capacity for sustained attention. Women were employed in occupations that were thought suited to their gender: "The female patients in the Retreat, are employed, as much as possible, in sewing, knitting, or domestic affairs; and several of the convalescents assist the attendant" (Tuke, 1813, p. 156).

At the Asylum, occupation functioned to divert and control the body and mind. As Tuke (1813, p. 151-152) explained, in the case of melancholia: "Every means is taken to seduce the mind from its favorite but unhappy musings, by bodily exercise, walks, conversation, reading, and other innocent recreations." Occupation worked to shape and mold individuals away from disorder and towards the dictates of a particular ethical system. Work occupations, for example, could cure but they could also lead the individual down improper paths. Tuke (1813, p. 155) related the case of a gardener and worried that this form of labour might actually result in a sense of "self-complacency" due to the individuals expertise in this occupation. In this case, Tuke proposes that another occupation in which the individual was not as skilled would have been more suitable. In a foot note, Tuke (1813) also took the time to assure his readers that patients were not permitted to gamble when engaged in games of chance, for example.

From Foucault's (1961/2009) perspective, work functioned in Pinel's asylum in a different and more complicated fashion. However, notwithstanding Foucault's analysis, there did appear to be some agreement on particular issues. For example, Pinel (1809/2008, p. 60) unequivocally stated:

> There is no longer a problem to be solved. It has now been shown by the most constant and unanimous experience that in all public asylums such as prisons and hospices the surest and perhaps only measure to guarantee the maintenance of good health, good behavior and order is the rule of mechanical work, rigorously enforced.

"Occupations or hard labour" would ensure "strict discipline within the hospice" (Pinel, 1809/2008, p. 122). For the women, like at The Retreat, sewing was thought to be appropriate. Pinel (1809/2008, p.65), like Tuke, also matched particular classifications of illness with particular occupation regimes when he stated: "what kind of life could be better and healthier for a melancholic person than the alternatives of labouring with his hands and studying at a desk!" However, he also seemed to believe that occupations, when possible, should be matched to the wants of patients as is evidenced by the following statement: "We must offer pleasant occupations varied with the differences in tastes, varied physical exercise, spacious accommodation planted with trees, all the joys and calm of rural ways, and, at intervals, gentle and harmonious music" (Pinel, 1809/2008, p. 97). In one case, an individual, who, while recovering, "bore the weight of an inactive life" difficultly, expressed a desire to try his hand at portrait painting and was quickly given the opportunity (Pinel 1809/2008, p. 92). However, according to Pinel, this turned into a lost chance to restore the individual's reason when the proper supports were not provided to allow success in this activity. At the institutions under Pinel's guidance, it seems that occupation would also ideally serve to reconnect the individual with natural routines. Describing what he believed were exemplary treatment practices adhered to in Spain, Pinel (1809/2008, pp. 90-91) depicted a picturesque scene of docile patients cheerfully engaged in all manner of work occupations:

> They wished to restore a form of counterweight to the distractions of the mind using the appeal and charm inspired by working the land, following the natural instinct which leads man to make the land fertile and thereby provide for his needs with the fruits of his labour. From early morning patients are seen, some doing menial household tasks, some going to their respective workshops, and the majority separating into groups led by a few intelligent and enlightened supervisors. They cheerfully spread out into different parts of a large enclosure belonging to the hospice and share out between themselves, a little competitively, the tasks relating to the seasons, growing wheat, legumes, vegetables, and busying themselves in turn with the harvest, trellis work, grape picking and olive picking.

Occupation in Pinel's (1809/2008, p. 91) hospices, like at the Retreat, was to cure "laziness, indolence and idleness," but, according to Foucault, would also serve a more complex function. A work role would give purpose to an individual, but it was a

purpose that confined the patient within a well defined social structure. A well defined work role would cure by outlining the boundaries of an individual's social station and responsibilities. Foucault (1961/2009, p. 478) contrasts two cases where Pinel removed the chains only to tie his patients more tightly with social roles and responsibilities. In one case a former common soldier would became Pinel's valet:

> He was a drunkard with delusions of grandeur, who took himself for a general, but Pinel had seen 'an excellent nature behind the irritation.' He undid his chains, declaring that he was taking him into service, and that he would require of him the fidelity that a 'good master' should expect from a grateful servant. The miracle happened, and the virtues of a faithful valet were awoken in the troubled soul … In the legend that grew up around Pinel, this good servant was to play his role to the full; he devoted himself body and soul to his master.

The second example Foucault used to make his point revolves around the freeing of an English Captain. On acquiring freedom this man slowly became useful at the institution and was able to exercise authority over other patients. Foucault explained that each example came to represent and become confined in a particular social type. The social role that each would obediently fill came with particular values that were also important. Here the chains were removed, but occupation, in this case a work role, served to imbue life with a purpose that tied the individual to a system of social relations. Within each role, Foucault (1961/2009, p. 478) highlights the ethical considerations that had to be adhered to. The treatment of an English captain had to reflect his station in life. His station in life and the values that related to it were all that could cure him:

> It would not have sufficed for the first man delivered to have become a normal healthy man; he had to become an officer, an English captain, loyal to the man who set him free, like a man kept in bondage to a conqueror by his word, a figure of authority for others on whom he exercised his prestige as an officer. His health was only restored in the social values that were both its sign and its concrete presence.

For the English captain "reason was honor. For the soldier [the 'valet'], it was to be fidelity and sacrifice" (Foucault, 1961/2009, p. 479). Each life and each occupational role related to a different set of "ethical coefficients" and truths. Within the institutions, it was Pinel's job to match occupation with the truths that would fit them

into a social structure. A third example of occupation at work in this way can be identified in Pinel's writing. A tailor being preoccupied with thoughts of condemnation and death was put to work in repairing clothing for patients: "There was nothing to compare with his enthusiasm and ardour to make himself useful," Pinel (1809/2008, p. 133) wrote, "He wasted no moment of the day and after working hard for about two months he appeared to be completely changed." This man, on recovering his reason through a resumption of the occupation that defined him, began to resume his other social responsibilities; he became a dutiful father:

> These were no more grumbles, no reference to his so-called death sentence; he even spoke fondly about a six-year old child he had appeared to have forgotten, and he showed a strong desire to have his company. This reawakening of his sensitivity seemed to me to be a most promising sign and this source of happiness was restored to him. There was then nothing more he wanted; he always set to work with renewed pleasure and never ceased repeating that his child, who was always with him, was the joy of his life. (Pinel, 1909/2008, p. 133)

Pinel's occupation cure was more complicated than the one employed at the Retreat. At the Retreat, occupation seemed to relate to a single set of values. For Pinel, occupation was a much broader phenomenon that corresponded to one's social type within a structured social system. Thus one sees here an adherence to a different ethical code, one born in, not beyond, society and reflective of its needs and structures.

5.4 The Limits of Critique

There is a limit to the validity of Foucault's critiques (Charland, 2007). This in some ways reflects what Foucault attempted to accomplish and is further evidenced by the shifting nature and subtlety of the critical framework that he constructed. Foucault was not necessarily in the business of documenting history, he was in the business of critique (Rabinow & Rose, 2003). It is in this sense that history in the hands of Foucault "becomes philosophy" (Bracken, 2002, p. 187). His critiques highlight the dangers that exist in the present and he was not predominantly concerned with the past (Dean 1994; Foucault, 1975/1995; Gastaldo & Holmes, 2002; Veyne, 1997). Still, in reading his work and digesting his arguments, one can get carried away. Foucault's perspective has been

criticized because of its tendency to boil everything down to an endless play of dominations (Ignatieff, 1983; Rabinbach 1992). Foucault's perspective begins to function in a similar fashion as the clinical gaze that he criticized. His critical gaze is pathologizing and can be difficult to escape. It can be hard to reconcile his perspective with a desire to continue with professional work in the present. And yet, despite the fact that Foucault died in 1984 and did not have an opportunity to continue with his work, there is still much to learn from him. And while his critique of moral treatment is something to which occupational therapists and scientists should pay attention, an effort to rescue our historical heroes from Foucault's grim and unrelenting deconstructions should be made.

The following quote is intended to demonstrate that Pinel anticipated many of Foucault's critiques. Perhaps Pinel believed that the science that he helped create would work to avoid the dangers of a professional attitude that condemned anything that might be considered aberrant. For Pinel, it was precisely the process of scientific discovery that would combat an indiscriminate censoring of the range of difference to be found in human life. On reading this statement, it becomes quite clear that he intended to limit what might be considered full blown illness and what was simply representative of the diversity of human behavior:

> So should the entire mistaken and inaccurate ideas one can have of things, all the outstanding errors of imagination and judgment, and everything which excites and provokes unrealistic desires, not be included under this heading [mental alienation]? This would then be setting oneself up as the supreme censor of peoples' private and public lives, taking into account history, morality, politics and even the physical sciences whose domain has so often been contaminated by dazzling niceties and dreams. (Pinel 1809/2008, p. 51)

One can interpret this particular statement in a number of different ways. Pinel's understanding of reason, the will, and what would be desirable for ideal human conduct is not changed. It is rigid and in many ways unforgiving. However, there does seem to be the beginnings of recognition that this ideal does not accurately capture what human life is about. Certainly, in reading his work one can easily identify particular expectations that will be seen as offensive to many in contemporary times. For example, Pinel (1809, p. 19), like many others in the 19th century, believed that women by their very nature were more susceptible to mental illness: "At almost all stages of life women, through their

extreme sensitivity and physical and mental disposition, are most exposed to mental breakdown and more or less complete loss of reason." And again, like many others operating in the 19th century, Pinel (1809/2008, p. 28) believed that same sex relations inevitably led to, or resulted from, depraved morals: "It may well be assumed that another unnatural vice, which requires the participation of two equally debauched persons of the same sex, also takes place in the psychiatric hospices. These intimate liaisons are sometimes seen to develop as a result of depraved morals." And yet, it also seems that Pinel cared very deeply for his patients and, despite his efforts to 'objectively' articulate the nature of mental alienation, often let his concern for human suffering seep into his writing:

> It is not without emotion that I have seen demented patients, casualties of a sensitive tender nature, repeating day and night the cherished name of a wife or son who had been taken away through premature death and whose images was always in front of them. (p. 64)

Here Pinel let himself feel emotion for the 'objects' he classified and categorized. While Foucault accused Pinel of creating a judicial space in which individuals with mental illness would be blamed for their condition, Pinel (1809/2008, p. 78) clearly did not want his patients to be thought of as prisoners deserving of punishment: "The insane, far from being culprits who need punishment, are patients whose sad state deserves all the consideration due to suffering humanity." Indeed Pinel also anticipated the work of sociologists like Erving Goffman when he began to discuss the devastating effects of stigma that those discharged from his institutions had to grapple with. Pinel related the story of a young woman, who, after receiving treatment and recovering, returned to her life only to be rejected and scorned because of her mental illness. Of this Pinel (1809/2008, p. 142) wrote: "One cannot but be moved by the fate of many mental patients, so often victims, even after they have been cured, of peoples' prejudices and ignorance." While one can see how Pinel's theories could function to condemn, it is also clear that he felt, in many cases, that his patients were not to be blamed for their condition: "After they are fully recovered, and they avoid meeting those who have seen them in that state, as if anyone could blame them for the unwitting results of an illness" (p. 34).

Foucault's censure of the operations at play at The Retreat must also be taken with a grain of salt. Digby (1985) asked her readers to consider if Foucault's wholesale condemnation of moral treatment at The Retreat ignored the realities of historical complexity. Moral treatment at The Retreat, in particular, is criticized for its paternalistic treatment of those suffering with mental illness (Charland, 2002). While the infantilization of individuals with mental health issues is something many find abhorrent today, in the 19th century equating patients with children was part of a general attitude that can be understood as something with both benefits and drawbacks (Charland, 2002). Digby (1985, p. 59) quotes a daughter of one of The Retreat's superintendents who had spent time growing up at The Retreat and believed that those with mental health issues were deserving of "all the loving truthfulness and sincerity which we should show to our children." Digby (1985, p. 59) went on to argue that "these public references suggest a tender solicitude for patients' welfare rather than the domineering paternal role suggested by Foucault." Further, Digby (1985, p. 64) pointed out that Foucault put himself in a precarious position when he criticized the practices at The Retreat wholeheartedly as operating under 'a constant principle of coercion.' The Retreat was a place built by Quakers to help other Quakers. Digby (1985) argued that it becomes difficult to criticize practices that aim to help Quakers using a value system that, presumably, was felt to be natural, acceptable, and desirable by patients themselves. Indeed many today might find it truly amazing that an institution like The Retreat could be built through the generosity and cooperation of a community. The Retreat was built with funds donated by Quakers. Individual Quakers or groups of Quakers could also nominate individuals without the means to pay for their admission:

> A contribution of one hundred pounds, from any Quarterly or other Meeting in its collective capacity; a donation of twenty-five pounds from any Friend; or a subscription of fifty pounds for an annuity, shall entitle such meeting, donor, or annuitant, respectively, to the privilege of nominating one poor patient at a time, on the lowest terms of admission. (Tuke 1813, p. 81)

Without question, on reading Tuke's Description, one does get the sense that he saw a proper way to live and that this corresponded to the dictates of Quaker morality, but this was not a sinister attempt to convert or control, it was what leaders in the Quaker community saw as right, as the best chance to help individuals in need of assistance.

They did not have a better way available to them. What Foucault did for us is highlight how a beneficent attitude, a desire to help, and caring for others who are unwell can become something horrifying if not coupled with an understanding of how notions like normalcy, health, and illness can become ethical judgments that contribute to the further deteriorization of an individual's sense of wellness and comfort with themselves. It may be true that there are particular ways of knowing that help to contribute to a real sense of the different ways in which the human condition can go awry. But it is also true that within these understandings there will always be room for gross injustice and compounded suffering. We live in a society of norms. We come to know ourselves within the grids of these expectations and while the occupational therapist's job may partially be about helping people to understand what it means to live in a society of expectation, it must also be about helping individuals who are different come to terms with their differences and combat those expectations in their day to day life (see also Kielhofner, 1986). As an occupational therapist who has worked with individuals with enduring mental health issues, I can see where Foucault's critiques hold some validity; however, I can also see the limits of that validity. But perhaps this is precisely what Foucault intended.

Foucault's critique, his search for a kind of moral impropriety, and his reinterpretation of the mechanisms of freedom at the Retreat and in Pinel's institutions is reminiscent of a story Pinel (1809/2008, p. 62) relates in his book. A misguided attempt was made by revolutionary reformers to search for wrongly incarcerated prisoners at the Bicêtre in order to liberate them. After searching through the establishment, this mob found an individual that they thought did not belong. However, after freeing and leading him away from the institution he got hold of a sword and slashed at his liberators in a furry. Pinel (1809/2008, p. 62) explained "The barbaric horde led him back to his lodge and appeared to submit, somewhat red-faced, to the voice of justice and experience" (p. 62). Pinel's categories of mental alienation – maniacal insanity, melancholic delirium, dementia, and idiocy – did hold some validity in his time. Aspects of some of these categories also continue to resonate with what many of us understand to designate mental illness today. This does not mean that these diagnoses did not have material consequences in the past that could, and should, have been avoided, and it does not mean

that our current classificatory systems do not carry with them similar consequences in the present. More importantly, this also means that the judgments occupational therapists and scientists make also carry far reaching consequences. Most importantly, we must recognize that the theoretical material employed in the present is not now free of ‘error’ that will seem terribly odd to the generations that follow. For example, it would seem quite odd today to construct illness expectations around an individual’s hair colour; and yet, Pinel did exactly that.

Chapter 6

6 Professional work in the present: Authenticity and the technologies of self formation

In the previous chapter, I outline some of Foucault's thoughts that relate to professional work in modernity. More specifically, I presented his critique of professional work as it related to the history of mental illness. In examining his critical history, complementing it with other historical and philosophical perspectives, and reexamining classic moral treatment texts, I began to chart a genealogy of normative technology in occupation therapy. In addition, I began to profile the potential utility of Foucauldian criticism in placing limits on professional practices. In what follows, I change my temporal focus and consider literature that relates to the contexts and traditions that organize professional work in contemporary times. First, however, I explore additional philosophical and professional work that both extends and challenges the critical perspectives of Foucault to better contextualize the scope of normative work that occurs in present times within the realm of mental health. The majority of this work relates broadly to the formation of subjectivity, the delineation of normative parameters that help to organize and guide individual conduct, and mental health practice. This chapter relates to steps 'g' and 'h' described in the method outlined in chapter three.

In building on work of Foucault, Ian Hacking developed a series of propositions that relate to how people are "constituted within a web of historical events" (1986a, p. 36). Foucault's work related to the formation of modern subjects served as the inspiration for Hacking who sought to describe the social formation of specific kinds of individuals. Human kinds, Hacking (1986b, 1995) contended, relate to systematic descriptions that work to classify people, their actions, and sentiments. These kinds are made up differently at different times in history. Clearly, this relates well to Foucault's (1961/2009) history of madness in that the classification processes that Hacking described actively produce particular kinds of individuals. Like Foucault, Hacking (1986b, 1995) contended that knowledge collected about people in the social sciences, for example, works to create the ways in which one is able to be and act that have real effects in terms of how individuals assemble their personhood. Human kinds are invented. As new classifications are created, potentialities "for action come into being" (Hacking,

1986b, p. 231). Some of Hacking's (1995) most often used examples relate to homosexuality and multiple personality disorder. Both, he contended, did not really exist as distinct identity possibilities for individuals before knowledge about them began to be collected and disseminated. An explosion of scientific discourse related to these human kinds led to their establishment in the social sphere as real categories of human experience. Individual experience and behavior conform to descriptions of these human potentialities, or actively react against them. For example, while the authors of modern classificatory schemes like the DSM-IV sought to make it clear that they were not in the business of classifying people,[8] but disorders that people have, descriptions of psychopathological states found within taxonomies of mental disorder help to create the limits within which human beings are molded (see Cooper, 2004). That is to say, as a basis for both practical and scientific work, knowledge 'collected' and organized in the DSM-IV works to make people into particular human kinds. The facts generated about psychopathological states create and cast people in particular molds. Far from uncovering a kind of transcendental Truth, Hacking suggested that facts transform the people they are intended to describe. History shows us that certain human problems are created and then pathologized. These are targeted for professional intervention.

In a slightly different way, Healy (1990) explained that psychological problems are construed as mental illnesses in particular social locations. While a diagnosis like depression, for example, may represent an actual breakdown in biological functioning, for Healy (1990), when it is construed as a 'mental illness' it becomes layered and enfolded within socially constructed material. For example, Charland (2006) outlined how descriptions of particular personality disorders in the DSM can be understood in terms of moral failings. Further, Hacking (1995, p. 367) seemed to argue that all depictions of human types "have intrinsic moral value." Here value bias is tied to knowledge generation by creating the molds and measures for what it means to be a healthy human in relation to particular social norms; however, this 'bias' is hidden in

[8] "A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV (as did the text of DSM-III-R) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."" (APA, 2000, Definition of Mental Disorder section, para. 4).

'thin' descriptive, scientific, and biological language (see Charland 2009a). In this sense, diagnostic systems not only create biological kinds by unearthing and assembling particular configurations of fact, they create categories of moral and social experience that are meaningful as fact is layered over and combined with the normative values and expectations that dominate a specific social context. Hacking (1995) demonstrated how particular biological differences become pathologized, created, and/or magnified in particular historical contexts. These have real psychological, social, and moral implications that alter how selves are formed and how lives are lived. Indeed in previous sections, in relation to Foucault's work, I have attempted to outline the historical intricacies of this process. Hacking further highlights the ethical dangers which appear as scientists and professionals in more recent times weigh out existence according to an implicit understanding of normality that is tied to the needs of a particular sociohistorical context. Categories of mental illness or occupational dysfunction, for example, are, at least partially, a response to the needs of a particular social context.

In a different way, Healy (1990) tied the breakdown of normal mental experience to a differentiated hierarchical model of evolutionary development. He postulated that there are three related but distinct systems that can create mental health problems; the brain, the psyche, and the mind. Biological etiological factors stem from problems in the brain, psychological from the psyche, and moral from the mind. Breakdowns in brain function correspond to problems with the nervous system. Breakdowns in psychological functioning correspond to problems in perception, memory, learning, imagination, and emotion, for example. Breakdowns in mind function, on the other hand, correspond to problems with symbol and abstraction, meaning, reason, morality, virtue, and truth. For Healy (1990), healthy mind function entails a search for 'authenticity.' In relating the mind from the previous levels in his system Healy (1990, p. 30) wrote:

> The mind only consists of the psychological capacities of perception, imagination, skilled activity, emotion, memory, motivation and intelligence pressed into the service of a search for meaning. A meaning that is not just another skill to be mastered by linguistic dexterity or symbolic manipulation, but which is a requirement of authentic human living without which human subjects are liable to self-destruct.

For Healy (1990), issues that relate to authenticity imbue human actions with meaning and purpose. In attempting to further differentiate between biological, psychological, and mind function Healy pointed to the meaning and purposes that underlie human action. Here, Healy (1990) speaks the language of 'occupation:'

> From the endeavor and agility of the mountaineer striving to conquer a peak and plant a national flag on its summit to the dexterity of the virtuoso musician straining to reproduce the musical nuances that bring audiences to their feet in tumultuous applause, muscles, nerves and heart respond precisely to the undertones and overtones of symbols. Not only muscles, nerves and hearts, but also memories, the capacity to grasp relations and the ability to imagine possibilities are harnessed to the tasks of discovering the dimensions of the universe.

Healy (1990) believed that in the routine treatment of mental illness, breakdowns in these three levels (brain, psyche, & mind) are often confused and substituted for one another. Different trends in scientific and professional practice create categorical systems that determine how normality and thus mental illness are conceptualized and subsequently treated. Once again, normative bias permeates the conduct of scientific and professional practice. However, Healy (1990) also argued that mental disorders may represent *real* biological breakdowns that are layered over with psychological difficulties which are tied to a kind of social bias. While a major mood disorder, for example, is often portrayed as a biological, *or* psychological, *or* moral problem, Healy (1990) believed that they most likely represent problems with biological *and* psychological functioning. Healy (1990) explained, for example, that depressed individuals present with a collection of compounded problems. Thus simply medicating or proselytizing, for example, may not be effective:

> Being a victim of disordered neuropsychological functioning effectively puts a subject in different cultural circumstances. Putting on the mind of such a person involves realizing that they have been and are being subjected to a host of unusual experiences. (Healy 1990, p. 124 see also p. 169)

These unusual experiences can lead to various sorts of interpretations on the part of both the individual in pain and those who work with them. The task, according to Healy (1990), may involve helping people to understand how their psychological system is reacting to an underlying neurological disturbance; helping people understand how their regular coping strategies, defense mechanisms, or self-symbolizations, might no longer

be appropriate or effective. According to Healy (1990), the problem with many of the major mental illnesses is that an individual's perceptions and reactions to life and themselves have become ridged and maladaptive in light of difficulties created in relation to a particular biological and psychological disruption[9]. Within Healy's (1990) scheme successful intervention would require the therapist to highlight blocks in perceptual awareness and shy away from questions that relate to the ultimate ends of life and authenticity (see also Beck, Rush, Shaw, & Emery, 1979).

This solution should be troubling to occupational therapists and occupational scientists. Steering clear of the authentic dimension would effectively limit one's ability to consider the meanings and purposes that lie behind human occupation. Healy (1990) made an attempt to strip mental health practice of its normative content by avoiding issues that relate to the ultimate ends, purposes, or meanings of life. This was done in order to render mental health practice morally benign. As a consequence, one might also be required to avoid questions that relate to meaningful occupation. Thus therapists would avoid issues related to morality, the mind, and the quest for 'authenticity' (Healy, 1990). Healy (1990) reasoned that failing to do so could potentially pathologize a person's moral character, lead away from recovery, and raise serious issues in relation to the psychotherapists' proper role:

> Depression, mania and schizophrenia function as black holes in regard to issues of authenticity such as these, sucking in all possible failings the subject has in the attempt to account for what is going wrong. Far from promoting authenticity, the therapist's task should be one of disentangling the subject from these issues. Failure to do this is liable to be spiritually oppressive. Indeed is even more liable to have serious long-term side-effects than any drug treatment. (Healy, 1990, p. 214)

As a result, Healy (1990) highlighted what he believed to be the effective components of contemporary psychotherapeutic treatment; their concrete, specific focus. Cognitive and interpersonal therapies, for example, focus on well defined situations that an individual has problems within their day to day life rather than on general interpretations about what existence is or should be about. That is, they focus in on the specifics of how psychological and biological deficits lead to pathological functioning in the context of a

[9] Occupational therapists working in the present are also directed to consider environmental disruptions (see Law, 1991).

specific individual's life. Successful therapies, according to Healy (1990), would then work to broaden an individual's understanding of how psychological and biological dimensions alter responses to specific life events and enable or disable healthy functioning. This solution seems to sidestep the problems that have been raised by people like Hacking and Foucault. For example, on close examination of interpersonal psychotherapy treatment processes, one can still identify normative assumptions. For instance, particular levels and qualities of affect are encouraged in the context of interpersonal relationships (Klerman, Weissman, Rounsaville & Chevron, 1984). In one case, normative processes of grieving are outlined that dictate how one should feel in regards to the loss of a relationship due to death. In the following quote, Klerman, et al. (1984, p. 171) outlined the plan that was used for the management of a patient's affect in relation to the loss of her husband:

> Elicitation of affect was a key aspect of Mrs. C's treatment. In reviewing her relationship with her husband there was an explicit attempt to help her experience sadness over the loss, with the plan of helping her realize that she can bear it; to feel anger at her husband, with the plan of helping her realize that it is an acceptable and normal feeling; and to experience loving feelings about her husband, with the plan of helping her see that she need not give these up even if she begins to allow new people and experiences into her life.

Of more concern to occupational therapists and occupational scientists is that while this solution centers on the concrete aspects of existence, its narrow focus on psychological and biological performance components circumvents a more holistic understanding associated with an occupational perspective (see Hume, 1999). Occupational therapists often take pride in the knowledge that the treatment they provide is focused on the mundane aspects of day to day life (e.g., do Rozario, 1999; Yerxa, 1979). The concrete focus of occupational therapy is often coupled with a reverence for the routine, the ordinary, and the everyday. In this sense, occupational therapy intervention includes questions of authenticity into the mix even as therapists focus on the concrete.

Alternatively, some have argued that treatment of mental health issues *does* require one to focus on issues that relate to the mind, authenticity, and value as they relate to the ends of life. Charland (2009a), for example, explained that there are some precedents which suggest that "psychotherapy cannot brazenly ignore questions of morality and ends of life as it currently does" (p. 56). Once again, this would require

professionals (and scientists) to wrestle with questions that relate to value. For example, in discussing more explicitly the role of the psychotherapist, Charland (2009a) contended that regulation of emotion necessitates an understanding of the ends of regulation. An understanding of what 'normal life' should be about is necessary before the therapeutic process can begin. This author argued that many of the more popular psychotherapeutic techniques (e.g., cognitive, interpersonal therapies) have inappropriately denied the inherent ethical character of emotional regulation and their role in day to day life. "What has been lost" Charland (2009a, p. 64) wrote, "is how affective states … actually function in daily life, where they are invariably associated with the normative ethical questions and assumptions." Dominant perspectives dictate that mental health intervention be stripped of moral content:

> Therapists talk to their patients about their emotions using words devoid of any evaluative content or normative force; patients usually respond accordingly, using the same hollow shells. This is now a domain where it is important to be clinical and objective; where the decisions of the patient must be respected as a fundamental right of autonomy; and where the psychotherapist is neither trained nor sanctioned to give moral advice or criticism. No wonder it often feels so pointless; there neither is nor can there be any real goal, ethically. How you ultimately should live does not enter into such discussions (Charland 2009a, p. 65).

It seems that some argue that effective treatment might require a focus on meaning and even morality. To be worthwhile therapy *must* be made meaningful in this larger sense.

As is indicated above, some occupational therapists also believe that successful intervention requires one to consider issues that relate to authenticity. I also exist, was educated, and practiced mental health occupational therapy in a Canadian context and as such examined different versions of the Canadian Practice Model. Within Canada, at least, in the conceptualization of occupational problems and solutions, issues of authenticity structure the core of clinical analysis. Questions that relate to meaning and spirituality organize the intervention process. In the subsections that follow, I critically review the literature that relates to the Canadian Model and, more specifically and thoroughly, spirituality in occupational therapy. To complement and broaden this analysis I also critically review a sampling of material that focuses on identifying values that guide practice.

6.1 Spirituality & Technologies of Self Formation in Occupational Therapy

Over the past 20 years a growing body of literature on spirituality has appeared within occupational therapy. This focus on spirituality seems to relate to what Healy (1990) referred to when he discussed authenticity. For example, Beagan and Kumas-Tan (2005) found that some occupational therapists working with clients on even the most concrete tasks like transfers take the time to uncover a client's values and what is, generally speaking, important and meaningful to them in the context of their life. This is done in order to contextualize intervention within broader life purposes and meanings. Wilding, May, and Muir-Cochrane (2005, p. 7) suggested that "in order to facilitate our clients to engage in meaningful doing, we need to help them first connect to their sense of their spiritual selves." Christiansen (1997, p. 171) implied that occupational therapists could become "custodians of meaning" and explained:

> By failing to acknowledge a spiritual dimension, occupational therapy practitioners lose important opportunities for understanding the full potential of occupation to enhance the health and well-being of clients. Denial of a spiritual dimension fragments our understanding of humans as occupational and spiritual beings and thereby does not reflect holistic practice.

Similarly, Hume (1999, pp. 368-369) urged therapists to "consider individual values, expectations and wishes. The sense of hope, meaning and purpose that the person has" (see also Luboshitzky & Bennett Gaber, 2001). To do otherwise, Hume (1999) argued, would be tantamount to neglecting the totality of a client's needs. The topic of spirituality within occupational therapy covers a range of concepts and ideas that relate to value, life's meaning, and its ultimate purposes. Indeed authors have pointed to the multiple and conflicting ideas that exist in this literature (Hammell, 2001). Drawing on literature both within and outside of occupational therapy, McColl (2003b) identified a variety of ideas, concepts, and relationships that relate to spirituality and have been connected to health in some way. Some of these include: courage, enthusiasm, hope, creativity, belonging, transcendence, purpose, mission, meaning, sacredness of life, awareness, unity, altruism, honoring the self, connecting with others, acquiring grace, transcending the self, celebrating life, adherence to a set of ethical principles, and bonds with others and a god.

In the following sub-sections, spirituality is discussed in relation to the Canadian Model of Occupational Performance. Discussions related to definitions of spirituality are

critically examined in an attempt to identify the transforming ways in which spirituality has been conceptualized in present times. Subsequently, some values that purportedly guide occupational therapy practice are presented. This discussion emphasizes the directional character of these values and relates them specifically to client-centered practice in Canada. In addition to client-centered technologies, the final sub-section presents a variety of treatment technologies that have been discussed in the occupational therapy literature that relate to spirituality. This discussion is critical in nature and is aimed toward the demarcation of limits beyond which occupational therapists risk jeopardizing the wellbeing of the clients and communities that seek professional attention (see Foucault 1968/1991a).

With some of his work Foucault (1966/2005c, p. xii) created an "open site" where questions could be asked, historical artifacts could be gathered, and consciousness encouraged. Foucault's works were neither total condemnations nor celebrations of what was uncovered. Similarly in the paragraphs that follow, and in the proceeding chapters, I present, in a critical way, some of the historical evidence that I have gathered. For the most part, I leave it to the reader to make decisions about the appropriateness of the practices that are presented and to determine if and how these practices should continue to be used. Readers are encouraged to compare what they find here to what was outlined in the sections that preceded this one. How do the technologies described work to construct particular human kinds? How do these human kinds correspond to a particular value system? What connections, can be made between these technologies and those that were employed in the 19th century? In the end occupational therapists will have to determine the appropriateness of each technology presented here. It is hoped that within the preceding sections and in the sections that follow I am successful in creating a space a dispersion that will assist occupational therapists in making these determinations.

6.1.1 The Canadian Model of Occupational Performance and Spirituality

A contemporary interest in matters related to spirituality in occupational therapy is commonly said to have appeared in Canada beginning in the 1980s. At that time, Canadian occupational therapy leaders highlighted the importance of harnessing 'spiritual dimensions' when working with clients. For example, intervention guidelines published

in 1986 feature a consideration of spirituality. Canadian occupational therapists were directed to uncover how spiritual imbalance impacted health and occupation: "the therapist must come to understand and accept what is at the centre of the client's being (spirit) in order to develop a therapeutic relationship, examine motivation and finally engage the client in therapeutic activity" (CAOT, 1986, p. 13). In these guidelines, therapists are challenged to explore the following themes with clients: "meaning and purpose of life; suffering and tragedy; self-esteem and personal dignity; guilt and forgiveness; healing and inner peace; joy and celebration; freedom, responsibility and personal courage; loneliness and the need for affection, intimacy and community" (CAOT, 1986, p. 14). Therapists are directed to begin discussion by asking clients the question: "What sense do you make of your life?" (CAOT, 1986, p. 14).

The Canadian Association of Occupational Therapists (CAOT) has maintained an interest in spirituality (Sumsion, 1999). Current CAOT guidelines continue to highlight the spiritual dimensions of occupational performance and engagement. Indeed the most recent edition of the Canadian guidelines published in 2007 features the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko et al., 2007a). This model represents an attempt to depict the various components of occupational performance, engagement, and their interrelationships. According to this model, engagement in, and performance of occupation, results from a dynamic but interdependent relationship between the occupations being performed, the person performing occupations, and the environment in which performance occurs (Law, Polatajko, Baptiste, & Townsend, 1997; Polatajko et al., 2007a). Within this model, 'occupation' is defined as "an activity or set of activities that is performed with some consistency and regularity, that brings structure, and is given value and meaning by individuals and a culture" (Polatajko et al., 2007a, p. 19). Even without further analysis, one can identify concerns that might be related to questions of authenticity in that occupations are imbued with value and meaning. Reading further, one learns that "occupation is a very personal thing; occupations are idiosyncratic" (Polatajko, et al., 2007a, p. 22). In outlining some factors involved in occupational performance and engagement, one is directed to consider, cognitive, affective, and physical components as being bound by a particular spirituality found at the core of the individual. In other

words, one is directed to consider how an individual's 'spiritual centre' influences how occupation performance and engagement occurs or might occur. Spirituality within the Canadian model has been defined as the "central core, essence of the self … our truest self … the manifestation of a higher self, a spiritual direction or greater purpose" (Law et al., 1997, p. 42). While spirituality has always been featured in the Canadian Model, it has not always been placed at the center of the Canadian Model. Since its first appearance in 1983, the model went through a series of transformations (see Hammell, 2001; Law et al., 1997).

For example, after reviewing literature and reflecting on a variety of clinical vignettes, Egan and Delaat (1994) proposed a change to the Canadian Model. Their proposal would mean that 'spirituality,' or one's 'spirit,' would take on a more prominent place. These authors proposed that spirituality become the defining core of the person and a person's occupational performance. Egan and Delaat (1994) argued that "an individual's spirit is the true essence of that person" (p. 96). In the early 1990s, these authors defined 'spirit' as "our truest selves which we attempt to express in all of our actions" (p. 96). According to these authors, in attending to the 'true self' and the values and feelings that define it, one is able to establish a "larger meaning or greater purpose in life" (p. 97). Spirit defined an individual and their occupational potential. Spirit was also described as being a part of something beyond the individual and connected to something universal and immutable. The spirit at a person's core could be blocked, but remained intact despite illness or injury. According to these authors, spirit gives an individual intrinsic worth and is expressed through an individual's occupational performance in work, self-care, and leisure:

> In our conceptualization of the model, the individual's spirit is not a single component of his or her being. The individual's spirit is, in fact, the individual. At the core of each person is a being, a spirit, which is an integral part of the universe and exists and remains whole despite injury or illness. Because everyone has such a spirit, every individual has intrinsic worth … Each individual's spirit is expressed through his or her engagement in everyday life, that is, his or her occupational performance in work, self-care and leisure … The spirit is seen as the essence of the person. In this way the spirit cannot be made more healthy. It can only be allowed greater freedom through a strengthening of or adjustment to the tools which it uses to express itself. (Egan & Delaat, 1994, pp. 100-101)

This depiction is reminiscent of ideas that revolved around the moral treatment that was conducted at The Quaker Retreat in England in the 19th century.[10] As Charland (2007) pointed out, treatment at The Retreat was intended to "awaken social and benevolent feelings" (Tuke, 1813, p. 96) and "assist nature in her own cure" (Tuke, 1813, p. 216-217). Kind treatment at the Retreat was intended to foster the conditions necessary to allow the 'inner light' of each individual to shine through (Charland, 2007). It was believed that this inner light could not be extinguished by mental illness (Charland, 2007). Thus this 'inner light' was connected to something more than human in that it could not decay or erode. Moral treatment worked to nurture and awaken this inner light (Charland, 2007). Digby (1985) explained that those working at the Retreat were thus seen as instruments of God's will. It is those that understood "the religion of the heart" (Tuke, 1841 as cited in Digby, 1985, p. 27) that made the best healers.[11] As Charland (2007) explained, "according to the Quakers, the mad may have lost their minds, but not their hearts" (p. 68).

These similarities are striking and a cause for concern. The Canadian Model, in its various guises, has been associated with a kind of client-centered practice that purports to promote non-judgment and respect for the values of each individual client.[12] It may be, however, that the assumptions on which the model rests, particularly in relation to spirituality, are locked into a particular axiological tradition (see also Iwama 2006; Molke & Laliberte Rudman 2009). In waiting for, or helping an individual to connect to their universal or immutable true essence, spiritual centre, spirit, or self, do occupational therapists hope to harness what the Quaker's believed was at the core of each person? If it is believed that this spiritual core defines and connects the individual to something universal and overarching (e.g., Egan & Delaat 1997; Hammel, 2001; McColl 2000) then it behooves us to attempt to articulate what our conceptions of spirituality point toward (see also Sharrott, 1986).

---

[10] See also Kang (2002, p. 98) for a discussion of the concept of 'centredness' which refers to "an inner stability based on knowing and recognizing that which lies at the core of one's being … For some, this inner centre is perceived in religious terms, e.g., the divine spark or soul within oneself; for others, it is a sense of silent clarity at the core of being." Howard and Howard (1997) discuss the divine image of God which exists within the individual. For these authors too, spirituality "provides the center, or life force, that causes us to act" (p. 183).

[11] See also Peloquin (1997).

[12] But see also Townsend (2002).

6.1.2 Defining spirit in occupational therapy.

It seems that no article or chapter on spirituality published in the occupational therapy literature is complete without some discussion of the need for a definition. For example, Bursell and Mayers (2010) argued that continued use of multiple definitions of spirituality provided by individual patients will cause professional confusion and insecurity. These authors proposed a ubiquitous definition with universal applicability. Urbanowski and Vargo (1994) also acknowledged that working with spirituality in clinical practice poses certain difficulties. These authors called for an "explicit, concise definition of spirituality that can be operationalized by the occupational therapist" (p. 89). Urbanowski and Vargo (1994) argued that if the profession of occupational therapy could not validate spirituality empirically then its existence should be questioned. Occupational therapists take on the task of gathering the definitive proof that a spiritual dimension exists; the concrete evidence that will prove that there is some merit in working with this component of existence. More than this, occupational therapists are charged with the task of defining what spirituality is and delineating a specific process through which work on an individual's spirit can occur. The Spirit, once defined and captured by the tools of the scientific method, can be controlled by the application of professional skill and expertise. Indeed this mission is reminiscent of Pinel's (1809/2008) quest to define a universal ethic that would guide the moral treatment process (see chapter five).

Kroeker (1997, 2003), a theologian contributing to the occupational therapy literature, carefully explained that while he could not supply a definition of spirituality for occupational therapists, he could outline some assumptions about the 'mind-body-spirit complex.' Kroeker (1997, 2003) discussed the rise of scientific and technological truth systems and the simultaneous decline of religious cosmology. Indeed this shift, that Kroeker (1997; 2003) described, can be linked to the differences discussed above in relation to the moral treatment of Pinel and Tuke. The universe, our world, and individual lives are now explained using truth systems defined by a scientific world view. According to Kroeker (1997), "our scientific representations of reality have emptied the cosmos of inner moral or spiritual meaning, of divine purpose and personality" (p. 124). McColl (2000) outlined this shift in thinking in more detail by systematically articulating some of the intellectual movements associated with it, their causes, and effects. Table 3

presents McColl's (2000) observations verbatim. Within the domain of spirituality, one can clearly see tensions that exist between an old way of thinking and a new way of thinking. This attempt to grapple with spirituality has moved many outside the bounds traditionally considered the realm of science. In an effort to be holistic (see Urbanowski & Vargo, 1994), some occupational therapists have made a continuing attempt to focus on spirituality.

Table 3: Some Paradigm shifts related to Spirituality in Modernity

- religion has been shifted from a public to a private focus (privatization);
- science has displaced religion as the source of ultimate answers (rationalism);
- confidence in human beings has surpassed confidence in a supreme being in many instances (humanism);
- the focus on individual rights has overtaken the focus on community responsibilities (individualism);
- waves of immigration have created a heterogeneous, multi-ethnic North American society (pluralism); and
- we have become increasingly tolerant of differences, including religious differences (liberalism)

Note: The contents of this table were taken from McColl (2000, p. 218)

McColl (2000, p. 218), for example, implied that a professional focus on spirituality should include considerations of "mysterious, sacred, supernatural content." She defines spirituality as "sensitivity to the presence of spirit" (McColl, 2000, p. 218) and effectively describes a concept that includes something beyond the physical, affective, and mental realms. McColl (2000) challenged the shift in thinking that has occurred in modernity towards secular and scientific worldviews by defining spirituality in a particular way. Yet, curiously, this author remained caught within the imperatives of a scientific and technical mindset. Spirituality, once defined, must be operated on by professionals. Indeed, elsewhere McColl (2003a) argued that occupational therapists must have two different kinds of knowledge about spirituality: theoretical and practical. This is because occupational therapists need to define and understand spirituality and also know how to work with it. For example, McColl (2003b) explained that, ultimately, the

goal would be to have agreement in terms of a definition; however, it was thought that the area of spirituality was "not yet sufficiently well developed to be able to do that" (p. 8). The work of science remains undone. Spirituality remains something that eludes the normalizing function of the scientific gaze, but not for long. The topic of spirituality creates an intellectual site where things are uncertain. Yet academics working in occupational therapy continue in their attempt to capture the human spirit in empirical nets, employing carefully worded definitions and concepts.[13] In modernity, theologians defer to health professionals who are guided by the scientific method even as they critique technological reasoning.

Kroeker (1997) explained that the actions of individuals have not been emptied of meaning. In fact spirituality, or the spirit, it seems, has retreated from the world and now resides within individual experience: "Human beings alone have spiritual meaning and purpose" (p. 124). With the rise of modern thought the meaning of what 'soul' entails changed: "from the spiritual principle of life and action present throughout the cosmos in relation to which each part finds its real meaning, it becomes the principle of purely individual subjectivity" (Kroeker, 1997, p. 124). Spirit, residing now solely inside the individual, is not safe from the scientific gaze. Kroeker (1997) argued that, in modernity, even the destinies of individuals come under the purview of scientific reasoning and technological control. The quest for a definitive definition of spirituality, or spirit, in occupational therapy blends two ways of understanding. One relates to the finite, the other the transcendent. For many in modernity, spirituality has lost meaning precisely because it cannot be defined concretely. On the other hand, concepts like subjectivity, individuality, and identity have become more important despite similar definitional difficulties.[14] These concepts, like spirituality, are ambiguous ones that have the potential to cause conflict. Kroeker (1997, p. 124) argued:

> The life of the spirit and the meaning of the good is increasingly seen as the product of individual human imaginations, and eventually, in modern liberalism, as mere value preferences that gain public legitimacy only through the external

[13] However, Townsend, De Laat, Egan, Thibeault, & Wright (1999, p. 3) argued that "Diverse spiritual expressions and meanings are culturally and ethically grounded in different value systems so there is no single definition of experience which can be named 'spirituality.'"
[14] See also Townsend (2002).

> power struggle of interest groups seeking control over policy instruments and outcomes.

Concepts related to individuality, subjectivity, and identity are elusive without external referents. Their 'truth' is not obvious. Yet they hold truth value within modern contexts.

Unruh et al., (2002, p. 7) asked: "Is spirituality the essence of the self and the central core of occupational performance?" Unruh et al., (2002, p. 11) contended: "As a subjective and personal construct, inevitably spirituality must mean what it means to the individual within her or his experience." At the risk of jettisoning considerations of 'good science' entirely these authors argued: "Whether the profession, or the occupational therapist, has a conceptual preference for a secular, sacred, or religious framework of spirituality in response to spiritual questioning is secondary" (p. 11). Here the issues revolving around spirituality are no longer solved with scientific reasoning. The problem of spirituality is solved by recourse to the values and philosophical assumptions that drive the profession: "A client-centered approach is key to ensure that the spirituality of the client is understood from the client's rather than the occupational therapist's perspective" (Unruh et al., 2002, p. 11). These authors suggested that the Canadian Model, which at that time outlined a theory of occupational performance, should place at its core the concept of occupational identity rather than spirituality. In other words, these authors seemed to argue that the model should reflect the beliefs and conceptual preferences of occupational therapists. These authors made an appeal to place the concept of 'occupational identity' at the core of the Canadian Model. Within this new conceptualization spirituality would play a part, but be relegated to the sidelines and become a performance component: "Applied to the Canadian Model of Occupational Performance, occupational identity could be conceptualized as the expression of the physical, affective, cognitive, and spiritual aspects of human nature." Occupational identity would become the essence of the self and define the individual.

Hammell (2001; 2003) traced the history of the concept of spirituality as it has appeared within the various conceptualizations of the Canadian model. Like others, this author argued that occupational therapists should settle on a single unambiguous understanding of spirituality that reflects the values and assumptions that undergird the profession. Hammell (2001; 2003) argued that the definition of spirituality advanced by

CAOT in practice guidelines published in 1997 combined contradictory notions not reflective of universal experience. In 1997 CAOT defined spirituality as:

> A pervasive life force, manifestation of a higher self, source of will and self-determination, and a sense of meaning, purpose and connectedness that people experience in the context of their environment.(CAOT, 1997, p. 182)

Hammell (2001; 2003) argued that spirituality could not be both a pervasive life force and connect to various ideas about spirituality that were also espoused by the 1997 document relating to the essence of self, the quality of being human, drive, will, motivation, personal control, and choice (see Law et al., 1997, p. 43). Hammell (2001, p. 193) believed that in being a 'pervasive life force' spirituality could not also relate to "a system of personal meaning intrinsic to the individual." Put slightly differently, Hammell (2003, p. 70) claimed that the CAOT combined notions of "pervasive life-force" with a "personal experience of meaning in everyday life," and argued that "spirituality is proposed as both an *experience*; and a *force* that, in and of itself, *gives* meaning to life." Hammell (2003) believed that this constituted not one definition but two.

Hammell's (2001; 2003) close examinations of these definitions of spirituality reveal more clearly the shift occurring in modern times. Just as Kroeker (1997; 2003) explained, meaning becomes invested more heavily in subjectivity in modernity. On rereading CAOT's 1997 definition of spirituality in light of Kroeker's commentary, one begins to see, not a contradiction, but the nature of a transformation. Within CAOT's 1997 understanding of spirituality, the essence of the self is a pervasive life force; however, this 'essence' is secular in nature. The contradiction that Hammell grapples with might relate to ideas that some believe have gone out of fashion. For many in modernity, what drives experience does not originate in something beyond the finite realm, but exists within this world. What fuels life relates more to the self than a divine spark. As Kroeker (1997; 2003) explained, spiritual experience has become a very individual thing. Notions of what makes one an individual are said to pervade, or fuel, all aspects of one's existence.

Hammell (2001; 2003) asserted that the term 'spirituality' should be replaced by the term 'intrinsicality.' According to Hammell (2001, p. 190), intrinsicality refers to "a personal philosophy of meaning that informs life choices and life satisfaction." This

author identified another definition of intrinsicality based on consultation with several dictionaries: "genuine, inherent, belong to a person's basic nature and of, or relating to the essential nature of a thing" (p. 191). Further, she proposed that intrinsicality also:

> relates to the thoughts, feelings and actions concerning the meaning we perceive in our daily lives. Thus, intrinsicality refers to an expression of self, volition, self-determination, autonomy, choice and meaning. It is the intrinsic values and beliefs about ourselves and our lives that are unique to the individual and formed in dynamic interaction between the person and his or her environment context, informing and guiding choices, plans and interpretations of life events. Embedded within all aspects of person/environment interactions, intrinsically is a central dimension of the self, is shaped by the environment and gives meaning to the occupations of everyday life. (p. 191)

Intrinsicality is the "intrinsic source of meaning … constitutes the essences of the self" (p. 193). If this proposal were to be accepted the transformation would be complete. The concept of spirituality would be cast aside and the modern concept intrinsicality would take its place. Intrinsicality defines the essence of the self which interprets experience and fuels volitions. Some might argue that intrinsicality is no less confusing or complex than the concept it would replace, but this confusion would be hidden in something more familiar. Intrinsicality is something big but it reflects modern values and better resonates with present truths. Christiansen (1999) is credited by some (e.g., Griffith, Caron, Desrosiers, Thibeault, 2007; Unruh, Versnel & Kerr, 2002) with reorienting occupational therapy's concern with spirituality. Christiansen (1999, pp. 592-593) concluded in the final paragraph of his Eleanor Clark Slagle Lecture:

> Biomedicine will experience many great advances in the years ahead. But no genetic code, no chemical intervention, and no microsurgical technology will be invented to repair broken identities and the assault on meaning that accompanies them. Because of this, the new millennium will realize the health-enabling, restorative potential of occupation, and the promise of occupational therapy will be fulfilled.

Occupation will restore 'broken identities.' Identity is a concept kept away from biology and medicine. It is safely hidden from the clutches of biomedical technology. It is not, however, safe from another kind of technology. An avenue is found that affords occupation access to the realm of meaning without recourse to the uncertain domain of spirituality. While research evidence has consistently shown that occupational therapists are uncomfortable employing concepts and tools associated with spirituality in practice

(e.g., Belcham, 2004; Collins, Paul, West-Frasier, 2001; Engquist, Short-DeGraff, Gliner & Oltjenbruns, 1997; Farrar, 2001; Hoyland & Mayers, 2005; Johnston & Mayers, 2005; Rose, 1999; Taylor, Mitchell, Kenan & Tacker, 2000), in working with 'identity,' it seems that occupational therapists have found alternative ways to deal with issues that relate to authenticity.

6.1.3 Values in occupational therapy.

Law et al. (1997, p. 42) argued that recognizing the spiritual dimension of each individual requires the occupational therapist to "respect their beliefs, values and goals, regardless of ability, age or other characteristics" (Law et al. 1997, p. 42). What are some of these beliefs and values and how do the values of occupational therapists relate to this process? Bockoven (1968, p. 23) argued that occupational therapists, as social agents, had a moral obligation and responsibility "to any individual whose future is in serious jeopardy as a member of society." It has also been argued, that on the most fundamental of levels, practice in occupational therapy should necessarily focus on occupation (Wilding & Whiteford, 2009). Clearly then, the practice of occupational therapy is driven by particular mandates. However, in different times and places, these mandates have been associated with different concepts, values, and assumptions. For example, in Canada in 2007, occupational therapy was described as the art and science of "enabling engagement … of enabling people to perform … of enabling a just and inclusive society" (Townsend & Polatajko, 2007a, p. 2). Occupations that have meaning and everyday occupational routines are targeted for intervention. The Canadian perspective highlights ''engagement,' 'performance,' and 'justice.' Outcomes focus on "everyday living … health and wellbeing … participation," and "potential" (Townsend & Polatajko, 2007, p. 2). Others working in alternative locations, and at different times, have emphasized different organizational concepts (see also Breines, 1995). For example, Mocellin (1988, 1992) highlighted 'occupational competence.' Occupational therapists concerned with competence work with individuals to develop skills to carry out tasks with functional adequacy to achieve a particular potential (Mocellin, 1988, 1992). Each framework has a slightly different theoretical focus. However, the foundation for both is an "occupational perspective" (Townsend & Polatajko, 2007, p. 2). Indeed, even in the early 20th century,

different ideas revolved around occupation treatment. For example, for Hall and Buck (1915) outcomes related predominately to 'efficiency;' Dunton (1919) described more varied outcomes, but spent a great deal of time discussing the concept of 'attention.'

Different ideas about occupation are rooted in different philosophical and causal assumptions that drive thinking about the nature of occupational therapy work in different contextual locations (Breines, 1995; Schemm, 1994; see also Mosey, 1981). According to the Canadian guidelines published in 1986, "professional competence (technical and ethical) is achieved through socialization within the profession or assimilation of the value system of the profession by contact with its members" (CAOT, 1986, p. 22). Socialization ensures that professionals adopt a particular value system and peers work to ensure that the particular values, once adopted, are adhered to: "Whenever an occupational therapist becomes aware of a breach in professionalism by a fellow therapist, tactful and appropriate action should be taken to put an end to it" (CAOT, 1986, p. 23). Socialization through education embeds the professional norms, ideals, and ideas within therapists and the watchful eye of peers prevent deviation from these norms. As is indicated above, surveillance also functioned to control the conduct of patients and the employees in the asylums of the 19th century. Some of the values that were thought to be important in 1986 are presented in Table 4. In 1986 CAOT values were simply stated and involved love and compassion, respect, honesty, wisdom, and humility. Value statements at this time did not delineate beliefs about cause and effect relating to occupation, for example. They outlined the virtues and character qualities to which the practicing occupational therapist should conform themselves; they defined the structure of a belief system and the nature of good professional conduct. In addition, these values outlined assumptions about the nature of human beings generally and connected them to political ideas. For example, respect for human beings involved an emphasis on a 'democratic and universalistic approach.' This approach highlighted 'human dignity, uniqueness of the individual and fundamental rights.'

Mocellin (1992) claimed that the fundamental beliefs of occupational therapists are based more on social sentiment than good science. One definition of the term belief in the Oxford dictionary states that a belief is the "mental acceptance of a statement, fact, doctrine, or thing" (Brown, 1993, p. 209). Particular statements and ideas have continued

to maintain validity within the profession, but this validity, according to Mocellin (1992, 1995), rests on historical legitimacy (see also Hammell, 2009; Kelly & McFarlane, 2007). Mocellin (1995, p. 502) argued that "subscribing rigidly to certain beliefs about

Table 4: CAOT Values in 1986

Occupational therapists place a high value on:

- A capacity for brotherly love expressed by a genuine desire to help;
- A democratic and universalistic approach reflected in a feeling of respect for human dignity, uniqueness of the individual and fundamental rights;
- A capacity to express compassion, caring and empathy;
- Truthfulness;
- Objectivity based on sound judgment;
- Humility in decision making.

Note: Taken from CAOT (1986, p. 22).

occupational therapy might be counterproductive in achieving desired professional solutions, particularly because clinical practice based on these beliefs often lacks scientific credence." Many efforts have been undertaken by those associated with the profession to collect the contemporary forms of evidence supporting an 'occupational perspective.' As we have seen above, one of the most important efforts in this regard has been the creation of 'occupational science' (see Yerxa, Clark, Frank, Jackson, Parham, Pierce, et al., 1990). For example, occupational therapists working with the discipline of occupational science have worked hard to explore and explicate links between occupation and health (e.g., Wilcock, 2006). Thus occupational therapists have made attempts to gather the evidence needed to support one of the central beliefs that drive the work they do with clients. However, as we have seen in this section, this is not the only assumption driving practice. Moreover, while efforts to gather evidence in support of the profession's beliefs and practices are laudable, for better or worse, occupational science was not created to scrutinize and question the core assumptions that provide a foundation for the profession (see Molke, Laliberte Rudman & Polatajko, 2004). In fact, as we have seen in chapter four, occupational science was initially envisioned as a discipline that would, in part, provide evidence in support of particular ideas that can be traced back to the moral treatment era. Scientific investigation would focus on collecting evidence that further established the link between occupation and health. Occupational science would focus on

issues related to the elemental routines normally adhered to within a particular culture. And, most importantly, occupational science would be a discipline that allowed occupational therapists to legitimately infuse these beliefs into health care. Mocellin (1995) explained that this kind of investigation was insufficient and called for critical engagement with the professions core beliefs through rigorous examination. As has been argued above, scientific methods alone cannot outline the ends to which occupational therapy work should aim. In fact, as has been shown, social sentiment does play a role in determining the mandates of the profession. This reality necessitates an examination of the values and sentiments that guide the profession. Indeed at the tail end of the 20th century occupational therapy scholars, like Mocellin, began to scrutinize the assumptions that underlie the profession.

Canadian occupational therapists are not unique in their attempt to systematically articulate occupational therapy beliefs and values. Occupational therapists operating in alternative locations have also made efforts to outline the philosophical values and assumptions that underlie practice (e.g., American Occupational Therapy Association [AOTA], 1993). These articulations of occupational therapy values have afforded those interested, with an opportunity to carefully examine, make comparisons, and highlight potential difficulties related to particular ways of valuing (e.g., Hocking & Whiteford, 1995; Peloquin, 2007 see also Hammell 2009; Owen, 1968). As Hocking and Whiteford (1995) argued, values articulated within a particular context can potentially conflict with values in alternative contexts or even within a context that supports divergent views and cultural realities. Hocking and Whiteford (1995) believed that multiculturalism would challenge the values that provided a foundation for occupational therapy practice. The AOTA (1993) outlined seven values: altruism, equality, freedom, justice, dignity, truth, and prudence. Hocking and Whiteford (1995, p. 173) questioned the universal bases of these values:

> Equality and freedom, for example, are conceptualized in the AOTA statement in terms of respect for individuals; individual rights and opportunities, and individual freedom and choice (AOTA, 1993). Individuality is clearly a Western notion, not a universal truth. In groups where identity is collectively determined through relationships to kin, the extended socio-cultural group and the land, individuality is not a meaningful concept. A quest for individual freedom may be perceived as impeding the attainment of collective goals or being contrary to the

> common good. Along with equality and freedom, occupational therapists will be challenged to re-evaluate notions of independence, self-determination and individual initiative.

Hocking and Whiteford (1995) also critically examined the values altruism, justice, dignity, truth, and prudence. For example, these authors argued that the concepts of truth and justice were defined narrowly in the AOTA statement. These definitions did not make room for alternative ideas of what truth and justice might entail. These authors asked: "If multiple, often conflicting realities are acknowledged, whose truth will be taken as the right one; whose justice … Whose moral code should be upheld when the moral code of the therapist and client differ" (Hocking & Whiteford, 1995, p. 173)?

Carefully examining AOTA (1993) core value statements revealed some additional information. Only two values relate to occupation: 'Freedom' and 'Dignity.' In the description of what freedom entails there appears a discussion of 'purposeful activity.' Freedom is actualized through purposeful activity. According to this statement, to be free one must be self-directive, take initiative, be interdependent, relate to the world, be adaptive, and establish a balance between autonomy and societal membership. Purposeful activity trains the individual to manage freedom. Purposeful activity is the mechanism whereby freedom can be obtained. This document implies that without purpose and activity one cannot be free. Dignity too, is obtained through one's ability to perform relevant activities. Dignity is "integrally linked to the person's ability" (AOTA, 1993, p. 1086). Dignity is nurtured through "a sense of competence" (AOTA, 1993, p. 1086). Self-worth in this sense is related to engagement in activity. This implies that without engagement in activity one cannot remain dignified. Thus despite statements that express the need to respect difference, value statements that discuss outcomes and make causal statements related to a therapeutic process highlight and celebrate particular values. Occupation here is linked to values that are extremely important in the Western world (i.e., Freedom & Dignity). A justification for the profession is connected to principles and ideals that are embraced by a particular segment of the world's population. This helps to ensure that the work of occupational therapists' will be valued and sought out. Within these statements, these values are not simply connected to neutral ideas about occupation. Here, statements found within value descriptions outline normative ideas that

articulate both what occupation and freedom, for example, should necessarily entail. True freedom cannot be obtained through engagement in just any occupation. AOTA (1993) value statements clearly denote how freedom is obtained through engagement in particular kinds of occupation. With a two page document, occupational therapists have established their relevance in relation to some of the values that are embraced in the West and support many of the normative expectations that structure life in the Western world.

There have been other instances of critical engagement with occupational therapy values. Yerxa (1979, p. 28) explored the axiological foundation of the profession and discussed value conflicts between values needed to work with individual clients and values needed to promote the profession and its mandates to society at large:

> The emphasis on patient self-directedness and the occupational therapist's function as a catalyst and facilitator seem to require valuing a lowkeyed, extremely sensitive occupational therapist role which rejects controlling the patient, exerting power over him or actively directing his life … In contrast, the valuing of creating positive social change, improving the status and image of the profession, needing to be proactive, autonomous, and powerful seems to require a self-directed, confident and highly visible occupational therapist role, one which embraces controlling and directing others and actively seeks power.

Yerxa (1979) argued that occupational therapy students should be educated to comfortably use different sets of values interchangeably in accordance with the demands of each individual situation. Yet, Yerxa (1979, p. 28) also argued that value conflicts like these create "considerable ambivalence, frustration and professional schizophrenia." How therapists are to resolve value conflicts, avoid these consequences, or recognize when one set of values is required and not the other, is not made clear in this particular article.

Elsewhere, Yerxa (1980) compared the values that she argues traditionally underlay occupational therapy and medicine. Yerxa (1980, p. 154) explained that the values of the two professions differed as a result of their different roles. While the physician's task was to "ward off the fear of death" and provide a cure, the occupational therapist was concerned with "reducing incapacity," and working with individuals with severe, chronic, and lifelong disability for whom there was no cure. Yerxa (1980, p. 153) argued that:

> The physician values freedom from disease, conferring of the sick role, control and direction of the patient, and an expectation that the patient conform to a treatment regimen designed to reduce pathology. The physician's superior

> knowledge, ethical principles, and healing skills are the sources of power supporting these values which are in effect as long as the patient is sick.

According to Yerxa (1980), the occupational therapist, on the other hand, placed importance on the:

> essential humanity of patients and their right to life satisfaction; concern with health and enhancement of the healthy aspects of the person; fostering patients' self directedness and ability to take responsibility for their lives; employing a generalist rather than a specialist perspective; fostering a therapeutic relationship based on mutual cooperation; viewing the patient as one who acts on the environment rather than being determined by it; having optimistic faith in each patient's potential; encouraging patient productivity and participation; recognizing the healthfulness of play, leisure activities, and a balanced life; and seeking to understand the subjective perspectives as well as objective characteristics of patients and their worlds. (Yerxa, 1980, 152-153)

The potential conflict identified between a desire to facilitate and remain sensitive to the needs of individuals and promote the value of this perspective has been resolved for this author. According to this author, occupational therapists must learn to advocate forcefully for themselves and their beliefs; occupational therapists must reject modesty when discussing what they believe works with clients and what defines their unique professional qualities. Yerxa (1980, p. 157) claimed that the values that historically guided occupational therapy practice have remained intact due to the audacity of occupational therapists:

> In many respects this persistence of professional values and a singular philosophy, in the midst of conflicting ideals and philosophies has been intrepidly daring. One wonders what might have happened to all of those who had tuberculosis, poliomyelitis, schizophrenia, cerebral palsy, or spinal cord injuries had it not been for the occupational therapy value system and its translation into practice designed to help develop life satisfaction, meaning, and autonomy for disabled persons.

Occupational therapists can no longer remain humble about their methods, even if these methods are driven by humility. Peloquin (2007) called this courage and related it to sentiments that existed in the first half of the 20th century. It seems that, at the tail end of the 20th century, occupational therapists advocated for their beliefs with vigor and would not be dissuaded by alternative perspectives that called these beliefs into question.

Kielhofner (1997) also outlined five value themes that he believed made up the occupational therapy perspective. These include: 'Client-Centered Practice,' 'Occupation,' Value of the Patient's/Client's Perspective,' 'Active Engagement and Empowerment,' and 'Balancing Art and Science.' Within this value system it seems that 'Occupation' is the vehicle through which transformation occurs; the theme 'Art and Science' defines a process of transformation, outcomes of transformation, and the nature of practice. 'Client-Centered Practice,' Value of the Patient's/Client's Perspective', and 'Active Engagement and Empowerment' define the process of change, the virtues that the therapist must possess, and the values that define individual human potential.

For example, here occupation has intrinsic and central value in 'good' human life. Occupations allow one to participate in human life and function to develop human potential through the exercise of "self-direction, initiative, interdependence, and relatedness" (Kielhofner, 1997, p. 89). Within this understanding, occupation has transformative potential. 'Occupation' allows one to live well, integrate into society, access the social aesthetic, and feel human. Here too, the beliefs that support 'Client-Centered Practice' suggest that while all humans have dignity, superior individuals have enhanced levels of competence and have in some way actualized their potential. Within this value theme, the occupational therapist is directed to conform themselves to the virtue of altruism and develop empathetic capabilities. 'Valuing of the Client's Perspectives' highlights respect. While Kielhofner (1997, p. 86) argued that this promotes a "non-normative" outlook, he also indicated that this perspective underlines the importance of subjective understandings and supports "a commitment to the patient's right to make choices and exercise decisions." For example, Kielhofner (1997) explained that when independence and self-determination are not valued by an individual, a value compromise might occur. For instance, if independence is not valued by an older adult the occupational therapist might negotiate with the individual to allow "respect to be maintained while the elderly person takes somewhat more responsibility for his own care." How this constitutes a compromise remains unclear. 'Balancing Art and Science' defines a process of transformation through occupation:

> Cultural practices, craft, celebration, art, music, everyday intimate acts of self-care, and work are among the types of occupations into which therapists invite patients. Bringing persons into the presence of those practices that constitute the

> fabric of everyday life requires a special care. Bateson once characterized the practice of occupational therapy through the metaphor of sacramental transformation, that is, an inner change wrought by participation in an outward act. He went on to remind therapists that the inner transformation of the patient would depend to a large extent on the therapists' reverence for the activities into which patients were led. (Kielhofner, 1997, p. 88)

It is everyday occupations that have importance. As well, those occupations that are extremely intimate, have cultural meaning, or involve some kind of artistic expression are encouraged. Religious undertones seep in. The process of therapy involves inner transformation. Particular kinds of occupation will bring about and sanctify transformation. However, only those therapists that revere occupation will witness a change; the therapist must embrace these beliefs or occupation will hold no power. The individual receiving the sacrament will undoubtedly become self-directed, possess enhanced competence, actively participate in the good life, take initiative, and achieve their potential (see also Molke & Laliberte Rudman, 2009). Once again professional work is tied to particular normative beliefs in regards to occupation. If these values and beliefs are rigidly adhered to, one can see where, in some cases, an 'audacious' attitude might lead to questionable kinds of practice.

Over the years the CAOT has continued to offer articulations of the values and beliefs that guide practice. Tables 5 and 6 outline the values and beliefs espoused by the CAOT in 1997 and 2007. A Significant change in terms of the number of beliefs supported by the CAOT between 1986 and 1997 is clearly apparent. Beliefs about the

Table 5: CAOT Values and Beliefs in 1997

About Occupation:

- Occupation gives meaning to life;
- Occupation is an important determinant of health and wellbeing;
- Occupation organizes behaviour;
- Occupation develops and changes over a lifetime;
- Occupation shapes and is shaped by environments;
- Occupation has therapeutic **effectiveness**.

About the person:

- Humans are occupational beings;
- Every person is unique;
- Every person has intrinsic dignity and worth;
- Every person can make choices about life;
- Every person has some capacity for self-determination;

- Every person has some ability to participate in occupations;
- Every person has some potential to change;
- Persons are social and spiritual beings;
- Persons have diverse abilities for participating in occupations;
- Persons shape and are shaped by their environments.

About the environment:

- Environment **is a broad term** including cultural, institutional, physical and social components
- Performance, organization, choice and satisfaction in occupations are **determined** by the relationship between persons and their environment

About health:

- Health is more than the absence of disease
- Health is strongly influenced by having choice and control in everyday occupations
- Health has personal dimensions associated with spiritual meaning and **life** satisfaction in occupations and social dimensions associated with fairness and equal opportunity in occupations

About client-centred practice:

- Clients **have experience and knowledge about their** occupations
- Clients **are** active partners in the occupational therapy process
- **Risk-taking is necessary for positive change**
- **Client-centred practice in occupational therapy focuses on enabling occupation**

Note: Taken from Law et al. (1997, p. 31). Bolded text denotes words, or sentences that do not appear in CAOT's 2007 list of values and beliefs.

Table 6: CAOT Values and Beliefs in 2007

About Occupation:

- Occupation gives meaning to life;
- Occupation is an important determinant of health, well-being, **and justice**;
- Occupation organizes behaviour;
- Occupation develops and changes over a life time;
- Occupation shapes and is shaped by environments;
- Occupation has therapeutic **potential**.

About the Person:

- Humans are occupational beings;
- Every person is unique;
- Every person has intrinsic dignity and worth;
- Every person has the right to make choices about life;
- Every person has the right to self-determination;
- People have some ability to participate in occupations;
- People have some potential to change;
- People are social and spiritual beings;
- People have diverse abilities for participating in occupations;
- People shape and are shaped by their environments.

About the environment:

- The environment includes cultural, institutional, physical and social components;
- The environment **influences** choice, organization, performance, and satisfaction in occupations.

About health, well-being, and justice:

- Health is more than the absence of disease;
- Health is strongly influenced by having choice and control in everyday occupations;
- Health has personal dimensions associated with spiritual meaning and satisfaction in occupations,

and **it has** social dimensions associated with fairness and equitable opportunity in occupations;
- **Wellbeing extends beyond health to quality of life;**
- **Justice concerns are for meaningful choice and social inclusion, so that all people may participate as fully as possible in society.**

About client-centred practice:
- Clients **are experts** regarding their own occupations;
- Clients **must be** active partners in the occupational therapy process.

Note: Taken from Townsend & Polatajko, 2007p. 3-4. Bolded text denotes words, or sentences that do not appear in CAOT's 1997 list of values and beliefs.

nature of particular phenomena and their relationship to other phenomena take prominence. For example, specific beliefs about occupation, people, and the effects of environments are outlined. As well, beliefs related to the desired outcomes of health, wellbeing, and justice are outlined. Finally, beliefs about the client-centered practice process are laid out. These statements relate more to the conceptual model that is supported by the CAOT than the characters that occupational therapists should possess. They seem to suggest that education should revolve not around the construction of occupational therapist identities, or virtue, but around the internalization of particular kinds of knowledge. Relationships between concepts and knowledge about the fundamental nature of human beings take on greater importance. The 1986 guidelines did outline some of these beliefs. For example, the following statement identifies particular beliefs about a universal nature of human beings and the practice process that best suits this nature: "A democratic and universalistic approach reflected in a feeling of respect for human dignity, uniqueness of the individual and fundamental rights" (CAOT, 1986, p. 22). However, subsequent guidelines break down beliefs associated with client-centered practice and articulate the related beliefs about human beings in more detail (see Tables 5 & 6). Thus, as is discussed explicitly above, while differences are obvious, recent CAOT guidelines continue to work with early Canadian concepts.

While the values and beliefs outlined in 1997 and 2007 are almost identical, some subtle changes are also apparent. Changes between the two years have been bolded in Tables 5 and 6. In 2007, occupation's therapeutic power is downgraded from being described as 'effective' to having 'potential.' The relationship between the person and the environment no longer 'determines' organization, performance, choice, and satisfaction in occupations, it merely 'influences it.' Although these changes may seem subtle, they signify an interesting trend. Causal beliefs advanced in regard to occupation are made

more tentative. It is a kind of retreat. At the same time, statements about client-centred practice are made with more force. Occupational therapy's link to client-centred practice is emboldened. While statements regarding the nature of occupation and its relationship to the environment are softened, statements about the therapeutic process that promotes change are made more vigorous. Clients no longer simply have 'experience and knowledge,' they are 'experts.' In 1997 it is recognized that "client's *are* [emphasis added] active partners in the occupational therapy process" (Law et al., 1997, p. 31). In 2007, there is a requirement that 'clients *must* [emphasis added] be active partners in the occupational therapy process' (Townsend & Polatajko, 2007, p. 4). As well, in 2007, occupation is a determinant of justice, and justice relates to the ideals of choice, inclusion, and full participation in society. Other changes include the elimination of the recognition that risk is necessary and the assertion that occupational therapy's focus is enablement.

As with the aims and objectives of occupational science, the values that are espoused in contemporary times can be linked to values that were thought to be important during the moral treatment era. As Kielhofner (1997) pointed out, the belief in the essential worth of individuals, the right to humane care, and individual choice can be traced back to the moral treatment period (see also Bing, 1981). Many of these values and beliefs can also be related to the periods that more directly prompted the establishment of the occupational therapy profession. However, how occupational therapists discuss values and imbue them with meaning change and will continue to change. In this sense there is no enduring value foundation to which we can appeal without thought. Norms change. For example, Peloquin (1991) and Spackman (1968) have articulated some of the character qualities that it was thought early occupation workers should necessarily possess. In examining early texts various similarities and differences between writers of the period and contemporary writers can be identified. For example, in an introduction to Susan Tracy's *Studies in Invalid Occupation*, Daniel Fuller (1918), a physician, highlights the importance of the occupation worker's personality:

> A dozen kinds of occupation may be suggested, material furnished and explanations and directions given, but without the constant cooperation of the teacher or nurse, without the daily expression of interest and the stimulus of example, the work is either never begun or, if begun, is soon thrown aside. The

> personality of the teacher and nurse therefore becomes an important factor. Her real enthusiasm and love for the work react most powerfully on the patient.

The possession of knowledge was important, but what was really required was something that stretched beyond knowledge. Fuller (1918, p. 9) explained:

> The technical and mechanical part of their work is but one aspect of their professional duty, that a broader conception must be attained – a sense of obligation to minister to the individual as well as to the disease. The value of wise human sympathy, of cheerfulness in word and mien, of tactful dealing with unreasonableness and irritability, of skillful diversion of thought from pessimistic channels.

Hall and Buck (1915) argued that the occupation worker required tact, patience, adaptability, common sense, steady purpose, and confidence in recovery. Tracy (1918, p. 18), a nurse, explained that "resourcefulness, unfailing patience, quick perception of capacities and limitations, an enthusiasm," and insight were important qualities to have. According to Dunton (1919), an occupation director needed to possess patience, knowledge of various crafts and occupations, tact, business ability, and the ability to inspire others. Dunton (1919, p. 51) claimed that tact related to a knowledge of "the psychology of everyday life." Above all, however, it was a 'fertility of invention' that was important and would allow an occupational director to "fill his position, rather than merely" occupy it (Dunton, 1919, p. 51). This last related to the possession of: "a vast amount of energy, an artistic sense of form and color, and other faculties which tend to make him [the occupational director] a broad-minded, cultivated man" (p. 51). The occupation nurse, on the other hand, was required to be a good companion to their patients. Dunton (1919, p. 84) explained that culture courses exposing nurses to literature, art, music, and dance were important in this regard. In addition, the nurse engaged in occupation work would also require tact, patience, self-control, and "a stock of ethical qualities that materialize themselves as character" (Dunton, 1919, p. 79). This last was thought to confer a kind of 'moral resistance.'

In the past, it was moral character that was important. Particular personal qualities and virtues defined the good and effective occupation worker. In more contemporary times, these virtues are codified in value matrices. Virtue was more heavily invested in the characters of those conducting the work and descriptions related to desirable

personality types (see also Colman, 1990; Bockoven, 1972). Dunton (1919) and Tracy (1918) did indicate that experience and study could build character; however, in reading these works one gets the idea that it was believed to be a particular kind of person that was desirable. One can see similarities between what was deemed valuable in the past and what is venerated in more recent times. As has been demonstrated above, the CAOT's 1986 practice guideline did focus on particular character virtues. However, as has also been demonstrated, subsequent Canadian guidelines refocused value statements toward fundamental beliefs about relevant constructs and the nature of human beings. Occupational therapy no longer occurs simply through contact with professionals in possession of a particular kind of moral integrity; rather, the transmission of particular norms occurs through more complex therapeutic processes. Client-centered care, for example, more effectively transmits the normative ideals that are venerated within particular contexts (see also Molke & Laliberte Rudman, 2009). Causal statements that relate to the power of occupation and the fundamental nature of human beings also provide a different kind of expertise that serves to effect individual transformation. This transformation occurs inside the individual and relates to the values that are deemed important within a particular culture. This is an expertise that no longer rests on virtue alone, but also the application of scientific knowledge. For better or worse, this is an expertise that denies itself all the while it takes a firm and unapologetic hold of the truths and ideals that define and organize the occupations of everyday life.

For example, Law, Baptiste, & Mills (1995) outlined the concepts and values fundamental to client-centred practice: partnership, therapist and client responsibility, enablement, individual autonomy and choice, respect for diversity, accessibility, and contextual congruence. Once again, the uniqueness of each individual and "respect for the diversity of values that clients hold" (Law et al., 1995, p. 253) was thought to be important. Here too, however, autonomy, choice, responsibility, and control seem to be valued most highly. Intervention might rely on specific techniques, involving education and counseling and the implementation of particular strategies like relaxation techniques, for example. All this is aimed to ensure that the individual is able to resume "meaningful roles" (Law et al., 1995, p. 255). This kind of treatment has the potential to reorient an individual's perspective. For example, 'Mrs. R,' after focusing on occupational

outcomes, "decided that a scooter was acceptable because of the freedom it allowed for outings with her children" (Law et al., 1995, p. 255). This is somewhat reminiscent of Pinel's (1809/2008) beliefs regarding the effects of occupation work and Foucault's (1961/2009) analyses of this work. Occupational roles and responsibilities are chosen and matched to the values of each individual. Resumption and continuing engagement in well matched occupations will work to bind an individual more tightly to the social roles and responsibilities that define their unique nature and social position. Fulfilling one's station in life is what constitutes freedom for a particular individual. For better or worse, 'correctly' selected goals that relate to each individual's unique nature serve to bind her or him to a particular social truth. In the example that Law and her colleagues provide, a woman on receiving treatment resumes her social responsibilities, becomes a dutiful mother, and is free. The assumptions that undergird client-centred practice promote the values of autonomy, choice, responsibility, and control, define freedom, and function to outline the nature of each individual's social typology.

However, there are differences between the past and the present. In the past, occupation work focused only on transforming individuals to induce them to participate and enmesh them within the social structure. In the present, a focus on environments, for example, also promotes and ensures this participation (CAOT, 1997, 2007; Law, 1991; Law, 1992; Law et al., 1995). This focus includes: "those physical, cultural, social, institutional, economic and cultural factors in a person's home, neighbourhood or community which influence participation" (Law, 1992, p. 193). Occupation is no longer the only mechanism through which marginalized individuals are brought back into the normative folds of society. Environments themselves are now tinkered with to promote maximal participation. During the moral treatment era the individual was removed from one social milieu and deposited in another. In the present it is the social milieus themselves that are altered. The processes and principles of client-centered practice determine how this occurs. It seems that what provides a foundation for occupation work changes over time (see also Reed & Peters, 2007, 2008).

6.1.4 Technologies of spirit formation in occupational therapy.

Within the previous section one technique used by occupational therapists has been outlined (i.e., client-centred practice). The literature on spirituality is full of other examples. Here, the spiritual dimensions implicit in occupation are discussed. Specific attention is paid to the religious dimensions of occupation and creative occupational engagement. Subsequently, professional preparation for spiritual work is discussed in relation to professional development. Next, spirituality is discussed in regards to the spiritual dimensions of community and the powers of inclusion. Specific questions that have been provided in the occupational therapy literature related to spirit formation are then presented. Afterwards, two contrasting functions of narrative are outlined. Finally, the ways in which hope can be utilized as a transformative tool are delineated as they have been discussed in the literature relating to spirituality. In each case an effort was made to submit each collection of tools to a kind of critical scrutiny that placed emphases on their potential to work with normative content. This analysis should be understood as an attempt to place limits on practice that is described as spiritual in nature and promote a kind of normative consciousness among therapists who wish to conduct this kind of work (see also Castel 1988; Foucault 1968/1991a; Lilleleht, 2002b).

6.1.4.1 Religion, creativity, occupation, and self formation.

As should already be apparent, according to many theorists, it is occupation itself that holds ‘spiritual’ power. Unruh, Versnel, and Kerr (2004) argued that the focus on spirituality in occupational science and therapy is its connection to occupation (see also Cunliffe, 1994). For some, occupation holds sufficient spiritual force in and of itself to reform identities. Indeed Vrkljan and Miller-Polgar (2001) discussed the transformative potential of occupation. As we have seen above, engagement in particular kinds of occupation can function to effect an inner change through participation in an outward act (see Kielhofner, 1997). Wilding (2002, p. 45) pointed out that Adolf Meyer, a psychiatrist and ardent supporter of occupational therapy working at the beginning of the 20th century, believed that occupation spoke to the “very soul of man.” Peloquin (1997, p. 168) argued that “occupation, the core of our therapy, animates and extends the human spirit.”

Some authors have written explicitly about the religious dimensions of occupation (e.g., Frank, Bernardo, Tropper et al., 1997; Howard & Howard, 1997). Particular kinds of occupational engagement connect the individual to something greater than themselves. Engagement in particular kinds of occupation lead toward a deeper association with the divine (Howard & Howard, 1997). Howard and Howard (1997, p. 185) claimed that the Christian god is present and "breaks into our ordinary existence through our daily activities." For these authors "occupation can be seen as fundamentally spiritual and spirituality as imbedded in occupation" (p. 185). Quoting John Paul II, Howard and Howard (1997, p. 182) suggested that "it is in their daily activity, their work, that humans express the divine image within them and link themselves to God … creative work activity is at the centre of the human-divine relationship." Disability can separate individuals from their active, reflective, and creative potential. Thus, according to these authors, the individual with a disability is prevented from "fleshing out ultimate meaning" because they are unable to engage in occupation (Howard & Howard, 1997, p. 183). Peloquin (1997) implied that the conduct of occupation extends the human spirit and allows the individual to participate in acts of creation and animation. Here occupation was conceptualized as something more than a connection with the divine and becomes a way for individuals to participate in divine action. Frank et al. (1997, p. 200) explained that different religious traditions assert differing beliefs about the relationship between occupation and spirituality:

> Theistic religions such as Judaism, Christianity, Islam, and others teach us that daily occupations and routines attain spiritual meaning when understood as commanded by God. Buddhism, a non-theistic religion, further teaches us that daily occupations have an intrinsic spiritual dimension.

These authors argued that Judaism, for example, "is not a religion of salvation by inner faith but the fulfillment of God's commandments" (p. 199). Frank et al. (1997) explained that some of the Orthodox Jewish people who participated in their research suggested that particular occupations that relate to the rules of Orthodox practice provide order and purpose, are invested with transcendent meaning, and function to bind individuals to God. As discussed above, moral treatment reformers emphasized particular dimensions of a healing relationship that developed between an individual receiving treatment and the professional providing care (see Pinel, 1809/2008; Tuke, 1813). In an article discussing

some principles of Eastern philosophy, Kelly & McFarlane (1991a) outline the nature of a relationship that might exist between a Zen master and their student: "The Zen master does not help the student in any way since helping would actually be hindering. On the contrary, he goes out of his way to put obstacles and barriers in the student's path. In this way he encourages a problem solving approach, forcing the student to achieve the goal independently" (p. 97). While some operating in 'Western' contexts might find this kind of relationship unusual, one can also identify an emphasis on values in this particular article (i.e., independence) that should be familiar to individuals operating in 'Western' contexts (see also Kelly & McFarlane, 1991b).

Taken together, this literature suggests that particular occupations take on a transcendent character that governs how one should use time in day to day life, and dictates who can connect with, or take on divine qualities. Belief systems are used to help outline how therapists might work with their clients. These ideas also provide the means through which individuals might come to structure their occupational engagement; however, these ideas also seem to place limits on whom and how one can participate fully in human life which could potentially exclude and alienate a variety of individuals.

Christiansen (1997, p. 170) argued that "sacred, soulful, and spiritual occupations are found in everyday living." These he suggested are "activities of spirit."
Any activity can be spiritual if attention is given to its context and style. Thus this author seemed to argue that any occupation can become an activity of the spirit if it is performed with style in the right context. This seems to suggest that connection to a spiritual dimension requires one to ensure a particular kind of aesthetic. Toomey (2003, p. 181) discussed creativity and the process of accessing "spirit" through occupation.
Engagement in meaningful occupation is thought to "open doors to spirit … and enhance a person's health and wellness." Creative occupations have the power to access the soul and artistic occupations are spiritual disciplines. Truly creative occupations demand that all aspects of the individual are employed: "the physical, the intellectual, the emotional, and the spiritual" (Toomey, 2003, p. 183). A musician, for example, is said to be creative only if the spiritual aspect of the person is engaged. Otherwise, it seems, they will play music without "depth, meaning and the ability to change both the musician and others listening" (Toomey, 2003, p. 181). Only those who have access to sprit have the power to

effect change in themselves and others. Toomey (2003) outlined various aspects of creativity that work to define what constitutes a healthy spirit. For example, through creative acts order is imposed on chaos, courage conquers a fear of oneself, and discipline harnesses one's inner energy. Creative occupations have a power to order and transform the self and others. And yet, within this understanding only those who have access to the full spectrum of human experience can engage in creative occupations. Toomey (2003) also argued that occupational therapists can help individuals engage in creative occupations, access the spirit, and integrate a disorganized self. For instance, the occupational therapist can ask specific questions to shape the thoughts of their clients; questions about religious worship and ritual, about fear, self-doubt, and risk, for example. Occupational therapists can work with clients to schedule their time in order to discipline the self in preparation for creative expression. In ways reminiscent of the advice given by the moral treatment reformers, Toomey (2003) also directs occupational therapists' attention towards the environment in which creative occupations are to occur. Distractions should be eliminated, energizing music played, and pleasing smells and textures provided. As well, individuals looking for inspiration are directed to engage in daily walks to awaken and discipline the creative self (see also Toomey, 1999). Once again this literature seems to deploy truth statements that create expectations about who can engage in particular kinds of occupation which have the potential to exclude a variety of people.

Unruh and her colleagues have written about the spiritual dimensions of gardening (e.g., Unruh, 1997; Unruh Smith, & Scammell, 2000). Unruh (1997) explained that gardening can provide an opportunity to escape the conflicts and tensions of life and engage in solitary reflection. In this way, the occupation of gardening is thought to bolster one's mental health. Gardening becomes the means through which one is able to "ventilate family, work, and health-related stresses" (p. 158). Gardening becomes a means to sublimate frustration and heal: "when my stomach roils, work becomes impossible and the world becomes mad, I know I must go into the garden to destroy a few bugs, stir up the compost, [and] break fallen branches into pieces … There is healing in planting and tending a garden" (p. 158). Unruh (1994) explained that in the garden one can reconnect with the future and find a renewed sense of spiritual hope and enthusiasm.

Gardening has a long history in both occupational therapy and moral treatment. Dunton (1918, p. 174), for example, seemed to capture the forward looking and hopeful consequences of gardening that Unruh discussed in the following quotation:

> Some persons have the idea that it [gardening] can only be followed out of doors during a few months of the year. But as soon as he has gotten over the Christmas holidays the true gardener is hard at work at his garden – on paper – and is laying out rows of bulbs and plants and vegetables. A seed catalogue is more absorbing than a best seller, and the joy of anticipation is his to the utmost.

As indicated in previous sections, Pinel (1809) and Tuke (1813) both discussed gardening; however, as indicated above, and much like Howard and Howard (1997), for these authors, gardening related mostly to the restorative effects of work and labour. For example, Tuke (1813) wrote of gardening in relation to its capacity to engage an individual in relation to "regular persevering labour" (p. 155). In previous sections I have also demonstrated how Foucault (1961/2009) related particular occupations to the internalization of the rhythms of nature. In this sense gardening was thought to allow one to connect with a natural Truth. It has been argued that within the moral treatment era gardening was an occupation that served to circumvent theology through the valuing of religion's most simplistic moral content (Foucault, 1961/2009).[15] It was a "trust in the benevolence of nature" that functioned to provide a cure for mental illness (Foucault, 1961/2009, p. 492). Similarly, Unruh (1997, p. 158) argued that for many:

> The occupation of gardening and being in the garden facilitate an intimate experience of nature and the cyclical nature of life … The land gives the gardener an opportunity to participate directly in the life process through the occupations of soil enrichment, planting, watering and fertilizing, weeding, deadheading, mulching, and protecting plants from hostile elements.

Unruh quoted another author who discussed a spiritual connection with nature:

> The day I plant my garden I feel a cosmic force of nature – as much a part of it all as the spring winds blowing past my face, as the wet earth into which I sink step by step, or as the soft sun that warms my bald head … I am a necessary part of the whole mysterious process. (Davids, 1976 as cited in Unruh, 1997, p. 159)

[15] See also Voltaire's (1759/1962) 18th Century work *Candide* for a satiric criticism of popularized philosophical thought related to naive optimism and the importance of work in the 'garden.'

Unruh et al. (2000) found that individuals battling cancer used gardening to reflect on the life cycle. Plants were imbued with personal meaning for participants and could come to symbolize renewal, or enable one to remain calm when confronted with one's own mortality. Unruh et al. (2000, p. 74) provided a quote from one participant: "[The garden] teaches you to calm down and that there is a season and a rhythm to everything … it begins to teach you that you are not on this earth forever anyway … and that there is regeneration and rebirth in the spring."

6.1.4.2 Professional development and self formation.

Occupational therapy researchers interested in spirituality have often claimed that increasing comfort and skill with spirit formation requires therapists to confront their own spiritual self (e.g., Toomey, 1999). For example, Schulz (2004, p. 74) argued:

> occupational therapists working in the clinic need to examine thoughtfully what are their own viewpoints on addressing spiritual issues in practice and what spirituality means to them. This should be done, ideally, prior to attempting to incorporate spirituality into practice.

Familiarization and competence using spiritual tools is often said to emerge through this kind of self exploration. Egan and Swedersky (2003) consulted with practicing occupational therapists in an attempt to better understand how spirituality might inform practice. Participants explained that competence with spiritual concepts and tools developed over time and could be enhanced through various means. Personal study related to "theology, philosophy, ethics, art and social analysis" was thought to be helpful (Egan & Swedersky, 2003, p. 530). Practice mentors were also thought to be useful. Engagement in activities targeting self formation was also thought to be important. Therapists took care to schedule their time to allow for their own development through engagement in particular kinds of occupation. Activities that fostered "connection with the self" (Egan & Swedersky, 2003, p. 530) were thought to be vital. Thus this literature implies that it is not enough for occupational therapists to work on the client's spirit. Before spiritual work can be accomplished occupational therapists must work on their own identity; their own spirit. The health professional must first utilize spiritual techniques to mold their own self (see for example, Townsend, De Laat, Egan, Thibeault & Wright, 1999). Activities that function in this regard include: "reflection, meditation,

reading, exercise, being in nature and valued hobbies and close attention to one's health and emotions" (Egan & Swedersky, 2003, p. 530). Without a doubt, connection to ideas that have existed for over two centuries can be identified. It seems that some of the beliefs that proved a foundation for moral treatment are alive and still active. While various authors report hesitation in directly incorporating spiritual practice into treatment, for better or worse, there is no such hesitation in terms of prescribing moral treatment for practitioners themselves. Old ideas regarding the moral potential of this kind of work remerge and provide the basis for professional development. Before the 'healer' can practice his or her craft she or he must first work on their own soul using time honored techniques. Participant data provided by Egan and Swedersky (2003) also seem to validate and critiques advanced by Hocking and Whiteford (1995). Therapist comments in relation to the benefits of giving are reminiscent of comments made by Hocking and Whiteford (1995) in relation to altruism. For example, one participant in this study explained:

> The process of interacting … I see it as you're not only giving to them, but they're giving to you also … indirectly, because they're not … the patient isn't there necessarily to help you, but … just through the process of helping them you can learn things about yourself or feel good about giving. They may also give back to you, in ways you didn't really expect. They may give you a compliment, or … they may observe something about you or share that with you. (Egan & Swedersky, 2003, p. 530)

The dimensions of a give and take relationship are laid out. The motivation behind altruistic giving asserts itself. In some ways, the therapeutic encounter becomes more reflective of a 'real' human relationship. The therapist develops through the encounter. A reciprocal relationship is described. However, one might also read this series of statements as evidence of an impulse to foster dependant professional relationships. As well, these relationships function to promote the development of the therapist. Within this interpersonal encounter two souls meet. The development of one depends on the other. Does this therapist describe a reciprocal relationship, or one defined by games of submission and domination? Here the therapist feels good about giving. Indeed Hocking and Whiteford (1995) criticize practice that becomes an outlet for altruistic sentiment. They argue that this kind of practice can create a power imbalance where giving and

receiving function to define a particular power dynamic that is in actuality potentially disempowering.

Occupational therapy literature on spirituality also contains examples of individual occupational therapists' experiences undergoing different kinds of spiritual exploration and expansion. For example, Baptiste (1997, 2003) generously described the spiritual changes and realizations that emerged over the course of her carrier as an occupational therapist and particularly during periods where it seemed that this carrier might be threatened. Thibeault (1997) provided an attempt to capture the transformative process she experienced as she grieved for her father who struggled with Parkinson's disease. These are moving accounts that work to draw out an emotional response in readers. Perhaps it was intended that others would benefit from their spiritual experiences. For example, Baptiste (2003, pp. 202-203), in reflecting on her experience of being forced to leave a valued work role, wrote:

> Perhaps one of the worst realizations was that things I had worked so hard to achieve would no longer become realities; that values I espoused, alongside so many colleagues, were visibly being eroded; that somehow the sense of connectedness we shared and the common purpose for which we strove were no longer the point of it all … I did not have time to waste in re-establishing a sense of internal equilibrium. I knew that my values were right for me; I also knew that they were right for the profession to which I had also given so much of my working life. However, a switch began to take place. No longer did I feel that who I was depended on my work as an occupational therapist, educator and administrator. Rather the reverse. I was beginning to define who I was more from a very personal space of what I believed in, how I wished to manifest that connectedness to my world and the investment I wished to make in society as a whole.

Here, Baptiste (2003) described a process of frustration, anger, and transformation. In it she outlined the effects of losing a valued occupational role and the process she went through to reaffirm her values and how they related to her sense of self. She became in the end as something that transcended what she had been. She no longer needed to define herself with titles or positions, but instead in a more ephemeral way that connected to the self that she had become through her work. This personal account captures both a process of development and a theory of transformation. It gives occupational therapists some expectations that allow them to anticipate how one might work with individuals to cope with loss and change. For better or worse, it provides clues that can be used to effect

change in others. This account sketches the faint outlines of a schematic that can be used to anticipate what might occur.

Thibeault (1997; 2003) also documented a process of maturation and coming to terms with mortality and change. Thibeault (1997) generously documented her attempt to find meaning in scientific and professional literature, how she worked to preserve memory, and establish tradition. She outlined a path that grief can take and how she coped with her anger in related to the loss of her father. Near the end of this work Thibeault (1997, p. 114) wrote:

> Finally, the experience has riveted to my soul the necessity of spiritual practice. I am not talking of organized religion or prescribed readings even though these can be worthy avenues. In my life, it is far simpler; keeping time, daily, for reflecting and feeling, and marveling at the serendipity of encounters and events, Just that, with a few rituals, to manifest softly the resilient beauty of the human spirit.

For Thibeault (1997), it is keeping time that works to recharge and define her spiritual center. The occupational therapist within her wins out here as spiritual reflection is scheduled into a routine of daily marvelment. Again, Thibeault (2007) generously shares her experiences in confronting the atrocities that can occur in the context of daily life. This is, in some ways, a less emotive depiction that focuses instead on revealing the truths that Thibeault uncovered in her personal spiritual journey. Here, scientific and theoretical scripture is propounded on and presented to her readers. The works of Erikson and Durkheim become touchstones that define a maturational experience that others can follow. Here, again, one can see the appearance of a therapeutic process that can be utilized. Through her personal experience, study, and writing, Thibeault (1997, 2003) outlined a therapeutic route that can be followed. For better or worse, different avenues are mapped out enabling each who encounters this discussion to work on their own spirit and find inner certainty. Thibeault (1997, 2003) outlined a journey that therapists are invited to pursue, but her journey also creates a momentum, a gravity that pulls others along in its wake:

> Occupation is what gives life a shape … but as health care professionals, we bear the double responsibility of maintaining health and promoting it, for ourselves, for others. The tide starts with us, individuals in quest of maturity. As we grow and change, so will our keenness for equity and social justice. And then, which form will we give our new identity? Membership? Activism? Community service? The choices are endless. And in our journey towards unity and congruence, when the

> line between our roles of healer and citizen starts to blur, we might also gain a new appreciation for the world, a place of sometime desperate beauty in need of maturity and resilience conductive to '…maintaining serenity in the face of adversity and being capable of love.' (Durckheim, in Goettman & Goettman, as cited in Thibeault, 2003, p. 93-94)

Thibeault's spiritual journey culminates with the articulation of the laws that function to structure her existence and further maturation. Occupation shapes life. The professional must be healthy to promote the health of others. Maturity relates to a valuing of equity and social justice. Mature identities are constructed through work relating to these concepts. In the end, a mature individual is a unified and congruent whole who no longer draws limits between varied social roles. Above all, the mature individual remains still, peaceful, and emanates love despite the adversity that confronts them. The way is cleared. A path opens in front of us. We are beckoned to follow.

Csontó (2009) found that final year students at a British university did not feel sufficiently prepared for practice that involved spiritual dimensions. Kirsh, Dawson, Antolikova, and Reynolds (2001) also collected data from Canadian students participating in an overnight retreat designed to deepen understanding of the concept of spirituality, one's own spirituality, the ways in which spirituality can be explored, how one's spirituality is effected by working with people with disabilities, and how disability itself effects spirituality. While these authors found that 81% of respondents felt that they understood their own spirituality, and 96% felt that spirituality was an important dimension of health with the potential to influence rehabilitation outcomes, only 32% felt that they had a clear understanding of the role of occupational therapy in relation to spirituality. While it seems that students feel that spirituality is important, despite the various techniques described in the literature, they do not understand how to work with spirit. It seems successful incorporation of technologies of spirit formation requires something more than knowledge about the spiritual dimensions in one's own life.

6.1.4.3 *Occupation, community, inclusion, and self formation.*

Gardening has also been discussed as a spiritual expression of community (e.g., Unruh, 1997; Unruh, Smith, & Scammell, 2000). While gardening is described in some of the literature that Unruh (1997) reviewed as an intensely personal spiritual experience,

it was also described as an obligatory communal occupation: "It was therefore one's duty, in accordance with nature, to create gardens that could be shared and enjoyed by others" Unruh (1997, p. 159). Others have highlighted the social dimensions of spirituality in occupational therapy. In the second decade of the 20th century, Pattison (1921) discussed trends in treatment for tuberculosis. Treatment was not simply to focus on the disease but on human character: "Our aim and objective should be the restoration of the sick to self-respecting usefulness and economic independence … He [the client] must make his contribution to the common welfare. His contribution may be spiritual (moral), intellectual or economic" (p. 20). Spiritual contributions to society included being a good mother, learning self-discipline, contributing to morale, conforming to rules and regulations, or simply taking care while disposing of one's sputum (Pattison, 1921, p. 20). Disregarding one's spiritual contribution to society might result in the exercise of "'police powers' to compel respect" (Pattison, 1921, p. 20). Individuals were required to make a 'spiritual' contribution to their community. This contribution functioned to protect and bolster the social order and reify its roles. In contrast, in the late 20th century, Townsend (1997) discussed inclusiveness as a community dimension of spirituality and distinguished this from personal dimensions of spirituality and its antithesis exclusiveness. Inclusive communities encourage respect for difference in terms of ability, or personal characteristics. Inclusive communities "create an energizing interconnectedness and sense of belonging and worth" (Townsend, 1997, p. 147). And yet, this author seemed to argue that spiritual transformation involves whole communities only when a common ideal or vision is pursued. Connectedness seems to demand a sharing of "philosophies, values, beliefs, ideas, and visions" (p. 147). When these communal dimensions are activated resources are unleashed "that bind people together and draws in those who are outside." However, drawing on relevant literature Townsend (1997, p. 148) also argued that:

> the community dimension of inclusiveness is visible in what people do and say; it is invisible in the beliefs, values, and ideas that shape policies, images, finding priorities and other organizational processes which determine how inclusive communities are in reality. Some communities offer an exclusive form of inclusiveness when they define which ideas, personal characteristics, abilities, heritage, culture, and ethnicity may be included. (Hamlin, Loukas, Froehlich & MacRae, 1992)

In the late 20th century, occupational therapists were directed to become cognizant of the inclusive dimensions of spirituality, the potentials that exist for promoting empowerment through inclusion, and the constraints which sustain exclusiveness. Promoting participation through inclusion can be a process that works to empower, but it can also function to forcibly delimit the scope of an individual's values, beliefs, and ability to engage in occupations that deviate from the norms defined by particular communities.

6.1.4.4 Questions and self formation.

As indicated above in relation to the work of Toomey (2003), occupational therapists are sometimes directed to ask questions that relate to spirituality that will shape client thoughts. Various authors have outlined questions related to different conceptions or aspects of spirituality to be used in practice. Table 7 presents some questions and points of consideration that have been outlined in the literature.[16] With even the most surface of examinations, one can identify particular concerns that are repeatedly brought up by researchers promoting questions that relate to spirituality. Clients are challenged to think, for example, about life's meaning and purpose; their identity and the roles they

Table 7: Questions to be considered/asked relating to spirit in occupational therapy

Baptiste (2003, p. 198): **Questions related to Spirit & Work Environments**

- When thinking about your own experience and knowledge, can you identify an organization that you feel exemplifies the visionary qualities that allow for the creation of a spiritually focused work place culture? What do you think are some indicators of a spiritually focused work place?

Baptiste (2003, p. 201): **Questions related to Purpose, Meaning & Work**

- When thinking about yourself, what makes life the most meaningful for you? How much meaning and personal purpose do you gain from the roles you fulfill within your working life? How would you identify yourself? What aspects of your life do you think illustrate your purpose most clearly?

Baptiste (2003, p. 203): **Questions related to Personal Control at Work**

- When considering your current workplace: How in charge of your role and expected tasks do you feel? How fulfilled by and connected to your work do you feel? How connected is your organization to the individual employee's needs for purpose and meaning?

Baptiste (2003, p. 205): **Questions related to Awareness and Congruence Between Self and Work Values:**

- How familiar are you with your own beliefs around the value of work to you? Do you feel rewarded, invested and

[16] See Unruh, Versnel & Kerr (2003) and Johnston & Mayers (2005) for discussions of formal assessment tools related to spirituality that might be employed in occupational therapy practice.

enriched by your work? Is there a congruence between what you do and what you believe? Have you considered what the key elements are for you in understanding the nature of your spiritual self in relation to what you do?

CAOT (1986, p., 14): **Themes to be explored and Question to be Asked**

- Meaning and purpose in life; suffering and tragedy; self-esteem and personal dignity; guilt and forgiveness; healing and inner peace; joy and celebration; freedom, responsibility and personal courage; loneliness and the need for affection, intimacy and community. Question to be asked: 'What sense do you make of your life?'

Csontó (2009, p. 446): **Questions related to spirituality**:

- Is spirituality important to you?

Egan & Delaat (1997, p. 117): **Themes to be explored**

- Identify occupations which have positive meaning and discuss their spiritual dimensions: How did these occupations allow the client to connect with self and others, and what meaning did these occupations have?

Hume (1999, p. 368): **Questions related to Personal Values and Meaning in Life**

- Who am I? What am I doing in life? What makes life worth living? What are the important things?

Low (1997, p. 218-219): **Assessing Spiritual/Religious Needs**

- Observe environment for religious articles and rituals and ask specific questions: Do you feel your faith/religion is helpful to you? Has being ill changed your belief about this?

McColl (2003c, p. 23): **Questions related to Spirituality, Relatedness, and Disability**

- Would you describe yourself as a spiritual person? Has your understanding of yourself changed since you acquired your disability? Have your relationships with others changed since your disability? Has your way of viewing the world changed since your disability? Have your beliefs changed since the onset of your disability? Have your religious practices changed? Has your soul or spirit been affected by your disability?

McColl (2003d, p. 136-139): **Questions related to Awareness of self, place, relationships, the divine, and occupational roles**

- What are your personal strengths? What qualities have allowed you to be successful in the past? When you have taken on something new, what qualities have helped you to be successful? How would you describe your role relative to other people in your life? Are you aware of what people expect of you and what you expect of them? Do you have a sense of where you belong in the world, and among other people? Are you aware of a supreme being or force that oversees the way things happen in the world? Does that awareness / lack of awareness give you comfort or cause you concern?

McColl (2003d, p. 136-139): **Questions related to Intimacy with self, network, world and divinity**

- Do you know what is meant by a sense of harmony within yourself? Can you imagine what that feels like? What do you think it would take for you to feel this way? Are there people who you are close to, and how would you describe those relationships? Do you feel that you belong in the world, that you are a part of something larger or more universal? Do you feel a connection with a supreme being? Do you feel that there is some force that cares about you and loves you?

McColl (2003d, p. 136-139): **Questions related to Trust in self, others, world, universe**

- Do you feel like you can trust your body and/or mind to do what you need it to do? Do you feel like your body and/or mind can rise to the challenges ahead? Are there people you can count on when you need something? How do you feel about having to ask others for help? How do you think they feel about giving help? Do you feel comfortable with the people you need to depend on for help? Do you feel like the world is a good, safe, just place, or do you feel that you have to be always on your guard? Do you feel that the force that governs the universe wants what's best for you?

McColl (2003d, p. 136): **Questions related to Vulnerability in relation to mortality, relationships, divinity, and the afterlife**

- Do you feel safe and secure within yourself? Do you feel that you are in any immediate danger? How do you think about death since your injury/disability? Do you think the people in your life have your best interests at heart most

of the time? Is there someone who looks out for you or for your interests? Do you feel safe and secure with the important people in your life? Do you feel as if you are in control of your life most of the time, or do you feel as if you are at the whim and pleasure of larger forces? Do you think about what happens to us after we're gone? Do those thoughts bring you comfort or concern?

McColl (2003d, p. 136): **Questions related to Purpose in occupation, others, cosmos**

- What is it that helps you to get up each morning? What is the most important thing that you do each day? What do you feel you are meant to be doing? Do you think there is a purpose to your life each day? What role do you play in the lives of other people you are close to? Do people depend on you for particular things, or even just to be there for them? Do your relationships with people close to you seem important to you? Do you think your life is part of a larger plan, or that there is ultimately a purpose to each person's life? Do you feel that you are fulfilling the purpose for your life? What would be required in order for you to do so?

Townsend, De Laat, Egan, Thibeault, Wright (1999, p. 11): **Questions for Adventurous Learners:**

- How much do my early experiences still colour and shape my spirituality?
- What have I kept and what have I discarded?
- Am I at peace with my spiritual heritage?
- Is there anything I would like to change? Why? And how?
- What steps do I take daily, in my simplest occupations, to remain connected to what is meaningful to me?
- Am I comfortable with issues of spirituality at work? What helps me or prevents me from being comfortable?

Tse, Lloyd, Petchkovsky & Manaia (2005, p. 184): **Themes to be explored**

- Understand the meaning of client activities; identify client values

Udell & Chandler (2000, p. 490): **Themes to be explored**

- Creativity, values and beliefs, & satisfaction with life

Urbanowski (2003, p. 103-104): **Factors to Consider when Assessing Spiritually**

- The substance of the life trajectory of the person; The nature of the changed occupational life; Disparity between an individual's life trajectory before and after occupational therapy; A listing of occupations deemed critical to spiritual wellbeing; The vulnerability of these occupations in relation to the nature of the client's situation; The protective factors that will maintain these occupations on an occupational trajectory; The risk factors that the client may face in the wake of attempting to keep an occupational trajectory

Note: Sources and page numbers are identified for each section of text. In some cases text was edited to compile, shorten, or increase clarity.

fulfill; their values and beliefs; vulnerability, loneliness, connectedness, trust, and intimacy; loss, suffering, and disability; responsibility and freedom; divinity and creativity; guilt and forgiveness; and their unique life path. In most cases, issues are to be tied to occupation in some way. Here, one begins to see how particular themes of conversation and lines of questioning prime the individual to think along certain pathways. Questions that control the directionality of conversation in therapy can function as a powerful tool to shape the spiritual core of the individual seeking professional attention. Thus occupational therapists must endeavor to critically scrutinize the questions they ask in an attempt to understand how and in what ways they will shape the identities of those who seek professional attention.

6.1.4.5 Narrative and self formation.

Unruh , Versnel & Kerr (2003) differentiated between process and outcome goals. A process goal might involve attending to spiritual issues and needs to build a relationship and effectively achieve functional goals. An outcome goal involves specifically targeting some aspect of spirituality, for example, spiritual wellbeing. In this sense occupational therapists are able to employ spiritual techniques to effect change or harness all their therapeutic tools to achieve particular spiritual outcomes. One example of a technique that blurs the boundaries between this distinction is narrative. Mattingly and Fleming (1994) described the 'narrative nature of clinical reasoning' and a therapeutic process that is used by some occupational therapists. This process begins when the practitioner imagines a treatment story and a possible future for their client. According to Mattingly and Fleming (1994, p. 241), these stories "revolve around the life history of the patient who experiences" disability. However, the stories that practitioners imagine are built on "stereotypical (collectivized) scenarios" and "projected onto new clinical situations" (Mattingly & Fleming, 1994, p. 242). Only when therapists are confronted with a narrative "misfit" of sufficient acute severity are clinical stories revised. This therapeutic procedure is said to focus more on process than a long list of particular objectives. Within this process, "patients are given powerful experiences of successfully met challenges, successes which can give patients the confidence to actively create a maximally independent life for themselves" (Mattingly & Fleming 1994, p. 245). These powerful experiences draw the individual into the narrative envisioned by the practitioner and propel the individual towards the conclusions imagined by the therapist. This occurs without discussion or dialogue. It is something that emerges from the 'experiential' nature of the therapeutic relationship:

> How is such a story constructed? Generally not through any explicit storytelling. Rather, it is constructed through sharing powerful therapeutic experiences that point to a prospective story – a path therapy will take. Clinical reasoning involves seeing possibilities for creating significant experiences in which the patient will become committed, making moves to act on these possibilities, responding to the moves that patient makes in return, and, if the therapist is lucky and can get something started – can get the patient 'in' – building on this experience by showing the patient a future in which this therapeutic experience becomes one building block. Or, in the language of narrative, the experience becomes one

> episode in a much larger story. The therapist tells the story not in words, but in actions that create an experience the patient can care about.

For better or worse, one can distil a number of directives from the preceding statement. Patients are tied to the storied expectations of their therapists without discussion. The stereotypical narratives that work to structure the clinical experiences of the practitioner in charge of care function to shape the structure of each individual's future. Here the power of narrative resides in the hands of those who provide treatment. It becomes a game in which the therapist and patient each make their respective moves. However, the patient is not told what rules to follow. They do not know that each therapeutic experience constitutes a 'building block' that prepares a foundation for a future that they have not imagined for themselves. In some cases all rehabilitative endpoints are forgotten or pushed aside as unimportant and the client is called on to become a new person, to transform into something that they were not before: "What is the meaning of the story for the client and therapist? Rehabilitation may be the stated reason for a client's treatment, but *renewal* (transformation) is the desired outcome that has meaning for all participants in the process" (Van Amburg, 1997, p. 188). Perhaps the individual enters into a therapeutic relationship seeking to enhance their functional abilities, but is drawn into a story which they did not author and exit the process changed. They are transformed. It should be apparent to readers that within many modern clinical contexts this kind of process would be discouraged as it has the potential to override and ignore the values, dreams, and beliefs that drive a particular individual. This kind of practice has the potential to violate the individual on the most fundamental of levels by circumventing their right to define the ends of intervention.

Kirsh (1996) described a slightly different therapeutic technique. In this case the therapeutic process involving narrative works to elicit a story from an individual: "Eliciting narratives, or facilitating the *emplotment* of one's life, is an approach directed at the individual as a whole – his or her feelings, thoughts, perceptions and beliefs … it places the narrator or client at the centre of the process, empowering him or her to voice himself or herself as he or she chooses" (Kirsh, 1996, p. 56). The client rather than the therapist becomes the narrator here. It is still described as an approach that is 'directed at the individual;' one wielded by the occupational therapist toward the elicitation of

thoughts, perceptions, feeling, and beliefs. According to this author, narrative emphasizes the discovery of personal meaning and purpose. This kind of narrative technique works to promote reflection "upon one's life, the path it has taken, and the road ahead." Spirituality is defined by the direction that one takes in life, or the story one tells in reference to one's life. Eliciting a personal narrative in the context of treatment works to create this story, provide life with direction, and enhance the spiritual dimension of the individual. Past actions and events are sorted through, ordered, and revised to find purpose. In conducting this work the therapist:

> Must be open to the unexpected, and must listen carefully, giving the narrator or client scope to develop his or her train of thought. Freedom to pursue topics of his or her choice may foster the process by which a client constructs an identity and makes meaning through his or her stories. (Kirsh 1996, p. 58)

For better or worse, within this perspective regarding narrative, it is the client's perspective that becomes important. It is their story that takes center stage. The therapist is silent, listens, waits for nothing, expects the unexpected, and works silently to weave every bit of information into a coherent whole that will move the individual into the future with purpose. Here too, one can see a subtle shift away from spiritual concerns towards identity. Permitting the client to tell her or his story allows him or her to construct an identity. It is now this identity that works to invest life with meaning and provide structure. Kirsh and Welch (2003) explained that when a plot is imposed onto a life it effectively structures life with clearer rules and meanings. Stories transmit values and beliefs. Indeed Kirsh and Welch (2003, p. 166) described narrative as a "crucial moral resource … that serves as an important vehicle for understanding and sharing our knowledge and the meanings we hold." Narrative is described as a "soul-searching, meaning-making process through which life's values and lessons can be realized and expressed" (p. 169). For better or worse, occupational therapists are directed to identify and capitalize on opportunities for narrative expression with clients to reinvent or build a strong and healthy sense of self, or find integrity within. A coherent narrative is said to enhance coping, promote personal growth, and provide opportunities for reconciliation. For example, particular values and beliefs can provide the basis that works toward the restructuring of an individual's narrative and sense of themselves. Kirsh (1996, p. 60) told the story of Don who reconfigured his life story around themes that related to:

> productivity, humanity, personal efficacy and identity as a person other than a patient. He [Don] was able to connect with the meaning and purpose in his life, to enhance his own spiritual self so that he experienced a sense of self actualization and hope for the future.

Perhaps this story slowly worked through this individual's memory highlighting particular events and altering details. Perhaps this story slowly redefined who Don was and what drove him. Perhaps it formed a new purpose for him that revolved around particular values, while other factors dropped out of mind and memory. In the process of constructing this narrative what role did the occupational therapist play? How did Don's story fit with his treating practitioner's clinical narrative and the values that structure and give it definition?

The shifting functions of narrative within occupational therapy are reminiscent of the transformations that Foucault (1961/2009, p. 510) described in relation to the therapeutic relationship in the 19th and 20th centuries and the shift from moral treatment to analytically oriented technologies:

> Beyond the empty forms of positivist thought, all that remains is a single concrete reality: the doctor-patient couple, in which all alienations are summed up, formed and resolved. It is in that respect that all the psychiatry of the nineteenth century really does converge on Freud, who was the first to accept the seriousness of the reality of the doctor-patient couple … Freud demystified all the other asylum structures: he abolished silence and the gaze, and removed the recognition of madness by itself in the mirror of its own spectacle, and he silenced the instances of condemnation. But, on the other hand, he exploited the structure that enveloped the medical character.

The individual is not forced to succumb to a therapeutic narrative that is imposed from the outside. Through a therapeutic relation that works to summarize and organize, a storied resolution is achieved. This shift does not denote the appearance of a dialogue, but the reversal of a monologue. A narrative is dissected and reordered by the analytical perspective that dominates the therapist-client couplet. In both cases, the process of narrative transformation described does not describe a process of reciprocity in which a 'real' conversation occurs; rather, a story is constructed in a unilateral way (see also Beck, Rush, Shaw & Emery, 1979; Linehan 1993). On the one hand, a narrative is imposed from without, on the other, it is said to emerge from within. For better or worse,

in both cases, it is a story structured by the expertise and authority that resides within the occupational therapist.

6.1.4.6 *Hope and self formation.*

Hope is frequently discussed in the occupational therapy literature in relation to spirituality.[17] Tse, Lloyd, Petchkovsky, and Manaia et al. (2005, p. 185) argued that hope relates to "an individual's perceptions of future and ongoing events and is closely linked to life's anticipated outcomes." Hope provides purpose, meaning, and motivation. These authors believed that accessing a spiritual component was vital to reclaiming hope. Neuhaus (1997) briefly linked technologies of hope to the occupational literature published in the first half of the 20th century and again in the late 20th century. Hope targets beliefs related to a possible future in which life is meaningful. Drawing on nursing literature, Neuhaus (1997) explained that hope is enabled through active listening, establishing personal support systems, the transmission of humor, courage, and determination, promoting a realistic outlook, affirming personal worth, remembering, caring, choice, fostering spirituality, making plans for the future, and targeting coping strategies. Neuhaus (1997) found that the occupational therapists who participated in her research facilitated hope by encouraging, expressing enthusiasm for progress, focusing on the future, incorporating peer support, and responding to immediate needs. Spencer, Davidson, and White (1997) identified cognitive, emotional, and spiritual aspects of hope. Cognitive aspects relate to the ability to creatively imagine and make choices among new future possibilities that are oriented in reality. These authors explained:

> The occupational therapist urges the client toward action that will test the reality of a goal and foster continued hope. Through analyzing and understanding the consequences of their actions performed in response to a wisely chosen challenge, clients can acquire or reconfirm the sense of being an active agent in designing their future. This experience of agency can form the groundwork for making choices about which future possibilities to establish as goals that direct future actions. (Spencer et al., 1997, p. 192)

Fostering hope revolves around 'reality' testing. It is hope for a *realistic* future that must be obtained. However, what is real is determined by the occupational therapist. The possibilities that await an individual relate to a carved out portion of reality in which they

[17] See also COTA (2006); Sumsion and Law (2006); Trentham & Dunal (2009).

can be active agents. Emotional aspects of hope relate to the processing of disappointment and grief and the harnessing of a new will to persevere. Through the testing of reality limits are imposed: "Hope involves understanding limits and experiencing the negative emotions they evoke, such as grief and despair, as well as rejoicing in the discovery of possibilities for the future" (Spencer et al., 1997, p. 1992). In the face of meaninglessness, despair, and suffering, freedom, choice, and responsibility emerge to imbue life with new meaning. New limits on existence are imposed and the individual resigns themselves to what is now possible. Spiritual aspects of hope relate to meaning and purpose. These authors argued that this occurs through "one's inherent worth as an individual or through connection with some larger entity through which one's actions acquire significance" (p. 193). Hope is a tool that relates to one's worth as a human being. In relation to occupation, hope relates to one's ability to perform in some way in the future; thus, purpose and meaning relate to action. Occupational therapists are directed to imagine future possibilities and future choices with clients, deal with both positive and negative emotions associated with change, and identify and confirm a meaningful future that has purpose. These authors outlined three approaches that can be used to conduct hope work. These involve goal setting, adapting how valued occupations are performed, and conducting life histories or using narrative techniques. For example, Spencer et al. (1997) told a particularly troubling story of a Korean adolescent's transformation during a procedure aimed to lengthen her arm and reduce the visible effects of deformity. While this young woman underwent a physical procedure the treatment was interpreted as a process of adolescent identity development, acculturation, and adaptation to disability:

> Particularly striking were changes in this adolescent's hope for the future. Her initial expectations were that her arm deformity would be 'fixed' and that she would return home with better prospects of marriage and a teaching career without disfigurement … Hopes about her disability changed from making her arm look good to being able to function well in valued activities. Other changes in hope for the future included a growing commitment to a career as a teacher and less emphasis on her potential future role as a wife. (Spencer et al. 1997, p. 196)

This person traveled to the Western world to receive treatment for a physical issue. On receiving care that targeted her hopes for the future and her understanding of life's purposes she underwent a change. Like occupational therapists, she began to value

function over appearance. Work occupations became more important than marriage. Her future goals now focused on attaining a career rather than becoming a wife; she underwent a ‘spiritual’ transformation. Hope builds a new future through individual reorientation. The technologies of hope reconstruct a self by tapping into imagined possibilities, setting limits, and highlighting particular priorities.

Chapter 7

7 The Limits of Critique and Authentic Occupational Therapy

I believe I need fear no contradiction in attributing to man the one natural virtue that the most extreme detractor of human virtue was forced to recognize. I speak of compassion, a disposition well suited to creatures as weak and subject to as many ills as we are, a virtue all the more universal, and all the more useful to man in that it comes before any kind of reflection, and is so natural a virtue.

Rousseau

Philosophy will ensure that the man who has obeyed its laws shall never fail to be armed against all the hazards of fortune: that he shall possess and control, within his own self, every possible guarantee for a satisfactory and happy life.

Cicero

Working as a professional in the 21st century has become increasingly challenging. Practitioners are not always sure what is required of them; clients too, are often doubtful about the purposes and nature of professional work and their own place in the universe (see for example Bruce, Schreiber, Petrovskaya & Boston, in press). This might partially be because we live in a time where certainties have been called into question. Challenging social criticism has undermined even our most cherished assumptions and the values that we hold dear are transforming around us. New opportunities appear at a frightening pace. The world is transforming, without, it seems, the benefit of solid ground on which we can lay the foundations of our thought and action (see Bing, 1986). One begins to wonder how practice, including occupational therapy practice, should be structured. In the introductory paragraphs to this thesis I outlined solutions that various leaders in occupational therapy have advanced in an attempt to ensure that occupational therapy remained relevant in contemporary times. Foucault's work highlights how his world and worlds past have structured and ordered existence. His genius rests in identifying the mechanisms through which order is obtained. His critical edge gives us some perspective into where these mechanisms fail to incorporate many individuals who do not fit neatly into social life. For better or worse, governance is incomplete and becomes offensive for some. At times, our discourses and the values that underpin them fail to include those who might enhance our societies and may even cause

harm (see also Hammell, 2006; Krupa, 2008; Szasz, 1974). Authentic practice, practice that centers on meaning, the purposes, and ends of existence will help safeguard the profession's uniqueness and enhance its survival within particular social contexts. On the other hand, it may also promote unnecessary suffering and exclude those whose values, beliefs, and purposes are not captured or represented within the dominant discourses that circulate within these social contexts (see Bing 1981; Bockoven, 1972; Goldberg, 1999; Piercy, 1976). In this sense, the knowledge that we collect and deploy in professional practice can work to transform the lives of individuals and whole communities in beneficial ways, but may also work to change individuals and communities in ways that delimit or obliterate human potentiality (see Bing 1981; Bockoven, 1972; Goldberg, 1999; Piercy, 1976).

This research has helped to outline a sampling of the technologies that occupational therapists have at their disposal to conduct authentic practice. It also began to outline how knowledge collected about particular phenomena can work to define and delimit the nature of those phenomena. In discussing Foucault's (1961/2009) critique of observation in the asylums of the 19th century, I attempted to subtly show how research about the dimensions of human occupation can become something that works to preserve a particular social value system. In some ways, in pursuing a ubiquitous moral framework, Pinel placed limits on what would then constitute a worthy and morally sound existence. In contemporary times many occupational therapists attempt to outline a ubiquitous definition of spirituality, for example. This quest may delimit the ways in which individuals can express and actualize their human potentiality. Also, through the 'discovery' of knowledge about occupation, occupational science has the potential to help occupational therapy remain relevant and unique, but may also work to delimit the dimensions of occupational experience (see also Molke & Laliberte Rudman, 2009).

It may not be possible to advance timeless ahistorical notions that relate to our role with particular populations and the mechanisms that promote and protect health through occupation. Our very understanding of occupation changes, how we work with occupation changes, and different populations we work with appear and disappear across time and space (CAOT, 1986; 1997; 2007; Wilcock, 2002). Ensuring that members of the profession are able to help individuals tap into their potential safely may require the

development of a normative consciousness (see Castel, 1988; Charland, 2009a; COTO, 2002; Iwama 2004).

Yerxa (1967) called on occupational therapists to practice authentically. This research has certainly helped to reveal occupational therapy's historical lineage. Wilcock (2002) demonstrated how the work of occupational therapists' has changed over time. While we must be true to ourselves as occupational therapists and occupational scientists, and while we must contribute to society and work to enhance quality of life for the people who seek out our assistance, we cannot remain fixated on descriptions of our past roles, obligations, and technologies (see also Mocellin, 1995, 1996). Indeed Foucault argued that we should not expect the answers to particular problems of the past to have legitimacy in the present (1983/2003e). Exploration of the past gives us a sense of how things have been different and can help give us the courage to move forward in novel directions (see Driver, 1968; Peloquin, 2007). We must remain cognizant of and respect our classic foundations; however, we must not forget that times past were also imperfect and flawed. As the nature of the world changes so must our profession. In our quest for authenticity we must examine our goals, we must examine the ultimate ends embraced by the individuals and societies we work with, but we must also act (see Charland, 2002, 2009a; Sharrott, 1986). Friedland and Renwick (1993, p. 471) argued: "At this time in the evolution of our profession, it is important to reclaim the territory that once was ours." This, now more than ever, continues to be true. However, authentic occupational therapy may also involve letting go of the past. As Bing (1984) implied we must understand backwards but live forward.

Rousseau (1755/1984) believed that the human in a natural state possessed a kind of benevolent empathy that was hidden and distorted by society. Cicero (44bce/1979) believed that living a good and moral existence would necessarily lead to happiness. Living, and perhaps reading too much, leads me to believe that these ideas are somewhat naïve. And yet, I do want them to be true. There is something wonderful about these ideas. They preserve our innocence. They offer us a clear way through which we might work to change the experience of living for ourselves, individuals, and whole communities (see for example, Bockoven, 1971; Charland, 2007; Peloquin, 2005; Scull, 1983; Thibeault, 2003; Vanier, 1998). However, the cynical attitude I employed to review

literature in previous sections leaves little room to maneuver (see also Ignatieff, 1983; Rabinbach, 1992). Still, on rereading my own work, I see an array of glaring contradictions that give me hope (see Yerxa, 1980). [18] I had thought that on reviewing a mass of material I would find a new way forward, a new way out (see Molke 2009b). I would find a new answer, or an escape. Attempting to critically consider the conflicting impulses found within the occupational discourse has had an impact on how I view the world (Foucault 1968/1991a). It is true that I have come to value the mundane aspects of daily life (see do Rozario, 1999). It is true that I now see more clearly how being is expressed through a daily round of activities. Like many others, I also believe that occupation holds transformative potential and the profession of occupational therapy holds a great deal of promise. While I have made an attempt to wield a critical perspective in previous paragraphs, it must also be made abundantly clear that in combing through the literature, I was moved deeply. The contributions made by various academics and therapists are admirable. In reading work originating at various times, I was touched by the level of dedication apparent. Over the centuries countless individuals have recognized the importance of the work of occupation therapists. I experience a feeling of pride that I am an occupational therapist (see also Bing, 1967; Kielhofner, 1986; Trentham, 2001). The particular brand of research I set out to accomplish here, however, was not intended simply to applaud; rather, it was, in part, intended to scrutinize the techniques employed by professionals and highlight occupational therapy's sinister potentialities (see Foucault, 1961/2009).

On rereading this thesis, I notice that, following Foucault's example, I have meted out criticism indiscriminately. For example, at times I criticize one particular technique for being too directive, at others, I criticize another technique for not being directive enough. Perhaps this is the purpose that Foucault's critique was intended to serve. It gives us a sense of how to operate by outlining the dangers that exist in varying directions (see Dean, 1994). Readers can study this dissertation and allow it to deflate hope, or it can be used as a kind of compass that functions to highlight what might occur in the routine application of particular treatment methods and sentiments. In some ways this work helps

[18] See Barnitt & Mayers (1993) and Townsend, De Laat, Egan, Thibeault & Wright (1999) for other attempts to bring together different philosophical sentiments related to spirituality.

define what is acceptable and unacceptable when normative content comes into play (Foucault 1968/1991a). It highlights where occupational therapy has the potential to become more coercive than therapeutic (see also Hammell, 2006; Krupa, 2008; Szasz, 1974; Unruh, Versnel & Kerr, 2004).

Kielhofner (1986, p. 20) argued that "therapy operates at the interface of the individual and the social system and practitioners must perennially face the dilemma of whether the social good or the individual good must be emphasized." He explained that in the process of providing treatment, an occupational therapist may find that certain societal values threaten an individual's ability to adapt. He argued that in cases like these occupational therapists might be obligated to help these individuals reject such values. Extending this logic, in some cases, occupational therapists might also be obligated to help an individual reject the values that underlie the profession. Conversely, they may also be required to help by working with an individual to understand how the values that they reject may actually help them to adapt more effectively. This difficult task reflects the tension between freedom and its limits that preoccupied Foucault (1961/2009).

"The Human organism," Adolph Meyer, argued, "can never exist without its setting in the world. All we are and do is of the world and is the world" (as cited in Christiansen, 2007, p. 66). Practice cannot occur in a vacuum, we need a philosophy, values, and beliefs to guide us (Wilcock, 2000). As individuals who also act in the world we need norms to function effectively. Canadian occupational therapists, for example, should not simply reject the values espoused by their national association (e.g., CAOT 1986; 1997; 2007). However, occupational therapists also need to be careful in terms of how they position themselves in relation to these values and beliefs and the societies that support them (see Molke & Laliberte Rudman, 2009; Townsend, De Laat, Egan, Thibeault & Wright, 1999). Indeed, as we have seen, occupational therapists are not alone in struggling with this challenge. Without an array of ethical principles to guide us, the world can become a chaotic mess of uncertainty (see Bing, 1986). Human beings need meaning in their lives just as professional practice needs to be structured by an ethos (see Peloquin, 2005). Each of us needs a setting in the world, both literally and figuratively. However, we need to remain conscious of how we fit into and ask others to

fit into the settings we inhabit (see Castel, 1988; Charland, 2009a; COTO, 2002; Iwama 2004).

Foucault endeavored to teach us that norms are not reflections of an overarching Truth, but the sociohistorical contexts in which we live. Most of us are not privileged enough to have the time and ability that Foucault did to read, write, and consider how we are caught in a complex web of normative expectations, but as occupational therapists we can take some time to think about how our knowledge is prescriptive and work to limit its destructive potential. In his own way, like Foucault, Tillich (1957) worked to outline the different dimensions that structure the ultimate ends of human existence. On the one hand, we have a myth maker who sought to bolster the status of a particular normative value system in a secular age, on the other, a man who endeavored to shatter and smash the myths that structure life in modernity. And yet both conducted their work with the realization that human norms are limited in terms of their finite dimensions and reflect visions that will never capture the totality of experience. In the modern age, occupational therapists must continually struggle with this realization. We need norms and myths to guide efforts to care for those who seek professional attention, but we must also remain very conscious of how we work within and outside the normative structures that govern the present to protect the wellbeing of our clients, ourselves, and the societies in which we operate (see for example Castel, 1988).

Occupational therapy cannot be about the individual alone and it cannot be about society alone. It must be able to work within the space where the two come together. Occupational therapy must always remain relevant in relation to the realities and needs of the present (see Wilcock, 2002). The work of occupational therapists must also focus on the future and what might be (see Laliberte Rudman, 2010; Townsend & Polatajko, 2007). We cannot hope to discover or uncover the perfect set of values and tools that will have universal applicability (see Foucault, 1983/2003e; Tillich, 1957). In relation to spirituality[19], Collins (1998, p. 281) argued: "Occupational therapy as a profession should be wary of trying to define spirituality as a fixed frame of reference and should continue to develop awareness of the broader experiential context of clients' lives." Occupational therapy's visions and treatment techniques will always have the potential to violate the

[19] See also Townsend, De Laat, Egan, Thibeault & Wright (1999).

sentiments and rights of particular communities or individuals. We need to prepare for this potentiality. This necessitates a very broad understanding, one that can become disorienting in its scope (see also Egan & Swedersky, 2003; Thibeault, 2006). It also necessitates a continuing openness to otherness (Polatajko et al., 2007c). Indeed occupational therapists and scientists must now work to expand the "definition of spirituality to include other cultural or historical perspectives" (Townsend, De Laat, Egan, Thibeault & Wright 1999, p. 23) that do not currently appear in the literature that explicitly deals with spirituality.

Embracing an occupational perspective immediately suggests that issues of authenticity need to be addressed. It should also be clear that occupational therapy's trek into the spiritual realm is not new. Throughout its history, under various guises, occupational therapists and those that worked with occupation have dealt with spirit. At some points, to our collective dismay, this work may have bordered on the coercive. And yet, in the present coercion is not acceptable in the routine application of occupational therapy services and using fear to install a particular kind of conscience is not acceptable. But what should also be clear is that the construction of particular subjectivities continues to occur. Conscience is now called identity. Our tools are different but they are no less sophisticated and may be just as shocking to those working in the future and, indeed, to some in the present. Successful treatment may actually involve helping an individual understand the interactive effects of various physical, personal, social, and spiritual dimensions, for example. How one's morality, life's purpose, and occupations interact with the physical, and social domains, for example; how these issues will affect occupational performance and engagement in beneficial and detrimental ways, for example. What one will need, want, or have to do will depend on questions that relate to notions of what constitutes an authentic life that dominate specific historical contexts (see Polatajko et al., 2007a). However, as Healy (1990) argued, this kind of treatment, particularly in mental health, can quickly become detrimental to healthy human functioning.

While it seems that occupational therapists in certain contexts understand that spirituality plays an important part in day to day occupations, they are not directed to dialogue openly with their clients about the benefits of one kind of normative reasoning

over another. Indeed, this would be seen as unethical and authors warn against proselytizing (see COTO, 2010; Charland, 2008; Rosenfeld, 2001). As Cunliffe (1994) argued: "Within occupational therapy, patients have a right to be informed of the philosophy, theory, belief or spiritual belief contained in treatment. Equally important are giving an explanation and receiving agreement. There is no difference between the surgeon's knife and a treatment belief that cuts theoretically, psychologically or spiritually in the wrong place" (p. 481). The application of critical perspectives can help occupational therapists recognize when, where, and how coercion can occur. As various authors have suggested, more research must be conducted to understand what authentic practice should consist of and how issues of authenticity should be addressed with clients (e.g., Schulz, 2004; Wilding, 2002). However, in conjunction with these efforts, critical research projects that submit this work to careful scrutiny must also be undertaken.

7.1 Limitations

As is stated above in chapter one and three, this particular thesis is limited in a variety of ways. Not the least of which is its reliance of Foucault's critical perspective, which itself was not free of 'bias.' Foucault understood the impossibility of escaping from the effects of power relations in free societies (Foucault, 1994/1988b). His acknowledgement of this fact might also be understood as an acknowledgement that he himself was a social actor who deployed particular truths both willingly and unwillingly (see also Foucault, 1966/2005c). Foucault existed in a 'setting in the world.' He was human, so am I (see also Habermas, 1986). Those wishing to test this thesis for 'bias' might then question my reliance on this particular theorist and they would have a right to do so. Any piece of scholarship will be limited. Any particular methodology will be limited. This highlights the importance of the conduct of multiple works that draw on alternative theories, methodologies, and perspectives to outline, construct, and critique the ethos of occupational therapy.

In relation to the limitation outlined above, one should also expect that the concepts that are fundamental to Foucault's theoretical perspective will also reflect his 'bias.' Foucault's use of the concepts liberty and freedom, for example, was unique. These are concepts that have enjoyed a long history in Western philosophy. Being located

in the health sciences, the present thesis did not endeavor to understand or challenge the multiple, varied, and transforming uses of these terms through time. That would make for a good thesis topic in its own right, but was beyond the scope of the present discussion.

As well, adopting Foucault's methodologies create a number of consequences in terms of what data will be collected and, accordingly, what is discovered in that data (see Habermas, 1986). Foucault was concerned with discourse and not the "self-understandings" (Habermas, 1986, p.1) of particular social actors. As is stated in chapter one, this thesis was not concerned with the specific practices of occupational therapists. Instead it was concerned with occupational therapy discourse. Future research projects that adopt alternative perspectives might employ methodologies aimed toward the actual practices of occupational therapists or clients, for example.

7.2 Key Messages & Examples for Discussion

After combing through a long work of scholarship most of us look for a number of succinct points, or key messages that can be easily remembered, or, at the very least, mulled over. While it is not in keeping with the particular methodology used to guide this work to propose an overarching moral or lesson to be learned, resolutions did emerge in the process of undertaking this work. The overarching purpose of this work was to *uncover and make explicit some of the normative assumptions and end points that govern contemporary occupational therapy practice, through a critical examination of the various therapeutic technologies that have revolved around occupation since the 19th century*.[20] The concept of 'authentic practice' was used to denote practice that is explicitly tied to normative processes or ends. ***In the process of conducting this work I came to accept the assertion that practice devoid of normative content is ineffective and meaningless.[21] I also indicate above that the use of fear and coercion should not be tolerated in the normal and routine application of occupational therapy services.***

In outlining the criticisms that Foucault made in relation to moral treatment technologies, for example, it is my worry that these technologies will be picked up and used in the conduct of professional practice. I did not outline these techniques,

[20] See Castel (1988), Charland (2008), & Clark et al., (1991)
[21] Charland (2009a); see also COTA 2006

particularly in relation to the use of fear in moral treatment, so that they can be used by practicing professionals. Foucault's work was drawn on in order to emphasize where our practices in the present have the potential to become more coercive that therapeutic. In the practical examples and excerpts found in the introduction to this dissertation and again in the statements that follow, one can see how norms are a part of professional practice. As the example provided in the introduction of this thesis makes clear, occupational therapists are in positions of power and have the opportunity to influence how an individual will perform occupations in accordance with the norms rooted in various sociocultural traditions. Occupational therapists need to remain conscious of the power they hold when working with a client in performing the simple tasks involved in completing laundry, or making choices that relate to the meanings that structure occupational engagement more broadly. That power includes the conscious and unconscious use of fear and coercion. I have attempted to outline where the technologies that occupational therapists have available to them have the potential to become more coercive than therapeutic. In conducting professional work therapists must remain cognizant of how even one or two words can have a profound impact on how an individual will come to structure occupational life.

In outlining occupational therapy technologies that relate to what I have called authentic occupational therapy practice, I have helped to promote consciousness regarding the values and norms that structure occupational therapy practice (see Castel, 1988). This will allow for open dialogue concerning the relative appropriateness of the values and norms that structure practice in a variety of professional contexts. And yet, conflicts over what norms are to be employed will continue to occur. In order to make decisions in real time occupational therapists need to have a clear understanding of what provides a basis for practice and how that practice fits into the normative structures that organize existence within the particular contexts that they and particular client's inhabit. Indeed understanding how norms are deployed by occupational therapists will enhance our ability to communicate with clients and render our interventions more effective (see also Sherr Klein, 1997). Defending occupational work requires not only 'scientific evidence,' but understandings of the normative structures that organize professional work (see Charland 2008).

For example, how will we work with a client who seems to have no sense of the norms that govern the contexts that they want to be a part of? How will we work with a client who's beliefs seem to conflict with reality? What will we do when the rights of the individual seem to conflict with the rights of society at large? How will we challenge and on what basis will we help individuals live up to the ideals created by society and themselves? These are classic ethical dilemmas faced by professionals and discussed in a variety of professional literatures that deal with ethical decision making (see for example Yeo & Molke, 1996). The substantive content of this thesis should help professionals recognize how powerful normative work can be with both positive and negative consequences. This content should also help professionals recognize and adhere to limits. However, to answer questions like the ones posed at the beginning of this paragraph we need to move beyond the theoretical level and recognize that norms saturate real life and professional practice both in implicit and explicit ways (see also Brocket, 1996). Indeed, historically, occupational therapists have engaged in professional work easily and without a great deal of theoretical reflection (see Parham, 1987). Consider, for instance, the following three practical 'real world' examples appearing in occupational therapy and science text book chapters published in 1918, 1947, and 2000.

1. It is worth while trying to keep man's work manly. Invalidism does not make it necessary for its subject to become effeminate in effort. Beauty must truly hold sway here as elsewhere, but let there be strength and stability combined, and strive for that appreciated by the healthy subject as well as by the invalid. (Tracy, 1918, p. 123)

2. Restoration of good habits through a program of constructive, normal activities results in the improved social status of the patient by restoring his self-respect and interest in the world of reality. An attempt is made to persuade the patient to make an effort to recover by encouraging him to cope with the social order and by trying to convince him through appeals to his various senses that reality, however difficult, is better than unreality, fantasy and defeat. (Wade, 1947, p. 106)

3. It all came to a head last Friday when a neighbor dropped in and had to call my husband home from work. I was curled up in a corner. I was so depressed and anxious I could barely get words out. My daughter had been eating from the box of cereal I had left out for her, and the baby had been crying for what seemed like hours. Dirty dishes from the day before lined the kitchen, and I just wanted out. I feel better since I've come into hospital, but I'm frightened that the same thing will happen if I return home. I don't want to let everyone down again, and I'm worried that I can't be a good mother to my children. (Clark, 2000, p. 111).

Within each of these examples one can recognize how and why attention to norms occurs. In each case a very basic focus on norms can be identified. Examined in tandem, these examples might work to initiate dialogue concerning the appropriate and inappropriate use of normative expectations in occupational therapy practice.

For instance, as the first example demonstrates, at the beginning of the 20th century occupational therapists were directed to ensure that the prescription of occupation conformed to gender norms. In the production of some craft, for example, the occupational therapist was directed to ensure that man's work remained 'manly.' Beauty was paramount, but the occupational therapist was directed to ensure that 'strength' and 'stability' would also be featured. One might spend time comparing this kind of occupational intervention to those employed by Philippe Pinel, for example. Here, however, all that needs to be emphasized is that occupational therapists were directed to consider which activities meshed with the norms that governed the life of the individual receiving treatment. Is this directive still relevant today? Why? Why not? How is the occupational therapist directed to work with a client's spirit or identity? Is there a problem with this kind of directive?

With the second example, ties to moral treatment might once again be identified. However, here readers might simply attend to how 'normal' occupations functioned to restore an individual's connection to the realities of the social system within which they existed. Normal and constructive activities would realign the individual toward reality which in turn would allow them to cope with a particular social order. Should this continue to be the aim of occupational therapy practice? When? Why? Why not? How might an occupational therapist also challenge a particular social order to help an individual cope with that order more effectively? Which kind of practice would be 'better'? Why?

In examining practical examples written and published in contemporary times it becomes more difficult to immediately identify where and how normative content plays a role in professional practice. However, it is not impossible. In the third example, the failure to meet normative expectations signifies the presence of mental illness. In this case, occupational performance problems are problems that prevent an individual from fulfilling particular occupational norms. In this example, a mother struggling with the

crippling weight of an acute depressive episode cannot 'properly' take care of her home and children. Once again, like the example taken from 1918, gender role expectations emerge. This client struggles with guilt because, in her mind, she 'can't be a good mother.' In the late 20th century how would the occupational therapist deal with these kinds of normative expectations? Perhaps, a proficient occupational therapist would have had some understanding of the norms that revolve around childcare. Might a proficient occupational therapist have been able to both support and challenge the norms and ideals that revolve around what it means to be a 'good mother' in the year 2000? How would an occupational therapist in this case be working with a client's spirit or identity?

It is clear that occupational therapists must have an awareness of the dangers inherent in practice governed by normative considerations. A critical consideration of how occupational therapy's therapeutic technologies are loaded with normative content can help to highlight these dangers. In submitting what I have called authentic occupational therapy practice and occupational therapy labeled 'moral treatment' to the rigors of an in-depth Foucauldian analysis, I have helped to promote consciousness regarding how normative content might saturate occupational therapy practice in a routine and regular way. Understanding how norms explicitly and implicitly guide practice will help occupational therapists make better decisions (COTO, 2002). Understanding how norms saturate professional technologies will help occupational therapists comprehend why conflicts occur in the routine application of treatment (Castel, 1988).

References

Alsop, A. (2006). Qualifying as an occupational therapist: An educational journey from ward-based to workplace learning. *British Journal of Occupational Therapy, 69*(10), 442-449.

American Occupational Therapy Association. (1993). Core values and attitudes of occupational therapy practice. *American Journal of Occupational Therapy, 47*(12), 1085-1086.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association. Retrieved from http://online.statref.com.proxy2.lib.uwo.ca:2048/Document/

Baptiste, S. (1997). Editorial: Spiritually speaking. *Canadian Journal of Occupational Therapy, 64*(3), 104-105.

Baptiste, S. (2003) Gaining awareness of spirituality at work. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 193-206). Ottawa: Canadian Association of Occupational Therapists.

Barnitt, R. & Mayers, C. (1993). Can occupational therapists be both humanists and Christians? A study of two conflicting frames of reference. *British Journal of Occupational Therapy, 56*(3), 84-88.

Beagan, B. & Kumas-Tan, Z., (2005). Witnessing spirituality in practice. *British Journal of Occupational Therapy, 68*(1), 17-24.

Beck, A., Rush, J., Shaw, B. & Emery. (1979). *Cognitive therapy of depression.* New York: The Guilford Press.

Belcham, C. (2004). Spirituality in occupational therapy: Theory in practice? *British Journal of Occupational Therapy, 67*(1), 39-46.

Bing, R. (1967). William Rush Dunton, Jr.: American Psychiatrist and Occupational Therapist 1868-1966. *American Journal of Occupational Therapy, 21*(3), 172-175.

Bing, R. (1981). Occupational therapy revisited: A paraphrastic journey. *American Journal of Occupational Therapy, 35*, 499-518.

Bing, R. (1984). Living forward, understanding backwards. *American Journal of Occupational Therapy, 38*(7), 435-439.

Bing, R. (1986). The subject is health: Not of facts, but of values. *American Journal of Occupational Therapy, 40*(10), 667-671.

Bing, R. (2005). Looking back, living forward: Occupational therapy history. In K. Sladyk & S. Ryan (Eds.), *Ryan's occupational therapy assistant: Principles, practice issues, and techniques* (4th ed., pp. 2-13). Thorofare: NJ: Slack Incorporated.

Bockoven, J. (1968). Challenge of the new clinical approaches. *American Journal of Occupational Therapy, 22*(1), 23-25.

Bockoven, J. (1971). Legacy of moral treatment – 1800s to 1910. *American Journal of Occupational Therapy, 25,* 223-225.

Bockoven, J. (1972). *Moral treatment in community mental health*. New York: Springer Publishing Company.

Bracegirdle, H. (1991). Two hundred years of therapeutic occupations for women hospital patients. *British Journal of Occupational Therapy, 54(6)* 231-232.

Bracken, P. (2002). Listening to Foucault. *Philosophy, Psychiatry & Psychology, 9*(2), 187-188.

Breines, E. (1995). Understanding 'occupation' as the founders did. *British Journal of Occupational Therapy, 58*(11), 458-460.

Brockett, M. (1996). Ethics, moral reasoning and professional virtue in occupational therapy education. *Canadian Journal of Occupational Therapy, 63*(3), 197-205.

Brown, L. (Ed.). (1993). The new shorter Oxford English dictionary. Oxford: Clarendon Press.

Bruce, A., Schreiber, R., Petrovskaya, O. & Boston, P. (in press). Longing for ground in a ground(less) world: understanding existential suffering.

Bursell, J., & Mayers, C. (2010). Spirituality within dementia care: Perceptions of health professionals. *British Journal of Occupational Therapy, 73*(4), 144-151.

Busuttil, J. (1992). Psychosocial occupational therapy: From myth and misconception to multidisciplinary team member. *British Journal of Occupational Therapy, 55,* 457-461.

Canadian Association of Occupational Therapists (1986). *Intervention Guidelines for the client~centred practice of occupational therapy.* Ottawa, ON: Department of National Health and Welfare.

Carabine, J. (2001). Unmarried motherhood 1830-1990: A genealogical analysis. In M. Wetherell, S. Taylor & S. Yates (Eds.), *Discourse as data: A guide for analysis.* (pp. 267-310). London: Sage Publications Ltd.

Carlson, M., & Clark, F. (1991). The search for useful methodologies in occupational science. *American Journal of Occupational Therapy, 45,* 235-241.

Castel (1983). Moral treatment: Mental therapy and social control in the nineteenth century. In S. Cohen & A. Scull (Eds.), *Social control and the state*. (pp. 248-266). Oxford: Martin Robertson.

Castel (1988). The regulation of madness: The origins of incarceration in France. (W.D. Halls, Trans.). Berkeley: University of California Press.

Charland, L. (2002). Tuke's healing discipline. Commentary on Erica Lilleleht's 'Progress and power: Exploring the disciplinary connections between moral treatment and psychiatric rehabilitation.' *Philosophy, Psychiatry and Psychology, 9*(2), 183-186.

Charland, L. (2006). Moral nature of the DSM-IV cluster B personality disorders. *Journal of Personality Disorders, 20(2),* 116-125.

Charland, L. (2007). Benevolent theory: Moral treatment at the York Retreat. *History of Psychiatry, 18,* 61-80.

Charland, L. (2008). A moral line in the sand: Alexander Crichtion and Philippe Pinel on the psychopathology of the passions. In L. Charland & P. Zachar (Eds.), *Fact and Value in Emotion* (pp. 15-33). Philadelphia: John Benjamins Publishing Company.

Charland, L. (2009a). Technological reason and the regulation of emotion. In J. Phillips (Ed.), *Philosophical perspectives on technology and psychiatry.* (pp. 55-69). Oxford: Oxford University Press.

Charland, L. (2009b). The birth of evidence-based Psychiatry: The real legacy of Philippe Pinel (1745-1826). *Canadian Psychiatry Aujourd'hui, 5*(5), 483 Retrieved from http://publications.cpa-apc.org/browse/documents/483

Charland, L. (2010). Science and Morals in the affective psychopathology of Philippe Pinel. *History of Psychiatry, 21*(1), 38-53.

Christiansen, C. (1987). Research: Its relationship to higher education. *American Journal of Occupational Therapy, 41,* 77-80.

Christiansen, C. (1991). Research: Looking back and ahead after four decades of progress. *American Journal of Occupational Therapy, 45,* 391-393.

Christiansen, C. (1997). Acknowledging a spiritual dimension in occupational therapy practice. *American Journal of Occupational Therapy, 51*(3), 169-172.

Christiansen, C. (1999). Defining Lives: Occupation as identity: An essay on competence, coherence, and the creation of meaning. *American Journal of Occupational Therapy, 53*, 547-558.

Christiansen, C. (2007). Adolf Meyer revisited: Connections between lifestyles, resilience and illness. *Journal of Occupational Science, 14*(2), 63-76.

Cicero, M. (1979). Discussions at Tusculum V. In M. Grant (Ed.), *Cicero: On the good life.* (pp.52-116). (M. Grant, Trans.). New York: Penguin Books. (Original work published 44bce).

Clark, F. (2010). Power and confidence in professions: Lessons for occupational therapists. *Canadian Journal of Occupational Therapy, 77*(5), 264-269.

Clark, F., Jackson, J., & Carlson, M. (2004). Occupational science, occupational therapy and evidence-based practice: What the well elderly study has taught us. In M. Molineux (Ed.), Occupation for occupational therapists. (pp. 200-230). Oxford: Blackwell Publishing Ltd.

Clark, F., Parham, D., Carlson, M., Frank, G., Jackson, J., Pierce, D., Wolfe, R., & Zemke, R. (1991). Occupational science: Academic innovation in the service of occupational therapy's future. *American Journal of Occupational Therapy, 45*, 300-310.

Clark, J. (2000). Case study: A demonstration of the occupational performance process model. In V. Fearing & J. Clark (Eds.). *Individuals in context: A practical guide to client-centered practice* (pp. 109-121). Thorofare, NJ: Slack Incorporated.

Cockburn, L. (2001a). The professional era: CAOT in the 1950s & 1960s. *Occupational Therapy Now, 5*, 5-9.

Cockburn, L. (2001b). Change, expansion and reorganization: CAOT in the 1970s. *Occupational Therapy Now, 6*, 3-6.

Collins, M. (1998). Occupational therapy and spirituality: Reflecting on quality of experience in therapeutic interventions. *British Journal of Occupational Therapy, 61*(6), 280-284.

Collins, J., Paul, S., & West-Frasier, J. (2001). The utilization of spirituality in occupational therapy: Beliefs, practices, and perceived barriers. *Occupational Therapy in Health Care, 14*(3/4), 73-92.

Colman, W. (1990). Recruitment standards and practices in occupational therapy, 1900-1930. *American Journal of Occupational Therapy, 44*, 742-748.

Cooper, R. (2004). What is wrong with the DSM? *History of Psychiatry, 15*(1), 5-25.

COTA Health**.** (2006). A practice guideline for home-based occupational therapy for people with depression. Toronto: COTA Health.

COTO (2002). Conscious decision-making in occupational therapy practice. Toronto: College of Occupational Therapists of Ontario.

COTO (2010). Standards for Psychotherapy. Toronto: College of Occupational Therapists of Ontario.

Csontó, S. (2009). Occupational therapy students' consideration of clients' spirituality in practice placement education. *British Journal of Occupational Therapy, 72*(10), 442-449.

Cunliffe, M. (1994). Rights, ethics and the spirit of occupation. *British Journal of Occupational Therapy, 57*(12), 481-482.

Dean, M. (1994). *Critical and effective histories: Foucault's methods and historical sociology*. New York: Routledge.

Diasio Serrett, K. (1985). Another look at occupational therapy's history: Paradigm or pair of hands? *Occupational Therapy in Mental Health, 5(3)*, 1-31.

Diasio, K. (1971). The modern era – 1960 – 1970. *American Journal of Occupational Therapy, 25*, 237-242.

Dickie, V. (2004). Culture is tricky: A commentary on culture emergent in occupation. *American Journal of Occupational Therapy, 58*, 169-175.

Dickinson, E. (1990). From madness to mental health: A brief history of psychiatric treatments in the UK from 1800 to the present. *British Journal of Occupational Therapy, 53*, 419-424.

Digby, A. (1985). *Madness, morality and medicine: A study of the York Retreat, 1796-1914*. Cambridge: Cambridge University Press.

doRozario, L. (1999). Foreword. In E. Townsend, D. De Laat, M. Egan, R. Thibeault & W. Wright (Eds.), *Spirituality in enabling occupation: A learner-centred workbook* (1-2). Ottawa: CAOT Publications ACE

Driver, M. (1968). A philosophic view of the history of occupational therapy in Canada. *Canadian Journal of Occupational Therapy, 35*(2), 53-60.

Dunning, E. (1973). Philosophy and occupational therapy. *American Journal of Occupational Therapy, 27*(1), 18-23.

Dunton, W. (1918). *Occupation therapy: A manual for nurses*. Philadelphia, PA: W.B. Saunders Company.

Dunton, W. (1919). *Reconstruction therapy.* Philadelphia, PA: W.B. Saunders Company.

Dunton, W. (1947). History and development of occupational therapy. In H. Willard & C. Spackman (Eds.), *Principles of occupational therapy* (pp. 1 – 9). Philadelphia: J.B. Lippincott Company.

Eakin, J., Robertson, A., Poland, B., Coburn, D., & Edwards, R. (1996). Towards a critical social science perspective on health promotion research. *Health Promotion International, 11*(2), 157-165.

Egan, M., & Delaat, M. (1994). Considering spirituality in occupational therapy practice. *Canadian Journal of Occupational Therapy, 61(2),* 95-101.

Egan, M., & Delaat, M. (1997). The implicit spirituality of occupational therapy practice. *Canadian Journal of Occupational Therapy, 64*(1), 115-121.

Egan, M., & Swedersky, J. (2003). Spirituality as experienced by occupational therapists in practice. *American Journal of Occupational Therapy*, *57*(5), 525-533.

Engelhardt, H. (1977). Defining occupational therapy: The meaning of therapy and the virtues of occupation. *American Journal of Occupational Therapy, 31*, 666-672.

Engquist, D., Shortt-DeGraff, M., Gliner, J., & Oltjenbruns. (1997). Occupational therapists' beliefs and practices with regard to spirituality and therapy. *American Journal of Occupational Therapy, 51*(3), 173-180.

Epstein, L. (1999). The Culture of Social Work. In A.S. Chambon, A. Irving & L. Epstein (Eds.), *Reading Foucault for social work* (pp. 3-26). New York: Columbia University Press.

Farrar, J. (2001). Addressing spirituality and religious life in occupational therapy practice. *Physical & Occupational Therapy in Geriatrics, 18*(4), 65-85.

Fidler, G. (1981). From crafts to competence. *American Journal of Occupational Therapy, 35, 567-573.*

Fidler, G., & Fidler, J. (1978). Doing and becoming: Purposeful action and self-actualization. *American Journal of Occupational Therapy*, *32*, 305–310.

Fleming, M., & Mattingly, C. (1994). The underground practice. In C. Mattingly & M. Fleming (Eds.), *Clinical reasoning: Forms of inquiry in a therapeutic practice* (p. 295-315). Philadelphia: F.A. Davis Company.

Foucault, M. (1980a). Questions on geography. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 63-77). (C. Gordon, L. Marshall, J. Mepham & K. Soper, Trans.). New York: Pantheon Books. (Original work published 1976).

Foucault, M. (1980b). Two Lectures. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 78-108). (C. Gordon, L. Marshall, J. Mepham & K. Soper, Trans.). New York: Pantheon Books. (Original work published 1977).

Foucault, M. (1980c). Truth and Power. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 109-133). (C. Gordon, L. Marshall, J. Mepham & K. Soper, Trans.). New York: Pantheon Books. (Original work published 1977).

Foucault, M. (1988a). *Madness and civilization: A history of insanity in the age of reason.* (R. Howard, Trans.). New York: Vintage Books. (Original work published 1965).

Foucault, M. (1988b). The ethic of care for the self as a practice of freedom. (J.D. Gauthier, Trans.). Cambridge, Massachusetts: The MIT Press. (Original work published 1984).

Foucault, M. (1990). *The history of sexuality: An introduction — Volume 1*. (R. Hurley, Trans.). New York: Vintage Books. (Original work published 1976).

Foucault, M. (1991a). Politics and the study of discourse. In G. Burchell, C. Gordon & P. Miller (Eds.), The *Foucault effect: Studies in governmentality.* (pp. 53 – 72). (C. Gordon Trans.). Chicago: The University of Chicago Press. (Original work published 1968).

Foucault, M. (1991b). Questions of method. In G. Burchell, C. Gordon & P. Miller (Eds.), The *Foucault effect: Studies in governmentality.* (pp. 73-86). (C. Gordon Trans.). Chicago: The University of Chicago Press. (Original work published in 1978).

Foucault, M. (1991c). Governmentality. In G. Burchell, C. Gordon & P. Miller (Eds.), The *Foucault effect: Studies in governmentality.* (pp. 87 – 104). (C. Gordon Trans.). Chicago: The University of Chicago Press. (Original work published in 1978).

Foucault, M. (1995). *Discipline & punish: The birth of the prison*. (A. Sheridan-Smith, Trans.). New York: Vintage Books. (Original work published 1975).

Foucault, M. (1996a). The order of things. (J. Johnston Trans.). In S. Lotringer (Ed.), Foucault live: Michel Foucault Collected Interviews. New York: Semiotext(e). (Original work published 1978).

Foucault, M. (1996b). The discourse of history. (J. Johnston Trans.). In S. Lotringer (Ed.), Foucault live: Michel Foucault Collected Interviews. New York: Semiotext(e). (Original work published 1967).

Foucault, M. (1996c). The impossible prison. (C. Gordon Trans.). In S. Lotringer (Ed.), Foucault live: Michel Foucault Collected Interviews. New York: Semiotext(e). (Original work published 1978).

Foucault, M. (2003a). *Nietzsche, genealogy, history.* In P. Rabinow & N. Rose (Eds.), The essential Foucault (pp. 351- 369, D. Brouchard & S. Simon, Trans.). New York: The New Press. (Original work published 1971).

Foucault, M. (2003b). What is Enlightenment? In P. Rabinow & N. Rose (Eds.), *The essential Foucault* (pp. 43-57). (C. Porter, Trans.). New York: The New Press. (Original work published 1978).

Foucault, M. (2003c). *Society must be defended: Lectures at the College de France 1975-1976*. A. Davidson (Ed.), (D. Macey, Trans.). New York: Picador. (Original work published 1976).

Foucault, M. (2003d). On the genealogy of ethics: An overview of work in progress. In P. Rabinow & N. Rose (Eds.), *The essential Foucault* (pp.102-125). New York: The New Press. (Original work published 1983).

Foucault, M. (2003e). Question of Method. In P. Rabinow & N. Rose (Eds.), *The essential Foucault* (pp. 246-258). (C. Gordon, Trans). New York: The New Press. (Original work published 1980).

Foucault, M. (2005a). *The archaeology of knowledge*. (A. Sheridan-Smith, Trans.). London: Routledge Classics. (Original work published 1969).

Foucault, M. (2005b). *The birth of the clinic: An archaeology of medical perception*. (A. Sheridan, Trans.). London: Routledge Classics (Original work published 1963).

Foucault, M. (2005c). *The order of things: An archaeology of the human sciences*. (A. Sheridan-Smith, Trans.). New York: Routledge Classics. (Original work published 1966)

Foucault, M. (2009). *History of Madness*. (J. Murphy & J. Khalfa, Trans.). London: Roitledge (Original work published 1961).

Frank, G. (1996). Crafts production and resistance to domination in the late 20th Century. *Journal of Occupational Science, 3*(2), 56-64.

Frank, G., Bernardo, C., Trooper, S., Noguchi, F., Lipman, C., Maulhardt, B. & Weitze, L. (1997). Jewish spirituality through actions in time: Daily occupations of young orthodox Jewish couples in Los Angeles. *American Journal of Occupational Therapy, 51*(3), 199-206.

Fraser, N. & Gordon, L. (1994). A genealogy of dependency: Tracing a keyword of the U.S. welfare state. *Signs, 19*(2), 309-336.

Friedland, J. & Davids-Brumer, N. (2007). From education to occupation: The story of Thomas Bessell Kinder. *Canadian Journal of Occupational Therapy, 74*, 27-37.

Friedland, J. & Rais, H. (2005). Helen Primrose LeVesconte: Occupational therapy clinician, educator, and maker of history. *Canadian Journal of Occupational Therapy, 72*(3), 131-141.

Friedland, J. (2001). Knowing from whence we came: reflecting on return-to-work and interpersonal relationships. *Canadian Journal of Occupational Therapy, 68*(5), 266-271.

Friedland, J. (2003). Muriel Driver Memorial Lecture – Why crafts? Influences on the development of occupational therapy in Canada 1890-1930. *Canadian Journal of Occupational Therapy, 70*, 204-212.

Friedland, J., & Renwick, R. (1993). Psychosocial occupational therapy: Time to cast off the gloom and doom. *American Journal of Occupational Therapy, 47*(5), 467-471.

Friedland, J., Robinson, I. & Cardwell, T. (2001). In the beginning: CAOT from 1926 – 1939. *OT Now, 3*, 15-19.

Fuller, D. (1918). Introduction. In S. Tracy (Ed.), *Studies in invalid occupation.* (pp. 1-10). Boston: Whitcomb & Borrows.

Gastaldo, D. & Holmes, D. (2002). Foucault and nursing: A history of the present. *Nursing Inquiry, 6*(4), 231-240.

Glover, J. (2009). The literature of occupational science: A systematic, quantitative examination of peer-reviewed publications from 1996-2006. *Journal of Occupational Science, 16*(2), 92-103.

Goldberg, A. (1999). *Sex, religion and the making of modern madness: The Eberbach Asylum and German Society 1815-1849*. New York: Oxford University Press.

Gordon, C. (1991). Governmental rationality: an introduction. In G. Burchell, C. Gordon & P. Miller (Eds.), The *Foucault effect: Studies in governmentality.* (pp. 1 – 51).Chicago: The University of Chicago Press.

Gray, M., & McPherson, K. (2005). Cultural safety and professional practice in occupational therapy: A New Zealand perspective. *Australian Occupational Therapy Journal, 52*, 34-42.

Griffith, J., Caron, C., Desrosiers, J., Thibeault, R. (2007). Defining spirituality and giving meaning to occupation: The perspective of community-dwelling older adults with autonomy loss. *Canadian Journal of Occupational Therapy, 74*(2), 78-90.

Habermas, J. (1986). The genealogical writing of history: On some aporias in Foucault's theory of power. *Canadian Journal of Political and Social Theory, 10*(1-2), 1-9.

Hacking, I. (1986a). The archeology of Foucault. In D. Couzens Hoy (Ed.), *Foucault: A critical reader* (pp. 27-40). New York: Basil Blackwell.

Hacking, I. (1986b). Making up people. In T. Heller, M. Sosna & D. Wellbery (Eds.), *Reconstructing individualism: Autonomy, individuality, and the self in Western thought* (pp. 222-236). Stanford, California: Stanford University Press.

Hacking, I. (1991). How should we do the history of statistics? In G. Burchell, C. Gordon & P. Miller (Eds.), The *Foucault effect: Studies in governmentality.* (pp. 181 – 195).Chicago: The University of Chicago Press.

Hacking, I. (1995). The looping effects of human kinds. In D. Sperber & D. Premack (Eds.), *Causal cognition: A multi-disciplinary debate* (pp. 351-383). Oxford, England: Clarendon Press.

Hall, H. & Buck, M. (1915). The work of our hands: A study of occupation for invalids. New York: Moffat, Yard & Company.

Hall, S. (2007). Foucault: Power, knowledge and discourse. In M. Wetherell, S. Taylor & S. Yates. (Eds.), *Discourse theory and practice: A reader.* (pp. 72-81). London: Sage Publications Ltd.

Hammell, K. (2001). Intrinsicality: Reconsidering spirituality, meaning(s) and mandates. *68*(3), 186-194.

Hammell, K. (2003). Intrinsicality: Reflections on meaning and mandates. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 67-81). Ottawa: Canadian Association of Occupational Therapists.

Hammell, K. (2006). *Perspectives on disability & rehabilitation: Contesting assumptions; challenging practice*. Philadelphia: Churchill Livingstone.

Hammell, K. (2009). Sacred texts: A skeptical exploration of the assumptions underpinning theories of occupation. *Canadian Journal of Occupational Therapy, 76*(1), 6-13.

Haskell, T. (1984). Introduction. In T. Haskell (Ed.), *The authority of experts: Studies in history and theory* (pp. ix-xxxix). Bloomington, Indiana: Indiana University Press.

Healy, D. (1990). *The suspended revolution: Psychiatry and psychology re-examined*. Boston: Faber and Faber.

Healy, D., Charland, L., & Hickish, G (2008). Translators' preface In P. Pinel, *Medico-philosophical treatise on mental alienation.* (2nd ed., G. Hickish, D. Healy & C. Charland, Trans., pp. xiii-xviii). West Sussex: Wiley-Blackwell. (Original work published 1809).

Hocking, C. (2007). Early perspectives of patients, practice and the profession. *British Journal of Occupational Therapy, 70,* 284-291.

Hocking, C. (2008). The way we were: Romantic assumptions of pioneering occupational therapists in the United Kingdom. *British Journal of Occupational Therapy, 71,* 146-154.

Hocking, C., & Whiteford, G. (1995). Multiculturalism in occupational therapy: A time for reflection on core values. *Australian Occupational Therapy Journal, 42*, 172-175.

Hook, D. (2001). Discourse, knowledge, materiality, history: Foucault and discourse analysis. *Theory & Psychology, 11*(4), 521-547.

Hooker, C. (n.d.). Where history meets qualitative health research. Presentation retrieved from http://www.ccqhr.utoronto .ca/course_seminar_quig_prev.asp

Hooper, B. (2006). Epistemological transformation in occupational therapy: Educational implications and challenges. *OTJR, 26*, 15-24.

Horkheimer, M., & Adorno, T. (1972). *Dialectic of Enlightenment*. New York: Herder And Herder.

Howard, B., & Howard, J. (1997). Occupation as spiritual activity. *American Journal of Occupational Therapy, 51*(3), 181-185.

Hoyland, M., & Mayers, C. (2005). Is meeting spiritual need within the occupational therapy domain? *British Journal of Occupational Therapy, 68*(4), 177-180.

Hume, C. (1999). Spirituality: A part of total care? *British Journal of Occupational Therapy, 62*(8), 267-370.

Hunter, J. (1976). Research and occupational therapy. *Canadian Journal of Occupational Therapy, 43*(3). 121-125.

Ignatieff, M. (1983). State, civil society and total institutions: A critique of recent social histories of punishment. In S. Cohen & A. Scull (Eds.), *Social control and the state*. (pp. 75-105). Oxford: Martin Robertson.

Ilott, I. (2002a). Research: Does OT make a difference? In A. Wilcock (Ed.), *Occupation for health Volume 2: A journey from prescription to self health.* (pp. 319 – 322). London: British Association and College of Occupational Therapy.

Ilott, I. (2002b). Research in the 1970s. In A. Wilcock (Ed.), *Occupation for health Volume 2: A journey from prescription to self health.* (pp. 372-374). London: British Association and College of Occupational Therapy.

Iwama, M. (2004). Revisiting culture in occupational therapy: A meaningful endeavor. *OTJR, 24*, 2-3.

Iwama, M. (2006). *The Kawa Model; Culturally Relevant Occupational Therapy*. Edinburgh: Churchill Livingstone-Elsevier Press.

Johnson, T. (1993). Expertise and the state. In M. Gane & T. Johnson (Eds.), *Foucault's new domains*, (pp. 139-151). New York, NY: Routledge.

Johnston, D., & Mayers, C. (2005). Spirituality: A review of how occupational therapists acknowledge, assess and meet spirituality needs. *British Journal of Occupational Therapy, 68*(9), 386-392.

Jones, D. (1998). Deviance. In D. Jones, S. Blair, T. Hartery,R. Jones (Eds.), *Sociology and Occupational Therapy* (pp. 93-104). Toronto, Ontario: Churchill Livingstone.

Jones, J. (1988). Early occupational therapy education in Wisconsin: Elizabeth Upham Davis and Milwaukee-Downer College. *American Journal of Occupational Therapy, 42*, 527-533.

Jones, R., & Stewart, A. (1998). The sociology of the health professions. In D. Jones, S. Blair, T. Hartery,R. Jones (Eds.), *Sociology and Occupational Therapy* (pp. 131-142). Toronto, Ontario: Churchill Livingstone.

Kang, C. (2002). A psychospiritual integration frame of reference for occupational therapy. Part 1: Conceptual foundations. *Australian Occupational Therapy Journal, 50*, 92-103.

Kearins, K., & Hooper, K. (2002). Genealogical method and analysis. *Accounting, Auditing and Accountability Journal, 15* (5), 733-757.

Kelly, G. & McFarlane, H. (1991a). Zen in the Art of Occupational Therapy, Part One. *British Journal of Occupational Therapy, 54*(3), 95-100.

Kelly, G. & McFarlane, H. (1991b). Zen in the Art of Occupational Therapy, Part Two. *British Journal of Occupational Therapy, 54*(4), 130-134.

Kelly, G., & McFarlane, H. (2007). Culture or cult? The mythological nature of occupational therapy. *Occupational Therapy International, 14*(4), 188-202.

Kielhofner, G. (1985). The demise of diffidence: An agenda for occupational therapy. Canadian Journal of Occupational Therapy, 52(4), 165-171.

Kielhofner, G. (1986). A response to Sharrott's 'An analysis of occupational therapy theoretical approaches for mental health.' *Occupational Therapy in Mental Health,* 5(4), 17-23.

Kielhofner, G. (1997). *Conceptual foundations of occupational therapy,* (2nd ed.). Philadelphia: F.A. Davis.

Kielhofner, G., & Burke, J. (1983). The evolution of knowledge and practice in occupational therapy: Past, present and future. In G. Kielhofner (Ed.), *Health through occupation: Theory and practice in occupational therapy*. Philadelphia: F.A. Davis Company.

Kincheloe, J., & McLaren, P. (2000). Rethinking critical theory and qualitative research. In N. Denzin & Y. Lincolin (Eds), *Handbook of qualitative research* (2nd Ed.) (pp. 279-313). Thousand Oaks: Sage Publications.

Kinsella, A. (2001). Reflections on reflective practice. *Canadian Journal of Occupational Therapy, 68,* 195–198.

Kirsh, B. (1996). A narrative approach to addressing spirituality in occupational therapy: Exploring personal meaning and purpose. *Canadian Journal of Occupational Therapy, 63*(1), 55-61.

Kirsh, B., & Welch, A. (2003). Opening the door to spiritual expression: The power of narrative in occupational therapy. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 161-179). Ottawa: Canadian Association of Occupational Therapists.

Kirsh, B., Dawson, D., Antolikova, S., & Reynolds, L. (2001). Developing awareness of spirituality in occupational therapy students: Are our curricula up to the task? *Occupational Therapy International, 8*(2), 119-125.

Klemke, E., Hollinger, R., Rudge, D., & Kline, D. (Eds.). (1998). *Introductory readings in the philosophy of science* (3rd ed., pp. 481 – 491). New York: Prometheus Books.

Klerman, G., Weissman, M., Rounsaville, B., & Cheveron, E. (1984). Interpersonal psychotherapy of depression. New York: Basic Books.

Kroeker, P. (1997). Spirituality and occupational therapy in a secular culture. *Canadian Journal of Occupational Therapy, 64*(3), 122-126.

Kroeker, P. (2003). Spirituality and therapy in a secular, pluralistic culture: Toward an ethic of care. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 55-66). Ottawa: Canadian Association of Occupational Therapists.

Krupa, T. (2008). Part of the solution … or part of the problem? Addressing the stigma of mental illness in our midst. *Canadian Journal of Occupational Therapy, 75*(4), 198-205.

Kuhn, T. (1977). The essential tension. Chicago, IC: The University of Chicago Press.

Laliberte Rudman, D. (2010). Occupational possibilities. *Journal of Occupational Science, 17*(1), 55-59.

Law, M. (1991). The environment: A focus for occupational therapy. *Canadian Journal of Occupational Therapy, 58*, 171-179.

Law, M. (1992). Guest Editorial. *Canadian Journal of Rehabilitation, 5*(4), 193-203.

Law, M., Baptiste, S., & Mills, J. (1995). Client-centred practice: What does it mean and does it make a difference? *Canadian Journal of Occupational Therapy, 62*(5), 250-257.

Law, M., Polatajko, H., Baptiste, S., & Townsend, E. (1997). Core concepts of occupational therapy. In E. Townsend (Ed.). *Enabling occupation: An occupational therapy perspective.* (pp. 29-56). Ottawa: Canadian Association of Occupational Therapists.

Law, M., Steinwender, S., & Leclair, L. (1998). Occupation, health and well-being. *Canadian Journal of Occupational Therapy, 65,* 57-67.

Licht, S. (1983). The early history of occupational therapy: An outline. *Occupational Therapy in Mental Health, 3,* 67-88. (Original work published 1948).

Lilleleht, E. (2002a). Progress and power: Exploring the disciplinary connections between moral treatment and psychiatric rehabilitation. *Philosophy, Psychiatry and Psychology, 9*(2), 167-182.

Lilleleht, E. (2002b). Listening, acting, and the quest for alternatives: A response to Charland and Bracken. *Philosophy, Psychiatry and Psychology, 9*(2), 189-191.

Lincoln, Y, & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills: SAGE Publications, Inc.

Linehan, M. (1993). Cognitive – behavioral treatment of borderline personality disorder. New York: The Guilford Press.

Llorens, L. (1970). Eleanor Clarke Slagle Lecture: Facilitating growth and development: The promise of occupational therapy. *American Journal of Occupational Therapy, 24,* 93-101.

Lopez, S., Edwards, L., Pedrotti, J., Prosser, E., LaRue, S., Spalitto, V., et al. (2006). Beyond the DSM-IV: Assumptions, alternatives, and alterations. *Journal of Counseling and Development, 84*(3), 259-267.

Low, J. (1997). Religious orientation and pain management. *American Journal of Occupational Therapy, 51*(3), 215-219.

Luboshitzky, D. & Bennett Gaber, L. (2001). Holidays and celebrations as a spiritual occupation. *Australian Occupational Therapy Journal, 48,* 66-74.

Mackey, H. (2007). Do not ask me to remain the same: Foucault and the professional identities of occupational therapists. *Australian Occupational Therapy Journal, 54*(2), 95-102.

Major-Poetzl, P. (1983). *Michel Foucault's archaeology of Western culture: Toward a new science of history*. Chapel Hill: The University of North Carolina Press.

Mattingly, C., & Fleming, M. (1994). *Clinical reasoning: Forms of inquiry in a therapeutic practice*. Philadelphia: F.A. Davis Company.

McColl, M. (2000). Muriel Driver Memorial Lecture – Spirit, occupation and disability. *Canadian Journal of Occupational Therapy, 67*(4), 217-228.

McColl, M. (2003a). Spirituality and occupational therapy. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 2-4). Ottawa: Canadian Association of Occupational Therapists.

McColl, M. (2003b). Introduction. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 5-18). Ottawa: Canadian Association of Occupational Therapists.

McColl, M. (2003c). Spirituality and disability. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 19-29). Ottawa: Canadian Association of Occupational Therapists.

McColl, M. (2003d). Toward a model of practice for spirituality in occupational therapy. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 133-144). Ottawa: Canadian Association of Occupational Therapists.

McMullin, E. (1998). Values in science. In E. Klemke, R. Hollinger, D. Rudge & D. Kline (Eds.), *Introductory readings in the philosophy of science* (3rd ed., pp. 515 – 538). New York: Prometheus Books.

Mocellin, G. (1988). A perspective on the principles of practice of occupational therapy. *British Journal of Occupational Therapy, 51*(1), 4-7.

Mocellin, G. (1992). An overview of occupational therapy in the context of the American influence on the profession: Part 2. *British Journal of Occupational Therapy, 55*(2), 55-60

Mocellin, G. (1995). Occupational therapy: A critical overview, Part 1. *British Journal of Occupational Therapy, 58*(12), 502-506.

Mocellin, G. (1996). Occupational therapy: A critical overview, Part 2. *British Journal of Occupational Therapy, 59*(1), 11-16.

Molineux, M. (2000). Another step in the right direction. *British Journal of Occupational Therapy, 63*(5), 191.

Molineux, M. (2004). Occupation in occupational therapy: A labour in vain? In M. Molineux (Ed.), Occupation for occupational therapists. (pp. 1-14). Oxford: Blackwell Publishing Ltd.

Molineux, M., & Whiteford, G. (2006). Occupational science: Genesis, evolution and future direction. In E. Duncan (Ed.), *Foundations for practice in occupational therapy* (pp. 297-313). London: Elsevier.

Molke, D. (2009a, June). Outlining a critical methodology for historical work in occupational therapy. Presented at the annual Canadian Association of Occupational Therapists Conference, Ottawa, Ontario.

Molke, D. (2009b). Outlining a critical ethos for historical work in occupational science and occupational therapy. *Journal of Occupational Science, 16*(2), 75-84.

Molke, D., & Laliberte Rudman, D. (2009). Governing the majority world? Critical reflections on the role of occupation technology in international contexts. *Australian Occupational Therapy Journal*, *56*(4), 239-248.

Molke, D., Laliberte Rudman, D. & Polatajko, H. (2004). The promise of occupational science: A developmental assessment of an emerging academic discipline. *Canadian journal of Occupational Therapy, 71,* 269-281.

Morrow, S. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260.

Mosey, A. (1981). *Occupational therapy: Configuration of a profession.* New York: Raven Press.

Mosey, A. (1970). *Three frames of reference for mental health.* New Jersey: Charles B. Slack Inc.

Murray, S., Holmes, D., Perron, A. & Geneviève, R. (2007). No exit? Intellectual integrity under the regime of 'evidence' and 'best-practices.' Journal of Evaluation in Clinical Practice, *13,* 512–516.

Nelson, D. (1996). Therapeutic occupation: A definition. *American Journal of Occupational Therapy, 50,* 775-782.

Neuhaus, B. (1997). Including hope in occupational therapy practice: A pilot study. *American Journal of Occupational Therapy, 51*(3), 228-234.

Odawara, E. (2005). Cultural competency in occupational therapy: Beyond a cross-cultural view of practice. *American Journal of Occupational Therapy, 59*(3), 325-334.

Opzoomer, A., & McCordie, L. (1973). Occupational therapy – A change of focus. *Canadian Journal of Occupational Therapy, 40*(3), 125-129.

Owen, C. (1968). An analysis of the philosophy of occupational therapy. *American Journal of Occupational Therapy, 22*(6), 502-505.

Paré, D.A. (2001). Finding a place to stand: Reflections on discourse and intertextuality in counselling practice. *Theoretical Issues in Psychology: Proceedings of the International Society for Theoretical Psychology 1999 Conference*. Norwell, Mass: Kluwer Academic Publishers.

Parham, D. (1987). Towards professionalism: The reflective therapist. *The American Journal of Occupational Therapy, 41*(9), 555-561.

Paterson, C. (1997). Rationales for the use of occupation in 19th century asylums. *British Journal of Occupational Therapy, 60*, 179-182.

Pattison, H. (1922). The trend of occupational therapy for the tuberculous. *Archives of Occupational Therapy, 1*, 19-24.

Peloquin, S. (1989). Moral treatment contexts considered. *American Journal of Occupational Therapy, 43,* 537-544.

Peloquin, S. (1991). Occupational therapy service: Individual and collective understanding of the founders, part 1. *American Journal of Occupational Therapy, 45*, 352-360.

Peloquin, S. (1991). Occupational therapy service: Individual and collective understandings of the founders, part 2. *American Journal of Occupational therapy, 45*(8), 733-744.

Peloquin, S. (1997). The spiritual depth of occupation: Making worlds and making lives. *The American Journal of Occupational Therapy, 51*(3), 167-168.

Peloquin, S. (2005). Embracing our ethos, reclaiming our heart. *American Journal of Occupational Therapy, 59*(6), 611-625.

Peloquin, S. (2007). A reconsideration of occupational thearpy's core values. *American Journal of Occupational Therapy, 61*(4), 474-478.

Pierce, D. (2003). *Occupation by design: Building therapeutic power.* Philadelphia: F.A. Davis Company.

Piercy, M. (1976). *Woman on the edge of time.* New York: Knopf

Pinel, P. (2008). *Medico-philosophical treatise on mental alienation.* (2nd ed., G. Hickish, D. Healy & C. Charland, Trans.). West Sussex: Wiley-Blackwell. (Original work published 1809).

Polatajko, H., Davis, J., Stewart, D., Cantin, N., Amoroso, B., Purdie, L., & Zimmerman, D. (2007a). Specifying the domain of concern: Occupation as core. In E. Townsend, & H. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation.* (pp. 13-36). Ottawa: CAOT Publications ACE.

Polatajko, H., Backman, C., Baptiste, S., Davis, J., Eftekhar, P., Harvey, A., Jarman, J., Krupa, T., Lin, N., Pentland, W., Rudman, D., Shaw, L., Amoroso, B. & Connor-

Schisler, A. (2007b). In E. Townsend, & H. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation.* (pp. 37-61). Ottawa: CAOT Publications ACE.

Polatajko, H., Molke, D., Baptiste, S., Doble, S., Santha, J., Kirsh, B., Beagan, B., Kumas-Tan, Z., Iwama, M., Laliberte Rudman, D., Thibeault, R., Stadnyk, R. (2007c). Occupational science: Imperatives for occupational therapy. In E. Townsend & H.J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation*. (pp. 63-82). Ottawa, ON: CAOT Publication ACE.

Rabinbach, A. (1992). *The human motor: Energy, fatigue, and the origins of modernity.* Berkeley: University of California Press.

Rabinow, P., & Rose, N. (2003). Introduction: Foucault today. In P. Rabinow & N. Rose (Eds.), *The essential Foucault* (pp.vii-xxxv). (C. Gordon, Trans). New York: The New Press.

Reed, K., & Peters, C. (2007). Occupational therapy values and beliefs: Part III. *OT Practice, 13*(18), 17-21.

Reed, K., & Peters, C. (2008). Occupational therapy values and beliefs: Part IV. *OT Practice, 13*(18), 15-18.

Reilly, M. (1962). Occupational therapy can be one of the great ideas of twentieth century medicine. *American Journal of Occupational Therapy, 16*, 1-9.

Rerek, M. (1971). The depression years – 1929 to 1941. *American Journal of Occupational Therapy, 25*, 231-233.

Robinson, I. (1981). Muriel Driver Memorial Lecture – The mists of time. *Canadian Journal of Occupational Therapy, 48*, 145-151.

Rose, A. (1999). Spirituality and palliative care: The attitudes of occupational therapists. *British Journal of Occupational Therapy, 62*(7), 307-312.

Rose, N. & Miller, P. (1992). Political power beyond the State: problematics of government. *British Journal of Sociology, 43*, 173-205.

Rosenfeld, M. (2001). Spirituality, motivation and performance. *Occupational Therapy Now, 3*(6), 1-11.

Rothman, D. (1990). *The discovery of the asylum: Social order and disorder in the New Republic.* Boston: Little, Brown and Company.

Rousseau, G. (1973). Review: Whose enlightenment? Not man's: The case of Michel Foucault. *Eighteenth-Century Studies, 6*(2), 238-256.

Rousseau, J. (1984). *A discourse on inequality.* (M. Cranston, Trans.). London, England: Penguin Books. (Original work published, 1755).

Rudner, R. (1998). The scientist qua scientist makes value judgments. In E. Klemke, R. Hollinger, D. Rudge & D. Kline (Eds.), *Introductory readings in the philosophy of science* (3rd ed., pp. 492 – 498). New York: Prometheus Books.

Schemm, R. (1994). Bridging conflicting ideologies: The origins of American and British occupational therapy. *American Journal of Occupational Therapy, 48*(11), 1082-1088.

Scheurich, J., & McKenzie, K. (2005). Foucault's methodologies: Archaeology and genealogy. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 841-868). Thousand Oaks, CA: Sage.

Schulz, E. (2004). Spirituality and disability: An analysis of select themes. *Occupational Therapy in Health Care, 18*(4), 57-83.

Scull, A. (1983). Humanitarianism or control? Some observations on the historiography of Anglo-American psychiatry. In S. Cohen & A. Scull (Eds.), *Social control and the state*. (pp. 118-139). Oxford: Martin Robertson.

Scull, A. (1993). *The most solitary of afflictions: Madness and society in Britain 1700-1900.* New Haven: Yale University Press.

Segworth, A., Sittler, B., & Wilson, T. (2006). Occupational science: A source of validity and knowledge for occupational therapy practice. *Occupational Therapy Now, 8*(4), 24-26.

Sellar, B. (2010). Assemblage theory, occupational science, and the complexity of human agency. *Journal of Occupational Science, 16*(2), 67-74.

Shannon, P. (1977). The derailment of occupational therapy. *American Journal of Occupational Therapy, 31,* 229-234.

Shannon, P. (2005). Philosophy and core values in occupational therapy. In K. Sladyk & S. Ryan (Eds.), *Ryan's occupational therapy assistant: Principles, practice issues, and techniques* (4th ed., pp. 24- 32). Thorofare: NJ: Slack Incorporated.

Sharrott, G. (1986). An analysis of occupational therapy theoretical approaches for mental health: Are the profession's major treatment approaches truly occupational therapy? *Occupational Therapy in Mental Health, 5*(4), 1-16.

Sherr Klein, B. (1997). Foreword. In E. Townsend (Ed.). *Enabling occupation: An occupational therapy perspective* (pp. vii-x). Ottawa: CAOT Publications ACE.

Shimeld, A. (1971). Youth of today and their influences on the practice of occupational therapy. *Canadian Journal of Occupational Therapy, 38,* 3-13.

Spackman, C. (1968). A history of the practice of occupational therapy for restoration of physical function: 1917-1967. *American Journal of Occupational Therapy, 22*(2), 67-71.

Spencer, J., Davidson, H., & White, V. (1997). Helping clients develop hopes for the future. *American Journal of Occupational Therapy, 51*(3), 191-198.

Sumsion, T. (1999). Overview of client-centred practice. In T. Sumsion (Ed.). *Client-centred practice in occupational therapy* (pp. 1-14). London: Churchill Livingstone.

Sumsion, T., & Law, M. (2006). A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy, 73*(3), 153-162.

Sumsion, T., & MacKinnon, J. (2008). *Our history: An account of the development of the school of occupational therapy from 1971-2007 at the University of Western Ontario.* London, Ontario: University of Western Ontario.

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct.* New York: Perennial.

Taylor, E., Mitchell, J., Kenan, S., & Tacker, R. (2000). Attitudes of occupational therapists toward spirituality in practice. *American Journal of Occupational Therapy, 54*(4), 421-426.

Thibeault, R. (1997) A funeral for my father's mind: A therapist's attempt at grieving. *Canadian Journal of Occupational Therapy, 64*(3), 107-114.

Thibeault, R. (2003). Experiential and philosophical considerations on occupation and the genesis of meaning and resilience. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 83-94). Ottawa: Canadian Association of Occupational Therapists.

Thibeault, R. (2006). Globalization, universities and the future of occupational therapy: Dispatches for the Majority World. *Australian Occupational Therapy Journal*, *53*, 159–165.

Tiffany, E. (1988). Historical Roots. In H. Hopkins & D. Smith (Eds.). *Willard and Spackman's occupational therapy* (7th ed., pp. 361-379). Philadelphia: J.B. Lippincott Company.

Tillich, P. (1957). *Dynamics of faith*. New York: Harper & Row, Publishers, Incorporated.

Toomey, M. (1999). The art of observation: Reflecting on a spiritual moment. *Canadian Journal of Occupational Therapy, 66(4), 197-199.*

Toomey, M. (2003). Creativity: Access to the spirit through occupation. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 181-192). Ottawa: Canadian Association of Occupational Therapists.

Townsend, E. (1997). Inclusiveness: A community dimension of spirituality. *Canadian Journal of Occupational Therapy, 64*(3), 146-155.

Townsend, E. (2002). Preface 2002. In E. Townsend (Ed.) *Enabling occupation: An occupational therapy perspective* (revised ed., p. xvii-xxvii). Ottawa: CAOT Publications ACE.

Townsend, E., Beagan, B., Kumas-Tan, Z., Versnel, J., Iwama, M., Landry, J., Stewart, D. & Brown, J. Enabling: Occupational therapy's core competency. In E. Townsend, & H. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation.* (pp. 87-133). Ottawa: CAOT Publications ACE.

Townsend, E., De Laat, D., Egan, M., Thibeault, R. & Wright, W. (1999). *Spirituality in enabling occupation: A learner-centred workbook.* Ottawa: CAOT Publications ACE.

Townsend, E., & Politajko, H. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation.* Ottawa: CAOT Publications ACE.

Townsend, E. & Wilcock, A. (2004). Occupation justice and client-centred practice: A dialogue in progress. *Canadian Journal of Occupational Therapy, 71*, 75-87.

Tracy, S. (1918). *Studies in invalid occupation*. Boston: Whitcomb & Barrows.

Trentham, B. (2001). Diffident no longer: Building structures for a proud profession – CAOT in the 1980s. *Occupational Therapy Now, 7*, 3 – 7.

Trentham, B., & Dunal, L. (2009). Identifying occupational performance issues with older adults: Therapists' perspectives. *Canadian Journal of Occupational Therapy, 76*(5), 326-334.

Trider, M. (1972). The future of occupational therapy. *Canadian Journal of Occupational Therapy, 39*(1), 3- 8.

Tse, S., Lloyd, C., Petchkovsky, L., & Manaia, W. (2005). Exploration of Australian and New Zealand indigenous people's spirituality and mental health. *Australian Occupational Therapy Journal, 52,* 181-187.

Tuke, S. (1813). *Description of the retreat: An institution near York, for insane persons of the Society of Friends (1813)*. Whitefish, MT: Kessinger Publishing Rare Reprints.

Udell, L., & Chandler, C. (2000). The role of the occupational therapist in addressing the spiritual needs of clients. *British Journal of Occupational Therapy, 63*(10), 489-494.

Unruh, A. (1997). Spirituality and occupation: Garden musings and the Himalayan Blue Poppy. *Canadian Journal of Occupational Therapy, 64*(3), 156-160.

Unruh, A., Smith, N., & Scammell, C. (2000). The occupation of gardening in life-threatening illness: A qualitative pilot project. *Canadian Journal of Occupational Therapy, 67*(1), 70-77.

Unruh, A., Versnel, J., & Kerr, N. (2002). Spirituality unplugged: A review of commonalities and contentions, and a resolution. *Canadian Journal of Occupational Therapy, 69*(1), 5-19.

Unruh, A., Versnel, J., & Kerr, N. (2003). Spirituality in evidence-based occupational therapy. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 145-160). Ottawa: Canadian Association of Occupational Therapists.

Unruh, A., Versnel, J., & Kerr, N. (2004). Spirituality in the context of occupation: A theory to practice application. In M. Molineux (Ed.), Occupation for occupational therapists. (pp. 32-45). Oxford: Blackwell Publishing Ltd.

Urbanowski, R. (2003). Spirituality in changed occupational lives. In M. McColl (Ed.), *Spirituality and occupational therapy* (pp. 95-114). Ottawa: Canadian Association of Occupational Therapists.

Urbanowski, R., & Vargo, J. (1994). Spirituality, daily practice, and the occupational performance model. *Canadian Journal of Occupational Therapy, 61*(2), 88-94.

Van Amburg, R. (1997). A Copernican revolution in clinical ethics: Engagement versus disengagement. *American Journal of Occupational Therapy, 51*(3), 186-190.

Vanier, J. (1998). *Becoming human*. New York: Paulist Press.

Veyne, P. (1997). The final Foucault and his ethics. In A. Davidson (Ed.), *Foucault and hisinterlocutors* (pp. 225-233). Chicago: University of Chicago Press.

Voltaire. (1962). *Candide.* (J. Butt, Trans.). Baltimore: Penguin Books. (Original work published 1759).

Vrkljan, B. & Miller-Polgar, J. (2001). Meaning of occupational engagement in life threatening illness: A qualitative pilot project. *Canadian Journal of Occupational Therapy, 68*(4), 237-246.

Wade, B. (1947). Occupational therapy for patients with mental disease. In H. Willard & C. Spackman (Eds.). *Occupational therapy,* (pp. 81-117). Philadelphia: J.B. Lippincott Company.

Whiteford, G., Townsend, E., & Hocking, C. (2000). Reflections on a renaissance of occupation. *Canadian Journal of Occupational Therapy, 67,* 61-69.

Wicks, A. (2005). Understanding Occupational Potential. *Journal of Occupational Science, 12*(3), 130-139.

Wilcock, A. (1991). Occupational science. *British Journal of Occupational Therapy, 54,* 297-300.

Wilcock, A. (2000). Development of a personal, professional and educational occupational philosophy: An Australian perspective. *Occupational Therapy International, 7,* 79–86.

Wilcock, A. (2001a). Occupational science: The key to broadening horizons. *British Journal of Occupational Therapy, 64,* 412-417.

Wilcock, A. (2001b). *Occupation for health Volume 1: A journey from self health to prescription.* London: British Association and College of Occupational Therapy.

Wilcock, A. (2002). *Occupation for health Volume 2: A journey from prescription to self health.* London: British Association and College of Occupational Therapy.

Wilcock, A. (2006). *An occupational perspective of health*. (2nd Ed.), Thorofare, NJ: Slack Inc.

Wilding, C. (2002). Where angels fear to tread: Is spirituality relevant to occupational therapy practice? *Australian Occupational Therapy Journal, 49,* 44-47.

Wilding, C., & Whiteford, G. (2009). From practice to praxis: Reconnecting moral vision with philosophical understandings. *British Journal of Occupational Therapy, 72*(10), 434-441.

Wilding, C., May, E., & Muir-Cochrane, E. (2005). Experience of spirituality, mental illness and occupation: A life-sustaining phenomenon. *Australian Occupational Therapy Journal*, *52*, 2-9.

Wood, W. (1996). Legitimizing occupational therapy's knowledge. *American Journal of Occupational Therapy, 50*(8), 626-634.

Woodside, H. (1971). The development of occupational therapy 1910 – 1929. *American Journal of Occupational Therapy, 25*, 226-230.

Yerxa, E. (1967). Authentic occupational therapy. *American Journal of Occupational Therapy, 21*, 1–9.

Yerxa, E. (1979). The philosophical base of occupational therapy. In *Occupational Therapy: 2001,* Rockville, Maryland: American Occupational Therapy Association.

Yerxa, E. (1980). Audacious values: The energy source for occupational therapy practice. In G. Kielhofner (Ed.), *Health through occupation: Theory and practice in occupational therapy*. Philadelphia: F.A. Davis Company.

Yerxa, E. (1987). Research: The key to the development of occupational therapy as an academic discipline. *American Journal of Occupational Therapy, 41*, 415-419.

Yerxa, E. (1991). Seeking a relevant, ethical, and realistic way of knowing for occupational therapy. *American Journal of Occupational Therapy, 45,* 199-203.

Yerxa, E. (1992). Some implications of occupational therapy's history for its epistemology, values, and relation to medicine. *American Journal of Occupational Therapy, 46*, 79-83.

Yerxa, E. (1993). Occupational science: A new source of power for participants occupational therapy. *Journal of Occupational Science: Australia*, *1*, 3-10.

Yerxa, E. (1995). Who is the keeper of occupational therapy's practice and knowledge? *American Journal of Occupational Therapy, 49*, 295-299.

Yerxa, E., Clark, F., Frank, G., Jackson, J., Parham, D., Pierce, D., et al. (1990). An introduction to occupational science, a foundation for occupational therapy in the 21st century. In J.A. Johnson & E. J. Yerxa (Eds.), *Occupational science: The foundation for new models of practice* (pp. 1-17). Binghamton: The Hawthorn Press.

Yeo, M. & Molke, T. (1996). Beneficence. In M. Yeo & A. Moorhouse (Eds.), Nursing ethics (2nd ed., pp. 57-79). Peterborough, Ontario: Broadview Press.

Zachar, P. (2008). Fact and value in emotion: An introduction and historical review. In L. Charland & P. Zachar (Eds.), *Fact and Value in Emotion* (pp. 1-13). Philadelphia: John Benjamins Publishing Company.

Appendix: Questions for Genealogical Analysis

1) **What constitutes the true or ideal self?**

-What does occupation turn one into, what is the end product of occupation treatment?
-Which occupations or collections of occupations are important, proper or ideal?
-What kind opportunities do particular occupations afford?

[What part of one's self, or behavior is ethically relevant; what ontological material does a technology concern? (Foucault, 1983/2003x pp. 110-111). How does this relate to a particular *Telos*? What should one aspire to be in a moral sense (Foucault, 1983/2003x , p. 112)?

2) **What techniques are used to form the selves of others?**

-How does occupation function to mold, transform, or cure?
-What techniques are used to encourage engagement in particular occupations?

[What are the 'm*odes of subjugation.'* That is how is one incited to fulfill or recognize one's occupational and moral obligations (e.g., divine or natural law, rational or scientific rules). (Foucault, 1975/ 1995, 1983/2003x, p. 111)?]

3) **What techniques are used for self formation?**

-Where does work on the self begin?
-What attributes or skills should one possess?
-How are individuals compelled to engage in occupational life?

[What '*self forming activities'* is one compelled to engage in. That is what activities work to effect change; What modes of activities are ethically subjugating (Foucault, 1983/2003x, p. 112)?]

4) **What dangers might answers to these questions pose?**

-How do answers to the above threaten difference; exclude (Molke, 2009b)?
-What is missing, silent, absent (Carabine 2001; Hook, 2001)?
-How do answers to the above questions relate to particular "forms of hegemony, social, economic and cultural" (Foucault, 1977/1980c, p. 133)?

Curriculum Vitae

DANIEL K. MOLKE
COTO #: G0305458; CAOT #: 88582; OSOT #: 14020

EDUCATION

PhD in Health & Rehabilitation Sciences, University of Western Ontario [Candidate]

MSc in Occupational Therapy, University of Toronto

BSc in Psychology, **Honours,** University of Toronto

WORK EXPERIENCE

Self-Employed Occupational Therapist, Jan 2004 –
- Conducting independent in-home assessments with claimants injured in motor vehicle accidents.
- Provided in-home occupational therapy assessment and treatment for adults and older adults with chronic mental health issues in regent park area.

Research Assistant, Jan 2007 – August 2008
Dept. of Occupational Therapy, University of Western Ontario
- Assisted with the research project: "Shaping the modern retiree: A comparative discourse analysis of print media and individual narratives."

Project Coordinator, Sep 2004 – August 2006
COTA Health
- Coordinated the project: "Untangling the Fabric of What Contributes to Positive Outcomes in Community Mental Health." Which aimed to: review COTA mental health outcome data; describe a practice process for working with persons with depression and; develop a practice guideline to provide direction for occupational therapists practicing in the community with persons with depression.

Research Assistant, September 2002 – August 2003
Dept. of Occupational Therapy, University of Toronto
- Assisted with the research project: "Governing the modern retiree: Neoliberalism and positive aging."

Project Coordinator, June 2001 – Nov 2001
Dept. of Surgery, Mount Sinai Hospital
- Co-coordinated the research project: "Developing critical appraisal skills of community surgeons."

Research Assistant, June 2000 – June 2001

Dept. of Surgery, Mount Sinai Hospital,

- Assisted with the "Crohn's Disease patient preference study,"
- Maintained and updated the Inflammatory Bowel Disease database.

PUBLICATIONS

Molke, D.K. (2009). Outlining a critical ethos for historical work in occupational science and occupational therapy, *Journal of Occupational Science, 16*, 74-84.

Laliberte Rudman, D. & **Molke, D.K.** (2009). Forever productive: The discursive shaping of later life workers in contemporary Canadian newspapers. *Work, 32*, 377-389.

Molke, D.K.. & Laliberte Rudman, D. (2009). Governing the majority world? Critical reflections on the role of occupation technology in international contexts. *Australian Occupational Therapy Journal, 56*, 239-248.

Laliberte Rudman, D., Dennhardt, S., Fok, D., Huot, S., Laliberte Rudman, D., **Molke**, **D.K**.., et al. (2008). A vision for occupational science: Reflecting on our disciplinary culture. *Journal of Occupational Science*, 15, 136-146.

Molke, D.K.. Laliberte Rudman, D., & Polatajko, H.J. (2004). The promise of occupational science: A developmental assessment of an emerging academic discipline. *Canadian Journal of Occupational Therapy, 71*, 269-280. [Includes discussion].

Molke, D.K.. & Laliberte Rudman, D. (2003). Occupational science: Foundation and future. *Occupational Therapy Now, 5*(2), 10-11.

CONFERENCE / SYMPOSIUM PRESENTATIONS

Molke, D.K., (2009, June). *Outlining a critical methodology for historical work in occupational therapy*. Presented at the annual Canadian Association of Occupational Therapists Conference, Ottawa, Ontario.

Molke, D.K. & Fok, D. (2009, June). *Enabling occupation online: Disability, virtual accessibility & professional responsibility.* Presented at the annual Canadian Association of Occupational Therapists Conference, Ottawa, Ontario.

Dickie, V., Bailliard, A., Marterella, A. & **Molke, D**., (2008, October). *A Stock Take of Accumulated Insights*. Presented at the Society for the Study of Occupation Conference, Fort Lauderdale, Florida.

Laliberte Rudman, D. & **Molke, D.K**.. (2008, June). *Forever productive: Shaping the modern older worker and working retiree*. Presented at the annual Canadian Association of Occupational Therapists Conference, Whitehorse, Yukon Territory, Canada.

Molke, D.K. & Fok, D. (2008, May). *Real space, virtual space and the avatar: Reflecting on occupational identity in the 21st century*. Presented at the 4th Canadian Occupational Science Symposium, Thunder Bay, Ontario.

Molke, D.K. & Laliberte Rudman, D. (2008, May). *Power, occupation and discourse in international spaces.* Presented at the 4th Canadian Occupational Science Symposium, Thunder Bay, Ontario.

Molke, D.K., Dennhardt, S., Fok, D., Huot, S., Laliberte Rudman, D., Park, A., Zur, B. (2008, May). *Reflecting on relevance: Making occupational science matter*. Presented at the 4th Canadian Occupational Science Symposium, Thunder Bay, Ontario.

Zur, B., Dennhardt, S., Fok, D., Huot, S., Laliberte Rudman, D., **Molke, D.K.**, Park, A. (2008, May). *Placing occupational science: Reflecting on our disciplinary culture.* Presented at the 4th Canadian Occupational Science Symposium, Thunder Bay, Ontario.

Molke, D.K. & Laliberte Rudman, D. (2007, October). *Occupation, power and international development*. Presented at the Society for the Study of Occupation Conference, Albuquerque, New Mexico.

Molke, D.K. (2004, May). *Developing an occupational perspective. The good, the bad and the ugly.* Presented at the 2nd Canadian Occupational Science Symposium, Toronto, Ontario.

Molke, D.K., Laliberte Rudman, D. & Polatajko, H.J. (2004, May). *Exploring the relationship between a discipline and a profession.* Presented at the 2nd Canadian Occupational Science Symposium, Toronto, Ontario.

Stone, H., Cunningham, E., **Molke, D.K**., Mirza, F., Trentham, B., & Mckibbon, D. (2003, May). *Developing trans-cultural competency through a fieldwork experience.* Poster session presented at the annual Canadian Association of Occupational Therapists Conference, Winnipeg, Manitoba.

BOOK CONTRIBUTIONS

Polatajko, H.J., **Molke, D.K.,** Baptiste, S., Doble, S., Santha, J., Kirsh, B. et al. (2007). Occupational science: Imperatives for occupational therapy. In E. Townsend & H.J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation*. Ottawa, ON: CAOT Publication ACE.

ORGANIZATIONAL REPORTS

COTA Health. (2006). A practice guideline for home-based occupational therapy for people with depression. Toronto: COTA Health.

LECTURES

Molke, D.K. (2009, October). *Paradigms and theoretical fields in occupational therapy,* School of Occupational Therapy, The University of Western Ontario.

Molke, D.K. (2006, November). *A view from somewhere: Occupational therapy and 'spirit' in my community practice.* Faculty of Health Sciences, The University of Western Ontario.

Molke, D.K. (2006, September). *A Quest for Knowledge: The history and development of occupational science.* Department of Occupational Science & Occupational Therapy, University of Toronto.

Molke, D.K. (2006, May). *The history and development of occupational science and its relationship to occupational therapy.* Graduate Department of Rehabilitation Science, Faculty of Medicine, University of Toronto.

Molke, D.K. (2005, September). *The history and development of occupational science and its relationship to occupational therapy.* Department of Occupational Science & Occupational Therapy, University of Toronto.

Welch, A., & **Molke, D.K.** (2004, April). *Reflections on student experiences in Tamil Nadu, India.* Presented at the University of Toronto International Health Speakers Series, Toronto, Ontario.

Molke, D.K. & Welch, A. (2003, August). *Occupational science: The development of a basic science of occupation.* Presented at CMC Hospital, Vellore, India.

TEACHING ACTIVITIES

Teaching Assistant Sept – Dec 2009
School of Occupational Therapy, The University of Western Ontario
Assisted with the course: "Foundations of Occupational Science and Occupational Therapy"

Teaching Assistant Sept 2008 – May 2009
School of Occupational Therapy, The University of Western Ontario
Assisted with the course: "Enabling Occupation Through Macro-Environmental Change"

Teaching Assistant Sept – Dec 2007.
Faculty of Health Sciences, The University of Western Ontario
Assisted with the course: "Qualitative Research Methods in Health and Rehabilitation Sciences"

Teaching Assistant Jan – May 2007.
Faculty of Health Sciences, The University of Western Ontario
Assisted with the course: "Health Occupations"

Teaching Assistant Sept – Dec 2006.
Faculty of Health Sciences, The University of Western Ontario
Assisted with the course: "Health and the Human Spirit"

RESEARCH SUPERVISION

M.Sc. Department of Occupational Science and Occupational Therapy, University of Toronto. "The Story of Dr. Goldwin Howland: Lasting contributions to occupational therapy." Co-supervision.

CLINICAL SUPERVISION

2005 July – Aug: COTA Health For: Department of Occupational Science and Occupational Therapy, University of Toronto – Student Final Placement Block.