A STUDY IN OCCUPATIONAL THERAPY FOR PSYCHONEUROSIS

LLOYD H. ZIEGLER, A.M., M.D.

Passed Assistant Surgeon (R) United States Public Health Service, United States Veterans’ Hospital, No. 37 (For Psychoneuroses), Waukesha, Wisconsin

The impaired function from organic lesions of the body responds well in most instances to occupational therapy, and the results are measurable in terms of increased joint movement, increased strength, better coordination, and decreased time for recovery. The fact that the therapeutic product can be measured in terms of time and function bears valuable testimony for the remedy. The application of the curative agent is directly to the part injured, and this is usually a problem in mechanics of a concrete and specific nature.

The disabilities of psychoneurotic patients are diffuse and indefinite in comparison and do not offer offhand the opportunity for the direct application of work as a remedial agent. The need for measuring the results is no less important with the psychoneuroses, however, and an attempt in this direction forms the subject material of this study.

In the case of the hysterics, neurasthenics, psychasthenics, or hypochondriacs what are we trying to cure in the workshop? Knowing some things about the individual’s maladjustments, what methods are to be employed to bring about the desired changes by his contact with the workshop? And lastly, what are to be the criteria of the results?

The following rating sheet was made by having a number of successful people in various walks of life rank the characteristics

1 Read at sixth annual meeting of the American Occupational Therapy Association, held at Atlantic City, September 25 to 29, 1922, and approved for publication by the Surgeon-General, U. S. Public Health Service, and by U. S. Veterans’ Bureau.
by placing the most malignant first and the least malignant last, with those intervening properly ranked. Curve 1 represents the composite judgment of the group of successful people. In the rating sheet the arrangement of the characteristics is identical with that of curve 1, the most malignant being at the top and the least malignant being at the bottom.

The reconstruction aides in occupational therapy were instructed in the use of the rating sheet and given trial practice until their understanding of the method was assured. A month’s acquaintance with the patient was considered a prerequisite to rating him. Patients working in the shop were rated at about

<table>
<thead>
<tr>
<th>TYPE</th>
<th>ECONOMIC GROUP</th>
<th>EMOTIONAL GROUP</th>
<th>PERSONAL IDIOSYNCRASY GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurasthenic—25 cases</td>
<td>0.87 +’s</td>
<td>0.93 +’s</td>
<td>0.83 +’s</td>
</tr>
<tr>
<td>Hysteria—50 cases</td>
<td>1.13 +’s</td>
<td>1.11 +’s</td>
<td>1.03 +’s</td>
</tr>
<tr>
<td>Anxiety—12 cases</td>
<td>1.30 +’s</td>
<td>1.20 +’s</td>
<td>1.03 +’s</td>
</tr>
<tr>
<td>Psychasthenia—9 cases</td>
<td>1.33 +’s</td>
<td>1.42 +’s</td>
<td>1.15 +’s</td>
</tr>
<tr>
<td>Constitutional (11 cases)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Psychopathic Inferiority</td>
<td>1.40 +’s</td>
<td>1.45 +’s</td>
<td>1.16 +’s</td>
</tr>
<tr>
<td>b. Psychopathic State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Inferiority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous—26 cases</td>
<td>1.29 +’s</td>
<td>1.15 +’s</td>
<td>1.25 +’s</td>
</tr>
</tbody>
</table>

monthly intervals. One hundred and thirty-three were rated one or more times. Curves 2 to 7 inclusive give the average rating in each characteristic for several types of psychoneuroses.² For practical purposes the eighteen characteristics were divided into groups. The first six were designated the “economic group;” the seventh to twelfth, inclusive, were called the “emotional group;” and the last six were called the “personal idiosyncracy group.” Table 1 presents the average rating for each group as applied to the various types of psychoneuroses.³

² Miscellaneous group constitutes patients with organic conditions and psychoneurotic reactions of an atypical nature.
³ As diagnosed by the hospital staff and medical officers.
Occupational therapy rating sheet

Aides will never let patient see these ratings or let them know they are being made.

If a characteristic is present or absent, designate it as follows:

- Absent
- Slightly present +
- Moderately present ++
- Markedly present +++
- Very, very outstanding ++++

Aide

Date

---

1. Irresponsibility
2. Lacking industry
3. Uncooperative
4. Incapacity to plan—dependence
5. Running from job to job
6. Acting without due consideration
7. Lack of initiative
8. Indecisive
9. Easily influenced by others
10. Complaining
11. Hyperemotional
12. Unfriendliness
13. Stubbornness
14. Desiring to "show off"
15. Suspiciousness
16. Selfishness
17. Moodiness
18. Bashfulness

Remarks:

Curves 2 to 7 inclusive, and table 1 suggest that the reconstruction aides in occupational therapy, without a profound knowledge of psychiatry, have been able to make fair differential diagnoses. Also it has been observed that patients who are willing to work respond better to the other forms of therapy about the hospital and make a satisfactory adjustment sooner than those who will not work. In this sense, work has come to
be a kind of prognostic test—a measure of the seriousness of the neurosis. During the study the aides were making remarkable progress in the understanding of human beings—a very valuable asset in addition to the knowledge of arts and crafts. But the

real object of the study, viz., to measure the therapeutic effect of work on the patients was not realized. The ratings at monthly intervals showed considerable variation, and the ratings of different aides on the same patients, were hardly comparable. A most valuable observation was that some patients who came to
PSYCHONEUROSES

1. Irresponsibility
2. Lacking Industry
3. Uncooperative in plan - dependence
4. Running from job to job
5. Acting without due consideration
6. Lack of Initiative
7. Indecisive
8. Easily influenced by others
9. Complaining
10. Hypochondriasis
11. Unfriendliness
12. Easily influenced by others
13. Distracting to "show off"
14. Suggestiveness
15. Selfishness
16. Bashfulness
17. Stubbobness
18. Desiring to show off
19. Suggestiveness
20. Suggestiveness

CURVE II - Average Rating
Psychoneurosis, hysterical type (50 cases)

CURVE III - Average Rating
Psychoneurosis, neurasthenic type (25 cases)

CURVE IV - Average Rating
Psychoneurosis, Anxiety Type (12 cases)
CURVE V - Average Rating
Psychoneurosis, Psychasthenic Type (9 cases)

CURVE VI - Average Rating
Constitutional
(a) Psychopathic
Inferiority
(b) Psychopathic
State
(c) Inferiority

CURVE VII - Average Rating
Miscellaneous Group (26 cases)
the shop with certain maladjustments only accentuated them and left the shop no better—probably even worse than before. On the whole the success with the rating sheet was not as satisfactory, in itself, as was desired and only offered the incentive to go a bit deeper into the problem. The idea of the rating sheet was thought to be good because it gave to us the layman’s (aide’s) reaction to the patient at work—a reaction that is the very first with which the patient must cope on leaving the hospital. The by-products in the way of knowledge derived from it had made it worth while, but it needed modification. It was soon observed that the characteristics listed were too general; that irresponsibility, uncoöperative, etc., mean different things to different people and hence the unreliability of our results for measuring therapy. The need for defining more specifically the eighteen characteristics resulted in the following outline which is the product of much thought and observation, and is applicable to the patient in the shop.

Outline for studying defective work and behavior habits in occupational therapy

Aides will never let patient see the ratings or let him know they are being made. The ratings may be made on plain sheets of paper on which the patient’s name and date are placed. Aides will sign the rating sheets. If a sub-characteristic as A, B, C, D, under 1, 2, 3, etc., is present designate it as follows:

- Absent
- Slightly present +
- Moderately present ++
- Markedly present +++
- Very, very outstanding ++++

1. Irresponsibility.
   A. About reporting to work on time daily or permitting smallest excuse prevent work.
   B. About care of common tools and equipment and neatness and tidiness of shop.
   C. About use and care of raw material used in the shop—wasteful and negligent—lacking thrift.
   D. About consequences of evident defective work, and about mistakes.

2. Lacking Industry.
   A. Tendency to make a job last.
   B. Wanting credit for time present in the shop even though not working.
   C. Selecting the easiest thing to do.
3. Unco-operative.
   A. Objection to undoing a piece of poor work and correcting it.
   B. Inability to follow simple directions or be attentive to same.
   C. Not able to focus attention on anything that does not immediately and directly concern the self in a pleasurable or profitable way.

4. Incapacity to plan—Dependence.
   A. Inability to plan a project which involves a changing design, or careful apportionment of limited materials.
   B. Dependent on others for repair of the least defect of equipment.
   C. Inability to grasp ideas about work quickly—demanding much individual attention, and pleased most when being helped.

5. Running from Job to Job.
   A. Not satisfied to finish one piece of work; interest soon shifting to another.
   B. More interest in the work of others and in the “next thing” than in “this thing.”

6. Acting without due Consideration.
   A. Impatient about waiting for help on a design, for material, or for instructions.
   B. Completing a piece of work no matter how it looks—the whole object being to get done.

7. Lack of Initiative.
   A. No plans, ideas, or interests in any direction—floating.
   B. Willing to do what is prescribed without variation.

8. Indecisive.
   A. Torn between two or more things to do and not able to decide which to do.
   B. Difficulty in deciding what designs, or colors, or plan to use.

9. Easily Influenced by Others.
   A. Easily encouraged or discouraged by remarks and actions of others.
   B. Copying after, imitating, or following the suggestion of others without persuasion.

10. Complaining.
    A. Objecting to noise.
    B. Objecting to odors—paints, oils, etc.
    C. Objecting to evident defects of workshop and equipment.
    D. Making objections that are far-fetched and that make it appear that the patient is very unhappy at work.

11. Hyper-emotional.
    A. Angered easily.
    B. Frightened easily.
    C. Disgusted easily.
    D. Excessively “tender-hearted”—easily hurt.
    E. Elated easily.

12. Unfriendliness.
    A. Not able to get along with others in shop after attempts and opportunity to be on friendly terms.
    B. No attempt to be friendly or unfriendly—indifferent.
13. \textit{Stubbornness}.
\begin{itemize}
\item A. Holding to an idea or plan tenaciously and which interferes with work, and not yielding to argument or persuasion.
\end{itemize}

14. \textit{Desiring to "Show off."}
\begin{itemize}
\item A. Attracting attention of others by mannerisms, gestures, remarks, "hard-boiledness," very masculine characters, etc.
\item B. Evident desire to impress others by strength, cleverness, ability to "bawl out" people, tricks, unusual experiences related, and unique abilities.
\end{itemize}

15. \textit{Suspiciousness}.
\begin{itemize}
\item A. General distrust of others and their motives, especially the government.
\item B. Because of the distrust in others, thinks it only fair to take advantage of others and get even for being potentially cheated all of the time—mild provocative revenge.
\end{itemize}

16. \textit{Selfishness}.
\begin{itemize}
\item A. Wants best equipment and material for self—no disposition to use less desirable material.
\item B. Unwilling to share with others.
\item C. Can't think in terms of the other fellow—can't put himself in other person's place.
\end{itemize}

17. \textit{Moodiness}.
\begin{itemize}
\item A. Having any emotional response—anger, fear, disgust, elation, tenderness, over a considerable time.
\end{itemize}

18. \textit{Bashfulness}.
\begin{itemize}
\item A. Self-conscious, seclusive, and without any tendency to "show off," and easily shamed.
\end{itemize}

By the new outline each aide in addition to her routine duties with arts and crafts, studies one or two patients intensely and has occasional conferences with the reconstruction officer in which she details her method of getting the patient to change his defective work and behavior habits. By this outline we are able not only to determine toward what to direct our therapy, but we are devising methods for making the desired changes and can see results. This we believe to be true occupational therapy for psychoneuroses.

Table 2 presents the facts about five patients rated by the new outline.

\begin{center}
\begin{tabular}{l}
\textbf{Case J. A.} Age, thirty-three; single; occupation, salesman. Drafted May 30, 1918, and served in several United States camps, apparently with no difficulty. On March 2, 1919, he met with an accident on a street-car which resulted in what was diagnosed an atlas-axis fracture.
\end{tabular}
\end{center}
<table>
<thead>
<tr>
<th></th>
<th>J.A.</th>
<th>C.D.T.</th>
<th>Y.H.</th>
<th>W.O.</th>
<th>S.W.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Irresponsibility</td>
<td>A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3+’s</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>D.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td>2. Lacking industry</td>
<td>A.</td>
<td>-</td>
<td>-</td>
<td>4+’s</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td>3. Uncoöperative</td>
<td>A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>-</td>
<td>-</td>
<td>2+’s</td>
<td>-</td>
</tr>
<tr>
<td>4. Incapacity to plan; dependence</td>
<td>A.</td>
<td>-</td>
<td>-</td>
<td>1+</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>3+’s</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>4+’s</td>
<td>1+</td>
<td>3+’s</td>
<td>3+’s</td>
</tr>
<tr>
<td>5. Running from job to job</td>
<td>A.</td>
<td>-</td>
<td>2+’s</td>
<td>1+</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>1+</td>
<td>-</td>
</tr>
<tr>
<td>6. Acting without due consideration</td>
<td>A.</td>
<td>4+’s</td>
<td>4+’s</td>
<td>3+’s</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Lack of initiative</td>
<td>A.</td>
<td>-</td>
<td>2+’s</td>
<td>-</td>
<td>4+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Indecisive</td>
<td>A.</td>
<td>-</td>
<td>2+’s</td>
<td>4+’s</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>2+’s</td>
<td>4+’s</td>
<td>-</td>
</tr>
<tr>
<td>9. Easily influenced by others</td>
<td>A.</td>
<td>3+’s</td>
<td>1+</td>
<td>-</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10. Complaining</td>
<td>A.</td>
<td>-</td>
<td>3+’s</td>
<td>3+’s</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>3+’s</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>-</td>
<td>2+’s</td>
<td>4+’s</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>D.</td>
<td>-</td>
<td>1+</td>
<td>1+</td>
<td>-</td>
</tr>
<tr>
<td>11. Hyperemotional</td>
<td>A.</td>
<td>-</td>
<td>2+’s</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>C.</td>
<td>-</td>
<td>3+’s</td>
<td>1+</td>
<td>2+’s</td>
</tr>
<tr>
<td></td>
<td>D.</td>
<td>3+’s</td>
<td>2+’s</td>
<td>3+’s</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>E.</td>
<td>4+’s</td>
<td>1+</td>
<td>4+’s</td>
<td>-</td>
</tr>
<tr>
<td>12. Unfriendliness</td>
<td>A.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3+’s</td>
</tr>
<tr>
<td></td>
<td>B.</td>
<td>-</td>
<td>3+’s</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
His neck and back were immobilized with a steel and canvas brace from hips to head. He has been hospitalized most of the time ever since the accident. Discharged from United States Army May 17, 1920. J. A. says he does not like to be pitied, but he is able to attract the most refined forms of sympathy and is given more than average attention by the public. He has had some organic disability but is also now the victim of a functional disability.

J. A. was selected for discussion because he has fewer defective work habits than the average patient. Table 3 gives the results that have been accomplished in his case. He is very selfish and insistent in his demands for tools and material and wants what he wants without regard for shop schedules or the wishes of anyone else. The principal
method in dealing with him has been to rigidly refuse his extreme de-
mands consistently and explain to him how such behavior will get him
into trouble. He appears to possess the same characteristic after all
of our efforts but admits that he “goes too far.” This faulty habit
appears to be deeply established in him and if we have been able to
give him a bit of insight into its maladjusting possibilities with an em-
ployer we can expect him to change his ways. Insight nearly always
precedes actual change of a faulty work habit. Although we have
devised many methods involving persuasion, suggestion, criticism, and
certain shop rules, etc., for dealing with faulty work habits, there are
many methods and devices yet to be developed. This remains one of
our big problems and by focusing upon it we hope to work out some of
the most valuable technique in occupational therapy for psychoneuroses.

Case C. D. T. Age, thirty; white; single; occupation, commercial
artist. Enlisted December 15, 1917, in naval aviation—Michigan. In January, 1918, patient had diphtheria and was in the
hospital two weeks. At—in March, 1918, he was in the hos-
pital again for an alveolar abscess. In June, 1918, he was transferred to
the naval air station at——Florida. Shortly after coming
——the patient witnessed several accidents of a severe nature
and following these he developed an annoying occipital headache which
has persisted to the present. In October, 1918, he was transferred to
the New England states for special training. In November, 1918,
he had influenza and was in bed a little over a week. Discharged from
the United States Navy, November 22, 1918. For three months fol-
lowing his discharge he did nothing. In March, 1919, he went back
to his former occupation and after two weeks felt so irritable and unable
to do the work that he was placed at outside work which he continued
for nine months without success. Following this he has been hospital-
ized most of the time. He has had an appendectomy done, and has
had another attack of diphtheria. On two occasions he has had stupor-
ous spells lasting about twenty-four hours. His symptoms persist and
the patient is 20 pounds underweight.

This patient presents the marked temperamental reactions of an
artist, but does it gracefully. He is easily disgusted, and quite irritable;
weaker than normal, and very dissatisfied in the atmosphere of a
hospital. Stated once that the laboratory tests done on him made him
a veritable human guinea pig. He gladly gave his services to the navy
and would do it all over but says it was not a pleasure. He harbors
disappointment in his system—wants to get well but chafes under hos-
pital routine.
There are organic factors in the case but certain functional disabilities are evident. From the standpoint of occupational therapy his diagnosis follows in table 4.

In C. D. T. we have more faults than in J. A. They are not very marked or outstanding and are mostly in the emotional and personal

<table>
<thead>
<tr>
<th>CASE CHARACTERISTICS</th>
<th>APRIL 1, 1922</th>
<th>MAY 1, 1922</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 B. (Incapacity to plan)</td>
<td>3 +’s</td>
<td>3 +’s</td>
<td>No change</td>
</tr>
<tr>
<td>4 C. (Incapacity to plan)</td>
<td>1 +</td>
<td>1 +</td>
<td>Pleased when helped</td>
</tr>
<tr>
<td>5 A. (Running from job to job)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No change</td>
</tr>
<tr>
<td>6 A. (Acting without due consideration)</td>
<td>4 +’s</td>
<td>3 +’s</td>
<td>Insight, and has changed his behavior in shop</td>
</tr>
<tr>
<td>7 A. (Lack of initiative)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No change</td>
</tr>
<tr>
<td>8 A. (Indecisive)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No change</td>
</tr>
<tr>
<td>8 B. (Indecisive)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No change</td>
</tr>
<tr>
<td>9 A. (Easily influenced by others)</td>
<td>1 +</td>
<td>1 +</td>
<td>No change</td>
</tr>
<tr>
<td>10 A. (Complaining)</td>
<td>3 +’s</td>
<td>3 +’s</td>
<td>Knows he makes an undue fuss about noise</td>
</tr>
<tr>
<td>10 C. (Complaining)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>Insight into this complaining habit</td>
</tr>
<tr>
<td>10 D. (Complaining)</td>
<td>1 +</td>
<td>1 +</td>
<td>Insight</td>
</tr>
<tr>
<td>11 A. (Hyperemotional)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>Insight</td>
</tr>
<tr>
<td>11 C. (Hyperemotional)</td>
<td>3 +’s</td>
<td>3 +’s</td>
<td>Insight</td>
</tr>
<tr>
<td>11 D. (Hyperemotional)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No insight</td>
</tr>
<tr>
<td>11 E. (Hyperemotional)</td>
<td>1 +</td>
<td>1 +</td>
<td>No insight</td>
</tr>
<tr>
<td>12 B. (Unfriendliness)</td>
<td>3 +’s</td>
<td>3 +’s</td>
<td>No insight</td>
</tr>
<tr>
<td>13 A. (Stubbornness)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>Insight</td>
</tr>
<tr>
<td>15 A. (Suspiciousness)</td>
<td>1 +</td>
<td>1 +</td>
<td>No insight</td>
</tr>
<tr>
<td>16 A. (Selfishness)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No insight</td>
</tr>
<tr>
<td>16 B. (Selfishness)</td>
<td>1 +</td>
<td>1 +</td>
<td>No insight</td>
</tr>
<tr>
<td>16 C. (Selfishness)</td>
<td>1 +</td>
<td>1 +</td>
<td>No insight</td>
</tr>
<tr>
<td>17 A. (Moodiness)</td>
<td>4 +’s</td>
<td>4 +’s</td>
<td>Some insight</td>
</tr>
<tr>
<td>18 A. (Bashfulness)</td>
<td>2 +’s</td>
<td>2 +’s</td>
<td>No insight</td>
</tr>
</tbody>
</table>

In the short period he has been working he has developed much insight. It is beyond the scope of this study to detail the exact method of dealing with some of his faults. We are far from satisfied with our method of dealing with some faults. In his case it has required much cooperation between the aides and his medical officer, and the results are not all due to occupational therapy but to
intensive psychotherapy which the patient has had. It has been a source of much gratification to the psychotherapist to know that in occupational therapy the same goal was in mind.

Occupational therapy is not a new form of therapy. Charles Darwin, certainly a neurotic individual, did most of his life work in short work days of two to four hours because of poor health which he possessed until the ripe age of eighty-four, when he died. The interesting fact for us is that he continued to work and thus classified himself with the worth while people of the earth. Robert Louis Stevenson was seriously ill with pulmonary tuberculosis when he wrote "Treasure Island." It is reported that he got relief from his disease by writing. Thomas Carlyle, also an invalid for part of his life, in a lecture to the students of Edinburgh University made the following significant statement:

The most unhappy of all men, is the man who cannot tell what he is going to do, who has got no work cut out for him in the world and does not go into it. For work is the grand cure of all the maladies and miseries that ever beset mankind.

History is full of illustrations of the relief from distressful situations, organic as well as psychic, afforded by work.

What kinds of work are best? In general, it depends upon the patient, and the variety of work should be greater than is usually found in the work shop. Any work which requires the patient to think and plan, to cooperate with his fellows as regards working space and the use of tools, is good. One additional qualification has been found worthy of mention. Beauty should be emphasized in making things. Many patients, especially the moody and hyperemotional ones, get most satisfaction in their efforts to express beauty of design and pattern.

The word "disease" is made up of the parts "dis" and "ease," implying uneasiness. Anything which will give relief, permanent or temporary, from the distressful uneasiness that psychoneurotics have, is therapeutic. This view of occupational therapy makes the diversional aspect justified. It goes without saying that patients who are given a sympathetic insight into some of
the causes of their maladjustment are helped more than those who get mere diversion from the work.

In our shop we endeavor to relieve uneasiness—dis-ease—by work, not only for its temporary, but also for its more remote effects. Reéducation—converting faulty work and behavior habits into more desirable habits, or giving the patient insight into some of his maladjustments—constitutes a most valuable adjunct to our therapeutic equipment. The way is not easy. The maladjustments of the patient are in many instances deeply rooted and not easily changed, and the work shop is not an equipment isolated and doing its work independently. The entire personnel of the hospital must believe in it, cooperate with it, and only through such cooperation is it possible for the occupational therapy department to do its bit.

Much is yet to be derived from the thorough study of patients at work. The great importance of vocational guidance has occurred to us in view of the fact that faulty work habits in one occupation may be an asset in another. Further interest in preventive psychiatry would have us investigate thoroughly the very early life of people, and especially the origin and evolution of their work habits.

The writer wishes to express his appreciation of the splendid cooperation of the aides in Occupational Therapy at United States Veterans Hospital No. 37, during the course of this study.

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