

# What Is a “Health” Professional? The Changing Relationship of Occupational Therapists and Social Workers to Therapy and Healthcare in Quebec, 1940–1985

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**Abstract.** Studies regarding the medicalization process generally focus on the way various physical and psychological conditions have been identified as “health” problems, within specific historical contexts. Less well known is how the therapeutic roles of certain “health” professionals were also a result of the confluence of particular historical events. By comparing the professional trajectories of Quebec’s occupational therapists and hospital social workers from 1940 to 1985, this article demonstrates how professionals originally outside of the world of health care created new therapeutic roles for themselves within the constantly expanding institutional health care system.

**Keywords.** health professions, medicalization, occupational therapy, social work

**Résumé.** Les études portant sur le processus de médicalisation ont décrit la transformation, historiquement située, de diverses conditions en problèmes dits de santé. Il est plus rarement constaté, cependant, que le rôle thérapeutique de certaines professions « de santé » se révèle tout aussi ambigu. Par l’étude des trajectoires comparées des ergothérapeutes et des travailleuses sociales hospitalières du Québec de 1940 à 1985, le présent article entend montrer comment des professionnelles originellement extérieures au monde de la santé se sont progressivement octroyé de nouveaux rôles thérapeutiques qui leur ouvrent les portes de nouvelles positions dans les institutions, en croissance perpétuelle, de la santé.

**Mots-clés.** professions de santé, médicalisation, ergothérapie, travail social

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## INTRODUCTION

Today, both occupational therapists and hospital social workers are widely recognized as allied *health* professionals and carry out therapeutic interventions on matters labelled as health problems. Occupational therapists use crafts, games or daily-living related activities as means to achieve therapeutic goals. Children with autism or cerebral palsy, as well as adults affected by physical injuries or Alzheimer's disease, meet with occupational therapists who use such activities to restore impaired cognitive or psychomotor abilities. These patients, or their families, may also meet with social workers located at health facilities such as hospitals or rehabilitation centers. These social workers play both an administrative and a therapeutic role in the lives of their patients, overseeing things like the organization of homecare or financial support, while also offering a kind of counselling, which resembles psychotherapy.

Occupational therapists and social workers did not always play such therapeutic roles. While occupational therapists taught crafts, like weaving or woodworking in the first half of 20th century, the purpose was to restore people to a productive life of employment, not to provide therapy. Social workers were in a similar position: even in hospitals, their work had little to do with therapy, and consisted of administrative tasks and inquiries about the patient's economic and domestic life. Since the middle of the 20th century, however, the relationship of occupational therapists and social workers to the therapeutics and the basic provision of health and health care have changed significantly.

It is well recognized that the labelling of human conditions as health matters is a changing thing. Various conditions, from alcoholism to poor performance at school, are now considered to be health problems where previously they were not. In recent decades, this historicity of the "health quality" of things has inspired a narrative about the medicalization of society, whereby historians and sociologists describe how, since the 19th century, a growing number of problems or conditions have been reinterpreted in a way that allows them to be taken over by health experts. Thus, conditions like senility or shyness have been pathologized and reduced to their intraindividual dimensions (physiological and psychological), which require a therapeutic intervention from health specialists. Medicalization, then, has obvious repercussions because it leads society to define "as sickness behaviours and afflictions that had been once interpreted in religious, legal, or moral terms."<sup>1</sup> Generally, this narrative of medicalization focuses on the way yet-to-be "health" problems were taken over by existing health professionals. However, this process does not just effect the definitions of conditions or illnesses. It also operates to expand and redefine the occupational boundaries of workers whose jobs were not previously considered to have a clear therapeutic

purpose. In order to fit into new boundaries of practice, some of these workers had to work hard to make their skill sets relevant to populations labelled as having health problems.

This article illustrates just such a transition by comparing the history of occupational therapists and social workers in Quebec's healthcare institutions between 1940 and 1985. While their work was not originally considered to be of direct therapeutic value, both occupational therapists and social workers actively sought to redefine their occupational boundaries and to emphasize the relationship their work had with health and therapy in a context of important institutional change. Comparing the history of occupational therapists and hospital social workers illustrates how the situation of 20th-century health specialists was often more ambiguous than is generally stated.

Occupational therapy and hospital social work are unfamiliar professions to most historians. Both are predominantly female professions: in 1975, 90% of occupational therapists and 73% of social workers in Quebec's healthcare facilities were women. Thus, although this paper does not focus specifically on gender issues, these shall be noted all along the argument. Like other allied health professions, the growth and contribution of social workers and occupational therapists to the health sector accelerated quickly in the second half of 20th century: the number of occupational therapists in Quebec increased from 40 in the mid-1950s to 700 by 1985, and the total number of social workers rose from about 300 to more than 2,000 during the same period. While occupational therapists, at least after 1950, worked mainly in health institutions (hospitals and rehabilitation centers), only 20 to 25% of social workers consistently worked in hospitals, while other social workers practised mainly in welfare agencies and judicial courts. Despite these differences between their respective professions, however, both occupational therapists and social workers practising in healthcare settings between 1940 and 1985 shared a desire for new therapeutic roles in a rapidly changing environment.

Far from being straightforward, the road toward a more stable position in the world of health has followed a winding path. General transformations of health institutions after 1940 had a tremendous influence over professional aspirations. These transformations did not, however, create an environment that would comfortably welcome occupational therapists or social workers. Following an overview of the emergence and distant relationship of these two professions with health until World War II, I will show, after 1940, closer contacts with hospitals led both groups to aspire to more therapeutic roles. I will then show how the obstacles encountered by both professional groups between 1950 and 1970, made it impossible to reinvent occupational therapy and hospital social work without further adaptation. Finally, I will show how, from

1970 to 1985, a series of major public reforms led occupational therapists and social workers to migrate toward new practices, more genuinely therapeutic, although not without perpetuating some of the confusion about each professions' relationship to health and therapy.

#### A REAL BUT DISTANT RELATIONSHIP WITH HEALTH, 1900-1940

In Quebec and the rest of Canada, both occupational therapists and social workers emerged as distinct groups during the early years of the 20th century. Constituted in the wake of the social reform movements, these professions had a real but distant relationship with the world of health. Although many occupational therapists and social workers were frequently in contact with hospital patients, the aim of their work was not therapeutic as such. Their place in health's division of labour was, therefore, ambiguous. Moreover, despite the efforts of some professional leaders who, drawing inspiration from their American counterparts, sought places in fast-growing therapeutic fields like psychiatry, sources documenting actual field practice in Montreal reveal that practitioners' realities and points of view differed.<sup>2</sup>

At that time, social workers had a more direct relationship to health than occupational therapists. In North America, "social service" emerged at the end of the 19th century from the professionalization of philanthropic activities, when pioneers of the new profession took over the tasks of the "charitable visitors," meeting the poor to evaluate their economic needs. Because their practice was supported by methods of inquiry (what was then called "casework") and the use of differential classification (moral or psychological), social workers quickly defined their work by analogy with medical practice. As early as the beginning of the 20th century, this medical analogy was conveyed within some influential publications of the time, for example, the classic book *Social Diagnosis* (1917), authored by the American leader Mary Richmond. Some social workers worked in hospitals, where they managed relations between the institution and the patients, looking after the latter's ability to pay or to adhere to physicians' instructions. Labelled "medical social workers," these practitioners gradually formed a group sufficiently consistent to found, in 1918, the American Association of Medical Social Workers, which led to the creation of the more global American Association of Social Workers in 1922.

In Canada, the Canadian Association of Social Workers was founded in 1926, with a chapter in Quebec in the early 1930s, while undergraduate university programs appeared at the University of Toronto in 1914 and at McGill University in 1918. However, the real beginnings of a structured profession in Quebec emerged in the 1930s and 1940s, following the regrouping of the then-numerous charities into bigger "social

agencies." Established in order to rationalize the use of the resources devoted to social assistance, these agencies looked for competent staff trained in social service. In Montreal in 1938, the creation of the *Bureau d'aide aux familles* (dedicated to the assistance of families) fed a demand for French-speaking "social aides," leading to the creation of more major schools of social service at the University of Montreal in 1942 and at Laval University (Quebec City) in 1943, which produced a larger number of trained social aides.

As well, even though the social agencies were not health facilities, the role of the social worker continued to be connected in some respects to the idea of health. However, these links remained ambiguous. In the early 1940s, the social worker provided the poor with support, partly moral, but mainly economic and logistical in nature, essentially through the attribution of financial help or child placement. On one hand, this practice, despite having no therapeutic element, was often described by agency directors as being analogous to medical art. Consider, for example, Father George-Henri Lévesque, principal of the School of Social Work at Laval University: "for society, social services act as a true doctor" and casework allows "a diagnosis to be made and then a decision of the support that must be given" to "remake healthy cells for society."<sup>3</sup> Using this kind of metaphor, agency directors contrasted the technical expertise of their services with the disorganized charity of the volunteers in order to enhance their agency's prestige. On the other hand, this metaphor had little impact on the daily work of social workers. Called "social aides" by Lévesque and agency directors, social workers essentially continued to apply attribution rules that, in fact, tended to become more standardized. Even in hospitals like Sainte-Justine and the Montreal General, practitioners essentially acted as buffers between the hospital and the patients with regard to administrative and financial matters.

In the same period, what was becoming known as "occupational therapy" also held a similarly equivocal role, being somewhat related to health without displaying clearly therapeutic action. In fact, the emerging field was then closely related to social work. In the United States, the birth of the profession goes back to the 1910s when nurses and social workers introduced in a few places, including hospitals, the teaching of manual tasks, such as woodwork or weaving, to mentally or physically impaired people. Occupational therapy quickly became a field specialized enough to justify the creation of a school in Chicago in 1915 and a national American association in 1917.

From its inception, the relation of this new practice to the world of health was ambiguous. Although some individuals, including prestigious names like Adolf Meyer and Herbert J. Hall, envisaged a therapeutic role, in actual fact, the words "occupational therapy" concretely

came to refer to the teaching of crafts or industrial occupations to handicapped people in order to send them back to work. Furthermore, practitioners themselves were generally being called "occupational aides" or "professional aides," rather than "therapists."

In Canada, as in the United States, World War I stimulated the creation of the first program at the University of Toronto in 1918, a six-week course "aiming to prepare young women to teach various activities used to evaluate the interests and aptitudes of wounded soldiers."<sup>4</sup> Quickly abandoned, the program was raised from its ashes in 1926 by a new national association, the Canadian Association of Occupational Therapy. In the early 1930s, Canada had nearly 50 occupational therapists, equally divided between hospitals and occupational workshops. In Montreal, the Quebec Society for Occupational Therapy (QSOT) was created in 1930. Although some therapists worked in hospitals such as the Royal Victoria, most of Quebec's therapists worked in social-minded organizations, notably "sheltered workshops" dedicated to the economic rehabilitation of handicapped people, such as the Montreal Industrial Institute. Whether in hospitals or sheltered workshops, therapists dedicated themselves to the teaching of small tasks, to which they added some kind of solace. According to the words of the QSOT representatives in 1934: "Occupational therapy ... is helping and guiding ... persons back to health and happiness by teaching them simple handwork and crafts by which they may earn a little money and which at the same time occupies their mind and relieves them of their worries."<sup>5</sup>

Having worked to establish a sheltered workshop in Montreal in the early 1930s, the QSOT qualified as "lessons," rather than therapy, the classes in which handicapped people learned basket making or woodwork. In this context, the most genuine competence of the "occupational aide" mainly resided in the mastery of various crafts, rather than in well-defined therapeutic skills.<sup>6</sup> By instilling in their pupils a taste for good work and giving them edifying examples of moral righteousness, the "aides" of the pre-1940 era also stood for a cocktail of economic and moral concerns that brought them close to social work, in non-therapeutic ways.<sup>7</sup>

Thus, despite their indirect links to health, pre-1940 occupational therapists and social workers were not health specialists. In charge of financial allowances or the teaching of manual crafts for employment purposes, social or occupational "aides" were not seen as intervening on behalf of their clients' health. Moreover, this non-therapeutic face only comprised a small role beside medical or hospital patients for whom health was the main priority. After 1940, however, transformations in the hospitals' work market were to make such positions much more uncomfortable.

INSERTION IN THE HOSPITAL AND THE DE-QUALIFICATION OF  
NON-HEALTH EXPERTISE, 1940-1960

In the middle of the 20th century, hospitals expanded in size and number. Since the 1920s, in fact, the hospital market had been stimulated by public programs offering healthcare for the poor or victims of industrial accidents; after 1939, the return of economic prosperity allowed for a larger diffusion of private health insurance among the middle classes. After 1948, the National Health Grants Program supported the construction of new hospitals: from 79 in 1932, the number of Quebec's hospitals reached 122 in 1955, and 187 in 1970, while the number of beds per 1,000 inhabitants grew from 2.4 to 6 during the same period.<sup>8</sup> The situation came full circle with Quebec's entry, in 1961, into the federal hospital insurance program, which, by assuming a proportion of hospital expenses, made access to hospital easier for individuals. This growth occurred in tandem with emerging new medical practices in the hospital. Indeed, many doctors turned their back on office work in order to enter hospitals, where they found access to costly equipment and concentrated populations that, in return, supported the development of medical specialties like psychiatry or otorhinolaryngology. These specialized areas of medicine quickly gained considerable influence in medical practice: in Quebec, while the total number of doctors was growing fast, the proportion of specialists leaped from 22.5% in 1951, to 40% in 1961, and to 54.4% in 1971.<sup>9</sup> These various growing areas of medicine generated new hospital positions for allied health professionals, since specialists needed not only specialized equipment but also specialized auxiliaries. Although specialists continued to employ nurses, others hired members of the young "allied" professions, including female aides like occupational therapists and social workers. Between 1953 and 1967, while Quebec's hospital staff multiplied by four, the number of allied health professionals multiplied by eight, although the latter still represented no more than 2% of the overall professional workforce in Quebec hospitals.<sup>10</sup>

For all these reasons, a growing proportion of occupational therapists and social workers were involved exclusively in hospital work after 1940. This implied changes in usual practices, but also in professional aspirations. In keeping with the curative orientation of hospitals, the new resources made available by the state would support primarily therapeutic work, implying increased threats of de-qualification for those who worked in health settings without serving explicitly curative aims. As a consequence, new professional projects were formulated and championed by practitioners, like occupational therapists and social workers, more anxious in this context to show a therapeutic face. These projects took various paths. Occupational therapists tended to look for

doctors' direct sponsorship to give therapeutic outcomes to the use of manual crafts. In fact, the idea that "therapy by occupation" could play a curative role for patients not destined for employment, for example, tubercular patients or the mentally ill, had been circulating since the 1930s among some occupational aides and doctors. During World War II, political support from such doctors<sup>11</sup> allowed the incorporation of numerous occupational therapists in the Canadian army and the facilities of the new Department of Veterans Affairs. In military hospitals, occupational therapists used manual activities to stimulate and keep patients busy in order to counter the morbid effects of long-term hospitalization. This diversional use of craft fit the aspirations of many therapists who, once demobilized, applied their skills in civilian facilities for the old or the chronically ill. In the succeeding years, professional leaders strongly deemed such an evolution as necessary since occupational therapists were seeing more of their non-therapeutic, employment-minded tasks pass into the hands of less qualified auxiliaries.

In Quebec, the therapeutic future of the profession was oriented by doctors specialized in "physical medicine," or physical rehabilitation. This young medical specialty was then in great need of specialized auxiliaries, and its Quebec leaders, Dr. Guy Fisk from the Royal Victoria Hospital and Dr. Gustave Gingras from the Montreal Institute of Rehabilitation, initiated the creation and assumed the direction of new training programs in occupational therapy, physical therapy and speech therapy, first at McGill University in 1950, and then at the University of Montreal in 1954. Aimed at tying occupational therapy to medicine, these programs paired occupational therapy education with physical therapy in schools belonging to the faculties of medicine.<sup>12</sup> For the occupational therapists of the CAOT and the QSOT, this pairing was accepted as a voluntary merge in "the medical thought," implying that further therapists would join the direct service of doctors, particularly specialists of physical medicine. For a profession anxious to secure its future in healthcare, the choice seemed worthwhile. In Quebec, the new programs gave a new dimension to the profession, with the number of Quebec's occupational therapists rising from 40 in 1956 to 230 in 1973. Moreover, joining medicine's orbit held the promise that the future use of craft and activities would be seen as means for higher therapeutic purposes, associated with better professional positions. From then on, as a doctor suggested in 1951, "occupational therapy [was] not just making pot-holders."<sup>13</sup>

Social workers also increased their presence in hospitals after 1940. Just like occupational therapists, working in the changing healthcare environment pushed them to redefine themselves as therapists. Of course, agency social workers had had contacts with hospitals for a long time, managing the placement of handicapped children and referring



people for psychometric testing. Nonetheless, after World War II, hospitals tended to hire their own social workers more systematically. As in the case of occupational therapy, employment first increased in the DVA facilities, where social workers diversified their practice within the blossoming specialized physical rehabilitation or mental health medical departments. Some practitioners subsequently oriented their career path toward hospital work, such as Theodora Lambert, who, having joined the employment service of the DVA in 1943, continued her postwar career at the Queen Mary's Veterans Hospital of Montreal.<sup>14</sup> Whether or not they were associated with the military, hospitals continued to hire social workers in subsequent years, to the point that, in the late 1950s, healthcare had become an important sector of employment in social work.

As in occupational therapy, postwar social work saw the emergence of aspirations for a more therapeutic role, a wish that, again similar to occupational therapy, responded in part to a growing threat of professional downgrading for non-therapeutic workers in the hospital. However, appreciable differences existed between the two professions. First, because of a lack of direct medical invitations, the efforts of hospital social workers were both more unilateral and less evenly spread. Second, unlike occupational therapy, new professional projects did not necessarily originate solely from contact with the hospital.

At first, in fact, it was the agency social workers, feeling threatened by the hiring of non-university-educated "aides," who tried more vigorously to give substance to the medical analogy believed to support their work. Agency social workers intended to develop a genuinely therapeutic use of casework, whose scope they broadened into a more comprehensive type of counselling that resembled psychotherapy. At Montreal's *Bureau d'aide aux familles*, social workers even began to devalue their original financial assistance role in order to enhance what they were coming to see as "the genuine purpose of the Bureau: the social treatment of families."<sup>15</sup> When in 1953, the increase in demands for financial assistance threatened to bury counselling practice under administrative work, the social workers in charge of the Bureau reacted by assigning less qualified personnel to financial support in order to reserve for social workers cases of "persons asking for casework services [and] showing promise for rehabilitation."<sup>16</sup>

In hospitals, many social workers, even those originally hired for administrative matters, followed this trend by adding some therapeutic-minded tasks to their practice. At Montreal's Occupational Therapy and Rehabilitation Center, for example, social workers added the "restoration of self-confidence"<sup>17</sup> and the psychological adaptation of the handicapped to their tasks. However, it was within psychiatric settings that social workers had the most intimate contact with therapeutic activity

and vocabulary. At the neuropsychiatry clinic of the Notre-Dame hospital, for example, social inquiries by social workers after 1950 were often coupled with psychiatric inquiries or "social rehabilitation interviews." In general hospitals like Notre-Dame, where social workers traveled from one department to another, it was often practitioners experienced in psychiatry who conveyed therapeutic-oriented predilections.<sup>18</sup> Direct claims to practice psychotherapy were also expressed, especially after 1960. In Quebec, the first instances of such claims go back to the social worker Pearl Leibovitch, who, after she began to use group therapy at Queen Mary's Veterans Hospital in Montreal, started a private practice with a few colleagues in 1958. While such shifts toward private practice are often found, the origins of most of these were rooted in hospital psychiatric departments.

#### OBSTACLES TO THERAPEUTIC ASPIRATIONS, 1950-1970

Thus, the new healthcare environment of the post-war era encouraged Quebec's occupational therapists and hospital social workers to endow themselves with tasks of a more therapeutic nature in order to elevate their professional status. However, even though hospital context inspired these aspirations, it also resisted them. Reasons varied but largely came down to the specifics of the postwar hospitals' growth: this growth was mainly that of strictly medical domains, and doctors and hospital managers, mostly male, did not intend to compromise the integrity of medical professional turf to satisfy the aspirations of female allied professionals originally invited in as auxiliaries.<sup>19</sup> In this context, the acquisition of therapeutic-oriented tasks was limited to those necessary to support doctors, and often did not fulfill the aspirations of occupational therapists and social workers for clear mandates as health experts and therapists. Obstacles took various forms. While, for occupational therapists, medical sponsorship did not fulfill its promises and even allowed active obstruction from some doctors, hospital social workers suffered more simply from relative and passive indifference to their claims.

For occupational therapists, doctors' direct authority proved difficult to cope with when it diverged from their therapeutic aspirations. Directed by doctors, the program of the University of Montreal upset students who entered it on the promise that they would be trained to cure people. Indeed, even though the directors-doctors did stress the therapeutic applications of craft, actual training kept bearing on the mastery of the craft itself, making students spend most of their time training in the arts of origami or carpet weaving, while therapeutic uses, "prescribed and used under medical direction,"<sup>20</sup> remained under doctors' jurisdiction. Retrospectively, students from those years have remembered how bitterly they reacted to a training seen as unfit for the

exercise of a therapeutic role. Andrée Forget, for example, told how her enthusiasm was cooled, in 1955, by her first class "where I had to make an animal from newspaper and papier-mâché."<sup>21</sup> Therefore, benefits from working under the supervision and sponsorship of doctors, such as enhanced possibilities of employment in hospitals, came with an increased potential for tensions and conflicts.

Tensions also arose from different views on the clinical work of occupational therapists. In the early 1960s, while Dr. Gustave Gingras described occupational therapy as a physical training for the upper limb (pottery, for example, would train the motor skills of arthritic patients) under medical direction, the CAOT pleaded for a more global use of crafts to help the patient restore interpersonal abilities and re-conquer "what for him is a meaningful place in the community."<sup>22</sup> Indeed, many therapists disapproved of the fact that they were used for physical training and would rather use crafts for socialization purposes or at least, with the physically impaired, for the re-learning of daily functional tasks. Student Andrée Forget, once she recovered from her papier-mâché class, only persisted with occupational therapy after experiencing work on socialization and daily tasks training with paraplegic patients.<sup>23</sup> However, these perspectives were frequently incongruent with those of physicians, who were reluctant to attribute therapeutic roles to occupational therapists. In many general hospitals, craft workshops continued to be perceived as an entertainment service. Even in physical rehabilitation, where doctors had requested a therapeutic role for occupational therapists, the tasks failed to satisfy their aspirations. At the Montreal Institute of Rehabilitation, considered a model for other Quebec physical rehabilitation centers, occupational therapists worked with patients with spinal cord injuries or upper-limb amputations, using play activities as a form of physiotherapy of the upper limb that, because of their proximity to sporting activities, were seen by occupational therapists as incongruent with their aspirations for a therapeutic role. By controlling the definition of clinical tasks, doctors kept for themselves the job of directly addressing the patient's therapeutic needs.

One manifestation of the disappointment experienced in physical medicine was the hope invested in another field of practice: psychiatry. Existing since the 1930s, craft workshops in psychiatry had mainly played a diversional, non-therapeutic role close to entertainment for inpatients.<sup>24</sup> However, in the 1960s, the growth of outpatient practice enlarged the therapeutic horizons and suggested that crafts could become a therapeutic tool, to engage with sublimation of emotional troubles. In 1967, an experienced practitioner who had worked in psychiatry for 15 years shared her vision of an occupational therapy that would go as far as "to collaborate with psychotherapy and extend it."<sup>25</sup> However, in psychiatry, too, these optimistic perspectives encountered a

harsh reality. Psychiatrists, for their part, rarely seemed open to the aspirations of allied professionals. The experienced therapist cited above, having worked in various psychiatric facilities, bitterly complained about psychiatrists who, in her view, kept occupational therapists in check by maintaining a heavy hand over their work: "During their training, they are great unknowns in our departments but, armed with their diplomas, they can give us advice and orders right down to the smallest details."<sup>26</sup> Occupational therapists' lack of control over patient selection definitely handicapped their initiatives. Occupational therapist Jean-Guy Jobin, who worked in psychiatry at Notre-Dame Hospital in Montreal from 1964 to 1968, reported his sense that he was doing "the work of a key ring," in that patients saw therapists as the keepers of recreational craft material. Having first welcomed outpatient practice as an opportunity to act more genuinely as a therapist, he described how his creation, in 1965, of a therapy-oriented expressive workshop using paint and music with "inhibited" children was sabotaged by doctors referring numerous children who, far from being inhibited, demonstrated highly challenging behaviour difficulties.<sup>27</sup>

The various gaps between clinical realities and therapists' aspirations led to serious professional identity problems. These tensions haunted professional meetings of the 1950s and 1960s and can be summed up by the question, which was repeatedly asked: "Are we practicing occupational therapy?"<sup>28</sup> Many shared a persistent fear that too small a therapeutic role could make the profession vulnerable to de-qualification and substitution by other groups. Indeed, during the 1960s and 1970s, occupational therapists saw more and more non-therapeutic tasks, which were linked with employment or recreation matters, passing into the hands of less-qualified auxiliaries like recreational and education technicians.

Just like occupational therapists, hospital social workers also suffered from a lack of access to the patients for which they could better play a therapeutic role. Most often, they tried extending their action by offering counselling to patients who were originally met for administrative matters, such as financial help or the organization of home care. However, many of the patients found to have psychological problems were taken away to see psychologists or other specialists. In 1956, Ruth Gagné, a social worker of the Royal Victoria Hospital inspired by psychoanalytic readings to detect the "personal problems of her patients,"<sup>29</sup> was saddened that the hospital would not send her back such cases. Tired of waiting for referral from others, she built her own practice by detecting personal problems not among patients but among patients' relatives with whom she met for administrative matters. Many other hospital social workers did the same: for them, intervening in the patient's family environment had the advantage of implementing therapy without

departing from their original role as buffers between the institution and the patient's circle, and limited potential jurisdictional conflicts with doctors or psychologists. However, this cunning approach to accessing a therapy role kept interfering with the original justification for hiring social workers, forcing them to restrain their ambitions. At Notre-Dame Hospital, in the early 1960s, the increase in administrative tasks deprived social workers of time to devote to "social evaluation of the patient and his family" for the "social rehabilitation" of psychological problems like anxiety or other "latent problems" they would have liked to identify.<sup>30</sup> At the Montreal Institute of Rehabilitation, diverging views about the administrative tasks of social services led to conflicts with the medical direction and, in 1963, to the mass resignation of the Institute's social workers.<sup>31</sup>

Psychiatric departments, where aspirations for therapeutics (and psychotherapeutics) were often the keenest, paradoxically demonstrated the greatest resistance to an extension of the role of social workers. Indeed, psychiatric departments numbered several other—and often more pre-eminent—practitioners, like psychiatrists, psychologists and psychiatric nurses, who were also seeking a distinctive role based on a kind of counselling. Social workers, like psychiatric occupational therapists, were venturing into a busy professional space. Besides, for this reason, in general hospitals, it often seemed easier to transfer psychiatry-inspired habits to general practice than to sustain them in psychiatry. Interviewed in 1971, a social worker practising in a mental health institution typically complained about the limits commonly associated with psychiatrists' monopoly over therapeutic acts: "We are perceived as threats, looking to replace psychiatrists... According to hospital people, we should assist those in charge... Now, that is a role we are not always willing to play: like it or not, casework is a kind of psychotherapy."<sup>32</sup>

In the postwar era, hospital social workers highlighted how those constraints weakened the basis for real therapeutic, "psychosocial" social work at a time when it was henceforth the individual and psychological problems that best qualified as the appropriate object of intervention for a practitioner: "When I meet a patient for a somatisation, I feel much more at ease because it is about connecting with the patient to try to help him see the psychological root in his disease. Then, I feel like a caseworker."<sup>33</sup>

Thus, the efforts of occupational therapists and hospital social workers to attain a therapeutic orientation were, during the postwar years, neither smooth nor obvious. On one hand, because of their proximity to doctors and other specialists whose therapy-oriented role favoured professional promotion, hospital social workers and occupational therapists wished, especially in psychiatry and physical rehabilitation fields, to also deal with problems in terms of pathology and therapeutics. On the

other hand, it was difficult for them to access a therapeutic world dominated by other practitioners who, in some cases, had hardly asked for help. In the cases of occupational therapists and social workers, gender often accentuated the gap between aspirations and reality. It was this ambiguous context that, after 1970, incited occupational therapists and hospital social workers to try, with unequal success, to extend their practice beyond the existing fields in order to establish new territories in the public health system.

#### EXTENDING HEALTHCARE, 1970-1985

After 1970, the context of healthcare became more favourable to allied health professions. As in the postwar years, allied health professionals' aspirations were supported by both the continuing growth of health institutions and a new wave of public reforms, with Quebec joining the federal health insurance program in 1971.<sup>34</sup> For occupational therapists and hospital social workers, these changes modified the healthcare environment in three ways. First, allied health professionals were growing in number much faster than were doctors, especially specialist doctors who were struggling to supervise their expanding fields: in physical rehabilitation, in 1975, there were no more than 60 medical specialists, while occupational therapists, like other professionals, now accounted for hundreds of people. Overall, the number of allied health professionals jumped from 800 in 1961 to 5,425 in 1978, going from 2% to 10% of Quebec's hospital staff during this period—and from a ratio of one for eight physicians to one for two, and even reaching par with specialist physicians at the end of the 1970s.<sup>35</sup>

Second, while the expansion of the 1940s had been one of strictly medical domains, the 1970s and 1980s, in Quebec, saw an administrative momentum more neutral toward the various professions, thus creating greater opportunities for occupational therapy and social work. Reforms during these years moved the creation of clinical facilities away from medical authority: physical rehabilitation, for example, was set apart from the hospitals and doctors became more remote, which allowed many allied professionals to redefine their clinical work.<sup>36</sup> In hospitals, more generally, the increase and diversification of patient populations also helped allied professionals gain more control over the definition of their own tasks. Finally, these endeavours were also driven by the diffusion, among practitioners, of new conceptual frameworks that supported such claims for therapeutics. Similar to other groups, many occupational therapists and social workers perceived in this new context an opportunity to develop radically new fields of intervention that would imply tasks more clearly therapeutic, and more remote from doctors' authority.

Social workers in health facilities were looking for ways to implement a genuinely psychosocial practice. After 1970, many practitioners gathered around one mode of action: group therapy. In rehabilitation centers as well as hospitals, social workers created support or socialization groups that helped intensify a psychosocial counselling activity. Groups were typically formed for patients sharing a common condition (for instance, amputees, aphasics, or victims of multiple sclerosis). Initiated by social workers, these groups were used both as a therapeutic tool and as an occasion to detect potentially distressed patients.

Such groups offered two advantages. First, it was easier to create support groups than to officially obtain a therapeutic role in individual counselling. Second, it provided social workers with a more clearly therapeutic role than ever, by allowing them to be primarily interested in patients' feelings instead of having to arrive at these concerns incidentally during meetings about money or administrative matters. By their nature, groups more effectively revealed the eventual objects of therapeutic intervention, such as anxiety, grief or depression. In 1971, this new level of control over the objects of therapy led one hospital social worker, who was already animating groups for patients with cancer and arthritis, to declare: "I'll also start groups for cardiac patients because I realize that working with groups requires a different type of effort. I even thought I could invite a doctor so that he could see the current need [for new groups]."<sup>37</sup>

The clearly therapeutic role such groups supposed for social workers quickly helped social services improve their position. At the Montreal Institute of Rehabilitation, these groups welcomed patients sent by doctors or other specialists who otherwise would never have been sent to social services. This trend both diversified and expanded social work practice: from 1970 to 1974, the number of cases referred to social services by other departments of the Institute increased by 45%, even though the total population of the Institute was decreasing.<sup>38</sup> In some psychiatric hospitals, such as the Albert-Prévost Institute, some groups even came to serve as a replacement for individual psychotherapies.<sup>39</sup> The basis for the therapeutic use of groups was rooted in the diffusion of a new corpus of knowledge very popular among social workers in the 1970s: the family therapy trend, which primarily helped practitioners approach patients' families therapeutically. These approaches, derived from theoretical frameworks for "networked practices" inspired by structuralism and cybernetics, were formulated by clinicians and university-based researchers (notably at Laval University) and were widely disseminated through continuing education activities.

The use of peers groups was largely seen by social workers as an extension of the practice with families that had been initiated in previous years. In places where social workers were less successful at

implementing therapies—for example, the Centre Cardinal-Villeneuve or the Centre François-Charron in Quebec City—families remained the only sector in which a therapeutic role was assured. Besides, in psychiatric facilities, peer groups proved relevant as vectors for a therapeutic approach with families: in the 1980s, new programs for the emotional stabilization of families often “originate[d] from parent-child groups created by social workers” in which “the social worker sees herself ... as a therapist.”<sup>40</sup> More hospital social workers committed themselves to such activities, flirting more than ever with psychotherapy as a curative form of casework.

Occupational therapists were also trying to take advantage of the new context. In the 1970s, fears of substitution by technicians in recreation or specialized education inspired a number of vigorous clinical initiatives to renew and extend their practice. As in social work, these initiatives took various forms, all aiming to ensure a more therapeutic role by the use of new knowledge bases. Some occupational therapists articulated new outcomes for the use of activity. In 1975, therapists of the psychiatric department of the Maisonneuve-Rosemont hospital in Montreal declared themselves dissatisfied with “[their] occupational approach, mainly concerning evaluation,” which consisted of observing patients doing craft projects. They imposed a standardized activity and forbade patients from keeping their work, in order to break with a recreational image that undermined their authority.<sup>41</sup> Therapists then transformed crafts into a mode of evaluation of the cognitive and psychomotor health of their patients, successfully enhancing their status within the psychiatric team. In the succeeding years, other teams of occupational therapists, for example, at the Valleyfield hospital, were inspired by this experiment and the evaluation grid conceived for the occasion.<sup>42</sup>

Other therapists tried, more radically, to simply break away from craft activities. In physical rehabilitation centers, for example, therapists increased the time devoted to the teaching of activities of daily living to patients with back pain or spinal cord injuries. Very well developed in some facilities, daily-living training led occupational therapists to establish new intervention goals that moved them away from the fields of authority among physical medicine physicians. In the 1980s, daily-living training opened the door to new programs for seniors or other populations in places like the Constance-Lethbridge Centre. Seen as more therapeutic than previous uses of activities, this training increasingly stood out as one of the profession’s most characteristic features.<sup>43</sup>

Finally, other occupational therapists chose a third way to extend their practice beyond traditional tasks: intervention, mostly with children, to develop the more abstract, cognitive or “sensorimotor” abilities that govern the brain’s interpretation of signals conveyed by the



senses. Some pioneer therapists explored this path as early as 1970, and these endeavours quickly opened the door to an important role of evaluation and therapeutic intervention. At the Montreal Children's Hospital, occupational therapists followed newborns at risk of having delayed development, in order to observe their reflexes and sensorial responses and thus evaluate the risk of eventual motor or cognitive deficits, as well as to establish intervention protocols for therapeutic uses of occupational therapy, like sensorial stimulation.<sup>44</sup> Such initiatives inspired more general interests for domains that were until then more typical of psychology, such as cognitive or affective retardation. Moreover, in 1976, Quebec's professional corporation of occupational therapists began to claim, as an extension of its members' practice, access to those populations seen in psychology.<sup>45</sup>

The knowledge used by occupational therapists to address these developmental problems was largely borrowed from psychology itself. Universities were the first to institute a closer contact with psychological knowledge during the important reforms of higher education that occurred in the late 1960s and early 1970s. At the University of Montreal, the replacement of doctors-teachers by occupational therapists from 1968 on accompanied the addition of new courses on fundamental and applied psychology, like psychometrics, clinical psychology, child psychiatry, and projective techniques. In the 1970s, this training permitted both new graduates and practising therapists (through numerous retraining courses) to conduct their own evaluations not only of the patient's physical abilities, but also of his or her "perceptivo-motor" and psychosocial behaviour using evaluation tools that were until then the prerogative of psychologists, like interviews, tests or projective activities focused on the "expression of affects," behaviour or motivation.<sup>46</sup> It is on such a foundation that occupational therapists in psychiatric departments in Notre-Dame Hospital, for example, started to make "projective" uses of activities like drawing, from a psychoanalytic perspective.<sup>47</sup> At the Charles-LeMoine hospital, around 1980, occupational therapists even justified their use of behavioural techniques, like positive conditioning, by invoking what they described as the failure of "conventional occupational therapy" that undermined their professional status.<sup>48</sup> Indeed, the introduction of such evaluations, and of the therapeutic interventions they led to, did lead to an upgrade in professional status for the most aggressive therapists. For example, at the Douglas Hospital, the acquisition of psychotherapeutic abilities helped occupational therapists create, in 1982, a socialization group for psychotic patients who up until then had been deemed by psychiatrists "never ready enough"<sup>49</sup> for occupational therapy. By 1985, practitioners from various institutions were currently using evaluation tools borrowed from psychologists, like projective tests and various psycho-pedagogic devices.

In the 1980s, the addition of all these endeavours—the refocus of the use of activity as a therapeutic tool, the new emphasis on daily-living training, the conceptual shift to psychology—had given occupational therapy a more clearly therapeutic face than ever. In some cases, those changes even allowed occupational therapists to compete with other groups, like psychologists or speech therapists, on therapeutic grounds. In 1979, professional leaders of the CPEQ, the provincial equivalent of the CAOT, even predicted that occupational therapy, by connecting sensorial perceptions to their psychological repercussions, would occupy “the highest level of Bloom’s taxonomy”<sup>50</sup> and of the hierarchy of therapeutics that appeared to follow from it.

From 1970 to 1985, both occupational therapists and social workers took advantage of the new healthcare context to extend their activity to more genuinely therapeutic tasks, using new conceptual frameworks inspired respectively by psychology and social sciences, to assign themselves tasks that would lead them beyond administrative or diversional roles from which they were eager to extricate themselves.

## CONCLUSION

The story, of course, did not end in 1985, and transformations have continued to alter the face of occupational therapy and social work. Although their therapeutic role was not contested, the most ambitious claims of occupational therapists over the treatment of the human psyche came up against the authority of psychiatrists and psychologists. After 1990, these obstacles inspired a new conceptual shift toward approaches more specific to occupational therapy, like Ayres’ sensory integration or Kielhofner’s model of human occupation. In the 1990s and 2000s, this shift supported an extension of practice toward cognitive problems of neurological etiology such as autism, Alzheimer’s disease, and brain injuries.<sup>51</sup> Hospital social workers, for their part, came to use their administrative tasks in more systematic ways in order to access new patients, for example dying patients or grieving relatives.

Nonetheless, from 1940 to 1985, both groups created new therapeutic roles for themselves. Only in the early 1980s was it clearly established that occupational therapists and hospital social workers could interpret their clients’ problems as health troubles and work at their remission within a therapeutic perspective. Such a position, which rendered them a part of the curing world, had never been an obvious or natural endpoint. In the first decades of the 20th century, both occupational and social “aides” were mostly exogenous to the world of health. It is the continuing expansion of that world and the increase in hospital employment that changed their professional trajectories by reconfiguring practitioners’ aspirations. From 1940 to 1960, these groups’ entry

into growing medical domains pushed occupational therapists and hospital social workers, threatened by de-qualification, to redefine themselves as therapists: while occupational therapists benefited from medical sponsorship to give a therapeutic purpose to crafts and recreational activities, social workers offered their patients psychotherapy-oriented individual counselling. Between 1950 and 1970, various obstacles undermined those endeavours and many practitioners then complained about being restrained to recreational or administrative tasks in a hospital world where therapy remained the doctors' prerogative. From 1970 to 1985, other mutations in healthcare institutions allowed occupational therapists and social workers to explore new practices supported by new conceptual frameworks: while hospital social workers introduced psychosocial support for families and groups, occupational therapists refocused their use of recreational activities, became involved in social rehabilitation, and used psychological perspectives to intervene in developmental cognitive and sensorial problems.

Although both occupational therapy and hospital social work are predominantly female professions, this paper did not focus on gender issues. It is not to say that gender discrimination and gender stereotyping did not contribute to the struggle between physicians and both occupational therapists and social workers. It probably did. However, the history of allied health professions after 1950 remains largely unexplored and exactly how, to what extent, and in which ways gender intersected with it is uncertain. After all, social workers and occupational therapists, using similar tools, met similar resistances and outcomes to male or mixed professional groups like chiropractors, hearing aid practitioners, respiratory therapists or psychologists since 1950. Moreover, our views regarding the role of gender in healthcare work are essentially derived from nursing history. But after 1950, allied health professionals like occupational therapists and social workers, but also physiotherapists, speech therapists, and nutritionists considerably diverged from nursing about professional issues, both in terms of claims, strategies, and outcomes. For sure, gender remained a key factor in the structuring of occupational hierarchies in healthcare after 1950. But, if they are to be taken seriously, questions about the precise role of gender in the history of allied health professions after 1950 will have to remain open as long as we do not provide better understanding of the general institutional and professional trends affecting healthcare during this period. This is what I tried to do here.

By comparing the uneven trajectories of occupational therapists and hospital social workers, different professions that nonetheless experimented with similar changes, I have illustrated the changing, historical nature not only of the professional status of practitioners, but also of their very quality as therapeutic agents. To the well-known "medicalization" of

problems, one should thus add the "healthization" or, better, the "therapeutization" of the characters who participate in the process. This opens the way to a more refined reflection on the concrete, ambiguous situation of "therapists" in the general growth of the world of health. This may also shed some light on the present situation of non-therapeutic male workers, such as physical educators, prosthesis technicians, and attendants, who are currently seeking a new professional status based on more therapeutic roles. Moreover, the position of current therapists remains subject to change. In the 1990s and 2000s, many social workers came to understand that administrative tasks could very well once again become the best security for their jobs. Likewise, occupational therapists, now well established in health institutions, are slowly beginning to question their focus on health matters, now seen as too narrow, to suggest a still broader definition of "occupation."<sup>52</sup> These recent trends, also, confirm how changeable and transitory the therapeutic quality of "health" professionals can be.

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#### NOTES

- 1 Janet Golden, "'An Argument That Goes Back to the Womb': The Demedicalization of Fetal Alcohol Syndrome, 1973-1992," *Journal of Social History*, 33, 2 (1999): 270.
- 2 V. Metaxas showed that American associative leaders such as Eleanor Slagle opposed the "vocational" focus of the profession to defend a more therapeutic one, but does not demonstrate that this view was extensively shared among occupational "aides." At the same time, Metaxas confirms that "vocational" and "therapeutic" works were already seen as distinct and opposed categories in the 1920s. Virginia A. Metaxas, "Eleanor Clarke Slagle and Susan E. Tracy: Personal and Professional Identity and Development of Occupational Therapy in Progressive Era America," *Nursing History Review*, 8 (2000): 39-70. Joseph M. Gabriel offers a similar view about social work in: "Mass Producing the Individual: Mary C. Jarrett, Elmer E. Southard, and the Industrial Origins of Psychiatric Social Work," *Bulletin of the History of Medicine*, 79 (2005): 430-58.
- 3 Original quote in French: "...à l'égard de la société, le service social se conduit comme un vrai médecin" and casework allows to "porter un diagnostic et décider ensuite du secours qui doit être apporté" in order to "refaire des cellules saines à la société," Georges-Henri Lévesque, "Le bon Samaritain à Québec," *L'Action catholique*, 24 November 1943.
- 4 François Hudon, *Histoire de l'École de réadaptation de l'Université de Montréal, 1954-2004. Cinquante années au service de la société* (Montréal: Faculté de médecine de l'Université de Montréal, 2004), p. 25.

- 5 Original quote in English. Archives of the Ordre des ergothérapeutes du Québec (OEQ), file "Correspondance 1927-1931," bulletin of the Quebec Society of Occupational Therapy (QSOT), 1934.
- 6 Indeed, P. Twohig showed that, in both Canada and United States, therapy-oriented jobs were rare in occupational therapy in the 1920s and 1930s. W. S. Braznell explained how the development of occupational therapy in the 1940s was associated more with the revival of crafts like silversmithing than with clear therapeutic outcomes. Peter L. Twohig, "'Once a Therapist, Always a Therapist': The early career of Mary Black, Occupational Therapist," *Atlantis: A Women's Studies Journal*, 28, 1 (2003): 106-17; W. Scott Braznell, "The Early Career of Ronald Haynes Pearson and the Post-War II Revival of American Silversmithing and Jewelmaking," *Winterthur Portfolio*, 34, 4 (1999): 187-89. Also see: Lynn Downey, "'This Novel Employment of Untrained Hands': The Pottery of the Arequipa Sanatorium," *California History*, 73, 3 (1994): 202-15.
- 7 Up to the early forties, the services given to the victims of spinal cord injuries in hospitals of Canada or United Kingdom kept being referred to as "diversional occupational therapy" or, as the medical director of the up-to-date British center of Stoke Mandeville put it, "time-killing diversions," Julie Anderson, "'Turned into Taxpayers': Paraplegia, Rehabilitation and Sport at Stoke Mandeville, 1944-1956," *Journal of Contemporary History*, 38, 3 (2003): 471. See also: Lettie Gavin, "Reconstruction Aides in World War I: A Brand New Profession," *Minerva Quarterly Report on Women and the Military*, 12, 4 (1994): 65-74.
- 8 Pierre Bergeron and France Gagnon, "La prise en charge étatique de la santé au Québec: émergence et transformation," in Vincent Lemieux, Gérard Bélanger, Clermont Bégin, and Pierre Bergeron, eds, *Le système de santé au Québec* (Québec: Presses de l'Université Laval, 2003), p. 16.
- 9 Gilles Dussault, "Les médecins au Québec (1940-1970)," *Recherches sociographiques*, 16, 1 (1975): 70-73.
- 10 Nadia Fahmy-Eid, Aline Charles, Johanne Collin, Johanne Daigle, Pauline Fahmy, Ruby Heap and Lucie Piché, *Femmes, santé et professions. Histoire des diététistes et des physiothérapeutes au Québec et en Ontario, 1930-1990* (Montréal: Fides, 1997), 41-44.
- 11 Including the influential support of Dr. John Meakins, successively dean of the Faculty of medicine of McGill University and superior officer in the Canadian army involved in the organization of rehabilitation services for veterans. Archives of the OEQ, report from the congress of the Canadian Association of Occupation Therapy (CAOT), 1943, p. 1-4; 1944, p. 1-3; and 1945, p. 1-2.
- 12 In the meantime, at the University of Toronto in 1950, physical therapy and occupational therapy programs were both transferred from the Department of University Extension, where they had been created, to the Faculty of Medicine.
- 13 Original quote in English. Archives of the OEQ, report from the congress of the CAOT, 1951, p. 1-2.
- 14 *Savoir* [journal of the CTSPQ], 4 (1967): 10. On the DVA's influence over the emerging of new medical facilities and specialties, see: Mary Tremblay, "The Right to the Best Medical Care: Dr. W. P. Warner and the Canadian Department of Veteran Affairs, 1945-1955," *Canadian Bulletin of Medicine History*, 15 (1998): 3-25.
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- 16 Original quote in French: "personnes ayant demandé le service de casework [et] présentant des possibilités de réhabilitation," Archives of the OPTSQ, p. 3-9.

- 17 Original quote in English. Annual Report of the Centre de réadaptation Constance-Lethbridge (CRCL), 1951, p. 2; 1952, p. 12, 16; 1953; 1954, p. 2; 1955, p. 5, 17; and 1956, p. 6.
- 18 Annual report of the Notre-Dame de Montréal, 1960, p. 95, 127-29; 1961, p. 82; 1963, p. 76; 1964, p. 110; 1966, p. 111; and 1968, p. 133, 140.
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- 21 Original quote in French: "où je devais fabriquer un animal à l'aide de papier journal et de papier crêpé," *Le Transfert*, 8, 2 (1984): 8-9; *Revue québécoise d'ergothérapie*, 3, 4 (1994): 136-40. In 1967, many teachers of the school resigned in opposition to the doctors' decision to maintain a 78-hour woodwork course, Julien Prud'homme, "La formation universitaire et l'établissement d'une nouvelle profession. L'orthophonie-audiologie à l'Université de Montréal, 1956-1976," *Revue d'histoire de l'Amérique française*, 56, 3 (2003): 329-56.
- 22 Archives of the Université de Montréal, B 5940, file "Memoire: Royal Commission on Health Services," J. Bernd et al., *Brief on OT in the PQ prepared by the QSOT*, Montréal, QSOT, April 1962, p. 1; Gustave Gingras, *Brief on Physical Medicine and Rehabilitation*, 1961, p. 2-3; B 5952, file "Centre médical - École de réhabilitation," Gustave Gingras, *Aspect industriel de la réadaptation*, May 1962, p. 2.
- 23 *Le Transfert*, 8, 2 (1984): 8-9, 20-1.
- 24 Even in the most advanced facilities, like the Verdun Protestant Hospital for the Insane, near Montreal, the "therapeutic" use of work aimed primarily at distracting patients and keeping them in a good mood, while providing some much-needed economic benefit to the hospital. Supervising such activities were generally the business of a craftsman (carpenter, baker, plasterer, etc.) and not of an aide or a therapist. See André Paradis, "Thomas J. W. Burgess et l'administration du Verdun Protestant Hospital for the Insane (1890-1916)," *Canadian Bulletin of Medical History*, 14 (1997): 14-20.
- 25 Original quote in French: "collaborer à la psychothérapie et la prolonger," Archives of the OEQ, file "SEQ, 1967-1968," Anonymous, *Ergothérapie*, [1964-1968], p. 2.
- 26 Original quote in French: "Durant leur entraînement, ils sont de grands inconnus dans nos départements mais, diplômés en poche, ils peuvent nous donner des conseils et ordres jusque dans les moindres détails," Archives of the OEQ, file "SEQ, 1967-1968," Anonymous, *Ergothérapie*, p. 1-4.
- 27 *Le Transfert*, 14, 3 (1990): 23; *Revue québécoise d'ergothérapie*, 3, 4 (1994): 136-40.
- 28 Original quote in English. Archives of the OEQ, minutes of the QSOT, 5 October 1953; 22 September 1958; 7 January and 5 October 1964; and 3 May 1965.
- 29 Ruth Gagné, *Étude descriptive et évaluation du travail social dans un programme de réhabilitation*, MA thesis (social service), Université Laval, 1956.

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- 31 Annual report of the Institut de réadaptation de Montréal, 1963, p. 47; 1964, p. 69-70; and 1969.
- 32 Original quote in French: "Nous sommes perçus comme menaçants, voulant prendre la place des psychiatres... On est là d'après les gens de l'hôpital pour être les assistants de ceux qui sont en charge... Maintenant c'est un rôle que nous n'acceptons pas très bien toujours .... qu'on le veuille ou qu'on ne le veuille pas, le casework est une certaine forme de psychothérapie," Archives de l'Université de Montréal, B 3864, Jacques Larin et al., "Entrevue sur la santé mentale," *Recherche Option A*, Montréal, École de service social de l'Université de Montréal (ÉSSUM), 1971, p. 3-4.
- 33 Original quote in French: "Quand un patient m'est référé pour une somatisation, à ce moment-là je me sens beaucoup plus à l'aise dans ces problèmes parce que c'est la relation avec le patient pour essayer de l'aider à voir le problème psychologique à l'intérieur de sa maladie. Là, je me sens caseworker," Archives de l'Université de Montréal, boîte 3864, Jacques Larin et al., "Entrevue sur la santé physique," *Recherche Option A*, p. 2-3.
- 34 About Quebec's public reforms in healthcare in the 1970s, see Deena White, "The Rationalization of Health and Social-Service Delivery in Quebec," in B. Singh Bolaria and Harley Dickinson, eds., *Health, Illness and Health Care in Canada* (Toronto: Harcourt Brace, 1994).
- 35 Gilles Dussault, "Les producteurs de services sociosanitaires," in Vincent Lemieux et al., eds., *Le système de santé au Québec* (Sainte-Foy: Presses de l'Université Laval, 1994).
- 36 Julien Prud'homme, "Diagnostics, stratégies professionnelles et politiques de la santé. Les orthophonistes québécoises depuis 1970," *Recherches sociographiques*, 47, 2, (2006): 253-75.
- 37 Original quote in French: "je vais commencer [aussi] des groupes de cardiaques car je me rends compte que j'investis de façon différente avec un groupe. J'ai même pensé à inviter un médecin pour qu'il voie les besoins présents," Archives of the Université de Montréal, B 3864, Jacques Larin et al., "Entrevue sur la santé mentale," *Recherche Option A*, p. 4.
- 38 Annual report of the IRM, 1970, p. 7; 1972, p. 9; 1973; 1974 ; Annual report of the CRCL, 1974, p. 4-6; 1975, p. 5; 1977, p. 49-50; 1978, p. 22; 1980, p. 1; 1981, p. 8; and 1989, p. 11.
- 39 Archives of the Université de Montréal, B 882, ÉSSUM, *Projets et perspectives concernant le programme de l'École de service social*, Montréal, ÉSSUM, December 1963, p. 11, 14-16.
- 40 Original quote in French: "... originent des groupes de relations parents – enfants organisés par des travailleurs sociaux," and in which "le travailleur social se reconnaît... un rôle de thérapeute," Corporation professionnelle des travailleurs sociaux du Québec (CPTSQ), *Consultation sur la prévention en santé mentale des enfants et des adolescents*, Montréal, CPTSQ, 1984, p. 1-4, 6-7.
- 41 *Le Transfert*, 5, 1 (1981): 6-7.
- 42 *Le Transfert*, 7, 1 (1983): 10-11.
- 43 *Le Transfert*, 8, 2 (1984): 20-21; 12, 4 (1988): 18-21; 13, 1 (1989): 12; and 14, 3 (1990): 18.
- 44 *Le Transfert*, 4, 4 (1980): 18-19; 11, 2 (1987): 15; 14, 2 (1990): 11; *Revue québécoise d'ergothérapie*, 1, 2 (1992): 84; and 4, 2 (1995): 63-68.
- 45 *Revue québécoise d'ergothérapie*, 1, 2 (1992): 84. Archives the OEQ, file "Champs d'actions...", Raymonde Hachey, "Presentation Symposium Toronto," 1978, p. 3; letter from F. Drouin-Cloutier to G. Pothier, 17 janvier 1978.
- 46 Yearbooks of the ÉRUM, 1968-1984. CPEQ, *Avis au Comité de santé mentale du Québec*, Montréal, CPEQ, 1984. Québec, MTMO, p. 1-4, 10-17.

- 47 Examples can also be found at the Montreal General Hospital and the Cité de la Santé of Laval, *Le Transfert*, 7, 1 (1983): 6-10; 15, 3 (1991): 9-14; and *Revue québécoise d'ergothérapie*, 1, 1 (1992): 83-84.
- 48 *Le Transfert*, 4, 1 (1980): 5-6.
- 49 Original quote in French: "ne semblaient jamais assez prêts." The same can be observed at the Louis-Hypolite-Lafontaine psychiatric hospital. *Le Transfert*, 7, 4 (1983): 20-23; 14, 4 (1990): 16-17; and *Revue québécoise d'ergothérapie*, 1, 2 (1992): 75. Archives of the Université de Montréal, B 5938, file "Stages Rivière-des-Prairies," Brigitte Asselin et al., [Report on clinical training in occupational therapy], 1979, p. 5-10.
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- 51 This late shift from psychological concepts to neurological ones was very similar to the one of speech therapists during the same period, Prud'homme, "Diagnostics, stratégies professionnelles et politiques de la sante," p. 253-75.
- 52 For a Canadian view on this question, see E. A. Townsend and H. J. Polatajko, eds., *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, and Justice through Occupation* (Ottawa: CAOT Publications, 2007). I wish to thank Andrew Freeman for bringing this current trend to my attention.