Reprinted from British Medical Bulletin, *1949, Vol. 6, No. 3, pages 191–196*

1416

OCCUPATIONAL THERAPY AND MENTAL HEALTH

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It is important, in discussing occupational therapy, to emphasize that therapy means treatment, and that treatment presupposes diagnosis, prescription and application by selected and trained personnel. Note the two qualifications mentioned. Though undoubtedly important for all ancillary medical workers, selection and training are particularly important for the occupational therapist. An occupational therapist has to help the patient to help himself, a task far less easy than doing something for him. The success of the treatment is, in the first instance, particularly dependent on the person applying the treatment.

To clarify the subject-matter of this article it is essential to find a definition for " mental health ". This, unhappily, is more difficult than discussing conditions of ill-health. A broad charter for conditions of mental health may be taken from the following, by Nicole (1946) :

> Perhaps happiness and adaptability are the keynotes to the diagnosis of mental health—it has to be " diagnosed ", for it is so uncommon—or else liberty in the broad sense may become the hall-mark of the healthy man. Not liberty that comes from the refusal to recognize obligations, but an internal moral freedom that allows of full use being made of intelligent discrimination. . . . Crichton-Miller would measure man's liberty in terms of his detachment from fear of consequences ; that is, fear of frustration (self), fear of retribution (society) and fear of extinction (future).

These fears undermine health : they can be overlaid by, or converted into, physical or psychological symptoms and syndromes, or they can accompany certain conditions of physical or psychological illness. But " the development of . . . positive qualities inevitably eliminates their opposites " (Read, 1944) ; so occupational therapy is designed to provide these positive qualities and to help to dispel the symptoms of the disabilities for which it is prescribed. " One of the requirements for Mental Health is a task " (Carrington, 1946) —occupational therapy provides that task.

A. AIMS AND PRINCIPLES OF OCCUPATIONAL THERAPY

The occupations used in this form of treatment cover all forms of work or recreational activity, mental or physical, " medically prescribed and professionally guided to aid a patient in recovery from disease or injury " (Willard & Spackman, 1947). Occupational therapy is not just any work or recreation given to entertain the patient.

In spite of the necessary attention to the disability of the patient, no occupational therapy can hope to succeed unless the patient is treated as a whole individual with proper consideration for his economic, social, psychological and physical needs. Treatment must be part of a well-organized and co-operative scheme of rehabilitation, the occupational therapist having close connexion with other medical workers, such as almoners, nurses and physiotherapists, and with the aim of

and orthopaedics, psychopathology, psychiatry, department management, book-keeping, etc., and, of course, occupational therapy as applied to physical and psychological conditions. They further learn of the therapeutic possibilities of social activities, art, music, drama, literature, domestic and secretarial subjects, gardening and industrial occupations, and of correspondence courses. Certain crafts are taught with the intention of training the students in versatility, in the use of tools and in constructive methods. Emphasis is also put on ingenuity and capacity to help the patient to " make do and mend ". The manual arts are among the occupations most adaptable and readily acceptable to the patients, and give opportunity for objective observation of the patient as an aid to diagnosis and further prescription. Among these manual arts are woodwork, metalwork, textile design and construction, pottery, leatherwork, basket-work, and stool- and chair-seating. (See figs. 1–6.)

During training, students work in hospital rehabilitation departments under trained occupational therapists. There they learn the practical problems of application of treatment by occupation, and of departmental management, and how best to co-operate with other treatment departments.

In the early days the courses were of one year's duration. It has been found, however, that a longer course is necessary to give sufficient basic knowledge from which to work. The course now covers 2½–3 years, for those without previous experience; some students, offering previous training and qualification, may in less time gain the Diploma of the Association of Occupational Therapists; students from all schools in England enter the examination for this Diploma.

2. Co-operation with the Physician

The occupational therapist needs from the doctor in charge of the case the fullest co-operation, and á willingness on his part to understand the aims and methods of occupational treatment. The role of the physician, then, falls mainly under five heads, viz.: diagnosis, and the supply of facts relevant to the history of the case; prescription of treatment; prognosis; precautions to be observed; and supervision of treatment, up-grading and progression. It is recognized that all medical men are busy. If, therefore, specific information is given when treatment is prescribed, and special times for observations, reports and revision of treatment are arranged, the occupational therapist need not lose valuable time trying to make contact with the doctor, nor need she work without his expressed wishes. It cannot be too strongly emphasized that occupational therapy carried out with the really active supervision and co-operation of the doctor is successful, and can at times even be termed spectacular. Without this co-operation the treatment is, on the whole, wasteful of time, energy and money.

FIG. 3. WEAVING ON SMALL LOOMS

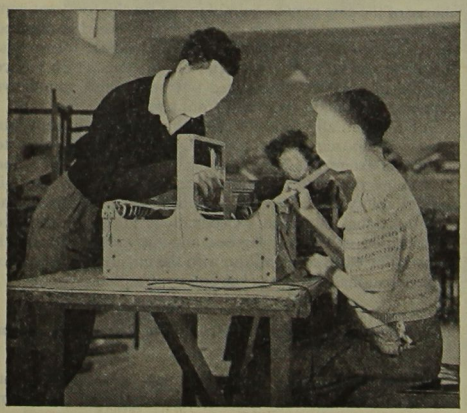


FIG. 4. SPINNING

Apart from the actual prescription and the clinical meetings for assessment of the case, which may be given or conducted by the patient's particular doctor, all ancillary medical services should, ideally, work under a co-ordinating and supervising medical officer, who will interpret to his colleagues the possibilities of the various treatments or the difficulties of the team of workers. This medical officer should correlate all treatments for the benefit of the patient and should distinguish between their usefulness. Not every patient needs every form of treatment.

3. Duties of the Occupational Therapist

These fall under two main heads, namely, administration and the actual carrying out of treatments.

FIG. 1. BASKETRY; EDUCATIONAL AND PRE-VOCATIONAL TYPING

re-establishment of the patient in former employment, or assessment and vocational training for new employment in normal, sheltered or " home-bound " conditions. Employment under " sheltered " conditions indicates the possibility of working and earning under special care and with special provision made for disability. Employment of the " home-bound " means taking work to the disabled in their own homes. These two latter services are being catered for by the Disabled Persons Employment Corporation.

Over-emphasis on the economic factors of the patient's treatment can be as detrimental as neglect of this aspect. It is true that at times the primary need of the patient may be economic re-adjustment. Proper choice of occupation as treatment can, undoubtedly, contribute to this. At other times, distraction from excessive economic anxiety may be the aim.

The maintenance or improvement of social adjustment in illness can lessen the period of sickness, and occupational treatment devised to this end can influence considerably the re-establishment and sense of security of a patient in convalescence and on discharge. A continued link, maintained with patients after discharge, through social clubs or by visits to sheltered workshop or home-bound cases, can sometimes prevent a return of symptoms or the necessity for re-hospitalization.

The main psychological benefits of occupational therapy are its normalizing effects and the contribution it makes towards the prevention of invalidism. It relieves emotional tension, arouses interest and helps to focus attention; it offers an outlet for creative and experimental needs, and can, by its practical demonstration of actual achievement, contribute towards the re-establishment of confidence.

Physically, occupational therapy can be useful in the maintenance of good general physical condition, for the restoration of function of joints and muscles, for contributing towards resistance to fatigue and for the assessment of work tolerance. Some further principles are given by Kidner (1930):

(1) In applying Occupational Therapy, system and precision are as important as in other forms of treatment. (2) The occupation selected should be within the patient's estimated interests and capability. (3) The only reliable measure of treatment is the effect on the patient. Employment in an occupation which would be trivial for the healthy may be attended with benefit to the sick or injured, but standards worthy of entirely normal persons must be maintained for proper mental stimulation. (4) As the patient's strength and capability increase, the type and extent of the occupation should be regulated and graded accordingly.

B. METHODS OF FULFILLING THESE AIMS AND PRINCIPLES

1. Selection and Training of Personnel

Occupational therapy, in its initial stages, and in its introduction to the patient, is a very personal matter. So much depends upon the occupational therapist making an acceptable and somewhat social approach, with a view to discovering the occupation which will be interesting to the patient, as well as progressive and therapeutic. The occupational therapist must be trained in the therapeutic possibilities of a large variety of occupations, and have sufficient accurate and scientific medical knowledge and administrative ability to carry out the prescriptions with intelligence and enterprise, coupled with a capacity for observation and skill in acceptable presentation.

Selection of the right candidate for this work is of paramount importance. It need not be limited to a particular type only: there is room for the pioneer, the plodder, the administrator and the executive; but, fundamentally, the applicants must have the following qualities in common: tact, good judgement, an optimistic outlook, emotional maturity, satisfactory personal integration, a sincere and friendly interest in others, a capacity for enjoyment, a wide background of interests, enterprise, imagination and tolerance, and a reasonable amount of assurance and determination in carrying out treatment.

In most training centres students have lectures and demonstrations in the following theoretical subjects: anatomy and physiology, general medicine and surgery, physical medicine

FIG. 2. METAL TURNING

FIG. 5. MEN'S WORKSHOP IN A MENTAL HOSPITAL

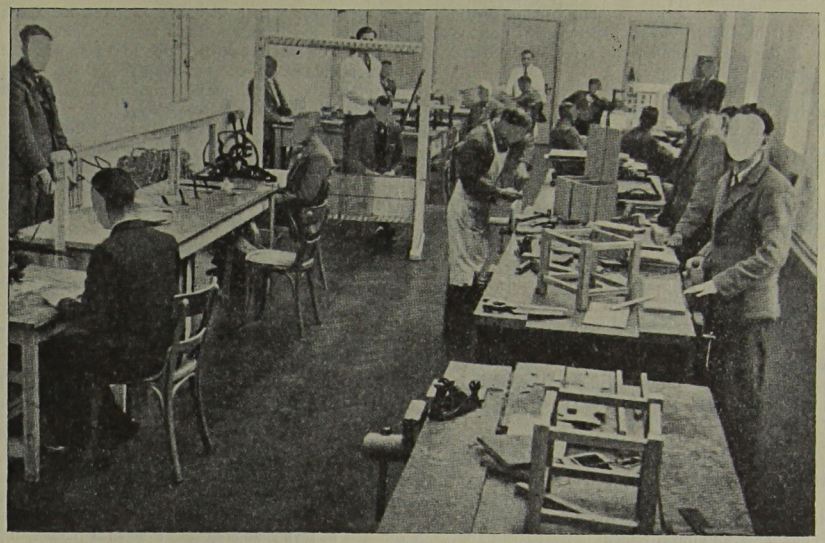
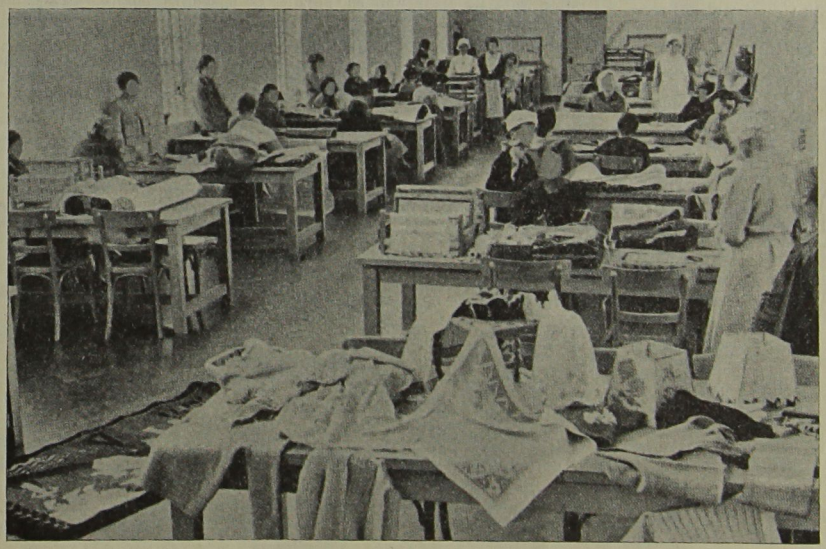


FIG. 6. WOMEN'S WORKSHOP IN A MENTAL HOSPITAL



Administration

Before opening his or her department in the hospital or rehabilitation centre, the occupational therapist must make assessments of the following: (i) area to be served by the rehabilitation facilities; (ii) local interests and industries; (iii) types of patients to be treated; (iv) whether the service is for hospital in-patients, out-patients or for home-bound cases, etc.; (v) the number of patients for whom treatment may be required. In addition there should be consideration of social facilities, ancillary services, transport for out-patients, home conditions, and the possibilities for light, productive and remunerative work for suitable cases.

In considering the question of assistance, what would appear a paradox is true: an occupational therapist with an assistant can more than double her usefulness. In addition to the assistance of further experts in treatment, good voluntary or paid help with stores or book-keeping can be a very great asset.

With regard to details of equipment for the department these vary with the needs and possibilities in different hospitals and centres. Their consideration, though important to each individual hospital, is not one on which generalization can be made, and is too detailed for the scope of this article.

Prescriptive Considerations and Particular Treatments

Occupational therapy is useful for physical as well as for psychological disabilities. The science of prescribed work can, however, in all cases be termed to some degree psychological. A happy, contented patient is a better patient for the doctor to treat.

All treatment falls into two categories: (i) general treatment, which aims at maintenance of normal work habits, prevention of invalidism, and maintenance of good physical and mental tone; (ii) special treatment, which carries with it the aforementioned obligations, but has, in addition, a particular aim in giving treatment for a particular disability or for restoration of a particular function.

General and special treatment should be carried out in as normal an atmosphere as possible. The lines of general treatment should be laid down in the light of an analysis of the occupations available; certain patients can be assigned to occupations which are at once useful and of therapeutic value. Naturally, the greatest benefit will accrue if these patients are under expert supervision and if regular reports are made on their progress. These patients should be reassigned to other occupations whenever their progress allows. It is necessary also to cater for their recreational needs.

Special occupational therapy makes a far more direct attack on the pathological reactions of the patient. In any given case, a full description of the patient and of his individual traits is necessary; but it may be feasible to indicate some of the general principles upon which the choice of methods of treatment is based. A distinction may be made between stimulative and sedative treatment, though this distinction is by no means always rigid. Stimulative occupations give large movements, variety, quick results and encouragement; they avoid monotony and hold attention. Sedative occupations may be repetitive; they should give continuous, rhythmic movements, at the same time holding interest and avoiding monotony.

The prescription of occupational therapy is as individualized a matter as is the diagnosis of the patient's illness. However, mental patients requiring occupational therapy do fall into certain broad groups, and a discussion of these with the appropriate type of therapy may be of value.

The therapy of psychotic and disorientated patients should have as its goals re-socialization, the maintenance of contact with reality, and arrest of deterioration. Occupational therapy should be part of a carefully organized programme for each day; it is more effective when given in groups in pleasant surroundings. The capacity of the patient and the need for precautions must be considered when the programme is arranged. Community singing, exercises to music, relaxation, and work with large movements are all useful in stimulating interest and initiative, penetrating self-absorption and maintaining work habits. Deluded and refractory patients may in some cases take part in these activities with value. With regressed patients, habit training must be a primary aim.

For many depressed patients, work with an element of challenge in it is a help towards overcoming apathy, a sense of guilt and feelings of inadequacy. Exercises are vital, as are social events and group work; some attention, also, to personal appearance may be stimulated by the making of clothes. Gardening, basketry and flat rug weaving may be beneficial.

For excited patients rhythm is essential, and an attempt must be made to hold and improve concentration. Fatigue, already being induced by the state of the patient, should be avoided; the spells of work should be regulated carefully. Gardening, weaving, wool winding and basketry are useful and safe occupations requiring few tools.

For the psychoneurotic patient, certain principles of the aforementioned methods are applicable. This type of patient should be encouraged to start treatment even in bed, and urged to persist in completing one task before proceeding to another. Occupational therapy can take almost any form in the practical or intellectual field that appeals to the patient and that meets his prescriptive needs and maintains a good balance of work and recreation (see figs. 1, 4). When possible, men should do work of a masculine nature, promoting self-esteem (see fig. 2); in other cases, combined work with women (fig. 3) has a socializing value. Art, modelling and pottery have also very valuable therapeutic possibilities. Reports from the occupational therapists to the medical officer in charge of the case may be helpful in the psychiatric treatment of these cases, and all occupational therapy should be planned in the closest co-operation with other medical treatments. Relaxation should be taught, and occupations which induce this are invaluable. They need not be without stimulative content but should bring relief from tension (see figs. 5, 6).

For the mentally deficient case, occupational therapy can make an important contribution, by helping to develop, to the fullest extent, the existent capacities of the patient; and by helping the disturbed and distressed patient to find his level of ability and achievement—this needs a very particular and individual approach. Occupations already mentioned can be used in varying degrees, and the greatest success is achieved by close co-operation with the nursing, maintenance and educational services of the colony, hospital or home.

4. Occupational Therapy in Relation to Physical Treatment in Psychiatry

In discussing occupational treatment given to patients during or after physical treatments, it should not be necessary

to enlarge upon or explain the effects of these physical treatments in detail. These will be known to the readers of this article and are discussed in the preceding issue of *British Medical Bulletin* (Hill, 1949). As yet experience of occupational therapy in this field is limited, but a few observations may be of interest.

If the occupational therapist makes contact with the patient before he receives the physical treatment, and if she is able to observe him in at least one of his treatments, she can develop a far more successful programme for him than if he comes only after treatment, as an isolated case of which she has had no previous knowledge; for, according to Sargant & Slater (1948), the make-up of the personality is not in any way changed by physical treatments, except in prefrontal leucotomy. In this latter case it is equally imperative that she have worked with the patient before operation.

Cases receiving *modified* or *deep insulin treatment* will usually receive their occupational treatment in the afternoon. A programme carried out at one hospital arranges the insulin treatment in the morning; after lunch, there is garden occupation for an hour, followed by indoor occupations for 1½ hours. These latter may be of a socializing nature, often in mixed groups, but limited by the physical condition of the patient as well as his psychological state.

Cases receiving *electro-convulsion therapy* should have visited the occupational therapy department on several occasions and become familiar with it before the convulsion treatment is started. Outdoor occupations are good for these patients. The occupational therapists must watch for the first signs of change and improvement in the patient after any one treatment. Advantage of the improvement must be taken immediately and, while the patient is more open to suggestion, further progress can be made towards achieving the highest level of occupation of which the patient is capable.

After *prolonged narcosis*, cases arrive for occupational treatment with visionary disturbances and transitory depression. They have to be given simple, re-assuring occupations within their capacities, though the challenge and quality should be increased with improvement.

Patients receiving treatment by *abreactive techniques* need, above all, to be re-assured and re-socialized in the occupational therapy department; they may be disturbed for days, worrying about what they have divulged to their doctor. It is important that they should meet the occupational therapist as a friend, without suspicion that she may be informed of the facts they have, for therapeutic purposes, been encouraged to reveal to the psychiatrist.

Opinions vary as to when occupational therapy should be started after *prefrontal leucotomy*. It is begun in some cases after 48 hours, in others not till a week later. The patients may now lack some ability and drive, but tension may be lessened, and a form of re-socialization and general occupational therapy is needed. In reporting the results of occupational therapy for the leucotomized patient, Hyde & Wood (1949) state:

> There was evidence of increased acceptance of the occupational activities proffered after the operation. Fifteen patients showed increased participation in occupational therapy, 5 were unchanged and 7 showed decreased participation. Ten showed increased socialization, 14 were unchanged and 3 showed decreased socialization. On the other hand, spontaneity was increased in 6, unchanged in 11 and decreased in 10 post lobotomy.
>
> There was a decrease in number of cases displaying self-preoccupation, hostility and compulsiveness and an increase in the number of patients displaying lethargia and malaise. Five patients showed a peculiar defect in their appreciation of the passage of time postoperatively. There was no defect noted in the ability of patients to learn occupational tasks postoperatively.

More could be said of detailed organization and treatment, of the possibilities of the more intellectual occupations, of "psychodrama", of occupational therapy through art, music or industry, but the foregoing information has been directed at giving as complete a general picture of occupational therapy in relation to mental health as is possible within the scope of a single article.

ACKNOWLEDGEMENTS

I should like to acknowledge and pay particular tribute to the work and inspiring example of Dr. Elizabeth Casson, psychiatrist and pioneer in the institution of training in occupational therapy in Great Britain.

I am indebted to the following for illustrative material and photographs: Professor Aubrey Lewis, Dr. A. Harris, Miss Olwen Owen, Mr. P. Chappel and Mr. E. Parish of the Maudsley Hospital, London and to Dr. Ström-Olsen of Runwell Hospital, Essex.

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