With the growth of occupational therapy and equivalent need of records has appeared a popular confusion as to the aims and limitations of records and charts. It should be recognized that "records" methodically show each detail of any progressing event whereas "charts" have their validation only in showing the relation of the work of any one day to that of any other day. Good records cannot be made in the form of charts. There should always be the cumbersome, methodical, exact record of all that has happened and there should preferably be in addition the less exact, pictorial chart. For later research the record is necessary. For the present rapid review of progress the chart is necessary. Records should represent as full and exact a statement of details as is possible. They should be the coldest thing about a hospital. Charts, on the other hand, must advertise—get some fact "across." They should make a direct emotional appeal.

This paper has nothing to do with occupational therapy records.

A PART OF A MORE GENERAL SCHEME

Elsewhere (American Journal of Psychiatry, April, 1922) we have described a form of conduct chart used at McLean Hospital. This is a pictorial scheme for describing the patient’s daily behaviour on the ward. It seemed imperative that, in addition, there should be a statement as to the patient’s progress at the building for occupational therapy. The scheme of which these were, in turn, merely a part was abandoned last July so that we have not extensively tried out the charts planned. They were made on an experimental basis with all expectancy of changes.
as events warranted. We still feel, however, that the principles are sound.

The nurse's record of the patient on the ward contained in addition to the other data one of four numbers in a special column. These numbers corresponded to the following facts:

1. Patient has no definite occupation. Just wanders about the ward, sits down all day or remains in bed with no definite occupation.
2. Patient busies self on ward, helps with house work, reads, writes or sews a little.
3. Patient goes to occupational therapy building every day.
4. Patient goes to occupational therapy building every day and also, during spare time, busies self in some way on the ward.

Naturally this list would in a short time be extended—for example adding a number for those who go "to the occupational therapy building some days and not on others." Our chart is, of course, applicable only to classes 3 and 4 of the above. It is filled in by the occupational therapy teacher twice each week.

THE FOUR ATTITUDES TOWARDS OCCUPATIONAL THERAPY

The fundamental idea is that in any patient in any occupation the following distinct periods may be recognized.

1. Period of intermittent interest.
2. Period of learning.
3. Period of initiative.
4. Period of automatic work.

These overlap but in our short experience the teacher had no real difficulty in differentiating them.

Only occasionally will any one patient go through the four stages in any one occupation. Some depressions will not get beyond 1 for months. Some excited patients go into 3 without (apparently) a moment's time in 1 or 2. Some praecox patients will always be found in 4 no matter what form of occupation is involved.

Later there may be further subdivisions but our present notion is that this would be a dangerous tendency. A chart must be simple. Any chart that cannot be read at a glance is useless.
A FORM OF OCCUPATIONAL THERAPY CHART

It must invite one to consult records or the occupational therapy teacher but must never attempt detailed information in itself.

WHAT THE CHARTS MEAN

Looking at the specimen charts certain things stand out. The many inevitable changes to come should not violate any one of the following three principles:
1. As you go from top to bottom you progress in time.
2. In general as you go from left to right you progress in the complexity and nicety of the tasks involved.
3. For each kind of task there must be four subdivisions, viz.:
   a. Intermittent interest.
   b. Learning.
   c. Initiative.
   d. Automatism.

On the basis of these three principles many changes may be made. Indeed, the rest of the structure must lend itself to the requirements of each institution. It will be noted that in the McLean charts we made a separate list of all of the activities and only referred to these by number in the chart. This was necessitated by the wide variety of activities represented there and solely from the point of view of the charts is unfortunate. It would be worthwhile to make some such grouping of activities as allowed of their being printed as an integral part of the chart itself. This would lend itself to easier reading. Such grouping should certainly represent approximate equalities in difficulty and interest. For example, in a certain hospital there are various rooms for differing types of occupational therapy and here one naturally thinks of making each bundle of four columns represent one room.

SPACING OF ENTRIES

Entries are made twice a week. From an extensive experiment in similar work (Patients' Conduct Scheme) we feel this to be the best period. Of course it can be changed but one must remember that:
1. It is easier to plan on making records always on the same days of the week.
| NAME | DATE: 8-17 | X | 6-15 | X | 5-22 | X | 2-6 | X | 2/1 | X | 2/2 | X | 2/8 | X | 2/10 | X | 2/13 | X | 2/15 | X | 2/17 | X | 2/25 | X | 3/7 | X | 7/10 | X | 7/13 | X | 7/15 | X | 7/17 | X | 7/24 | X | 7/25 | X |
|------|-----------|---|------|---|------|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|-----|---|

**Chart 1. M. H., Male, Age Forty-eight. Long-Standing Depression**

Patient is now "in a rut." Note that while the entries are over at the right side of the page they are in the "automatic" column. The patient did not progress to this point through the hospital's efforts but because of cultured surroundings and interests previous to his illness. Such a chart continually raises questions—it represents an unsatisfactory state of affairs. As a matter of fact, the teacher made many efforts to interest this patient in other things—not even arousing "intermittent interest." We believe that such a chart is a constant stimulus towards change. That M. H. still enjoys his daily walk and plans new trips indicates that there remains still some spark of emotional response upon
2. Too frequent entries make a record, not a chart.
3. Three day intervals represent very convenient periods for the more labile patients. Those who are making much progress usually show something new in that time.
4. If this period is to be changed it probably should be lengthened.

It is usually easy to make the entries. To ponder between two adjacent columns is of no importance beyond the analysis of the patient's activities which this engenders. It is the chart as a whole which gives the picture. Undoubtedly, on occasion, slight difficulties will arise. Some approximate entry should be made—perhaps with a question mark.

**WHAT THE CHARTS SHOW**

These charts represent a simple and easy way of showing what each patient is doing. They do not describe the quality of the work. Instead of the check mark the teacher might enter one of four numbers (1, 2, 3 or 4) to indicate the quality of the patient's performance. This would probably too much encumber the charts. Their pictorial character and value is paramount and this can be preserved only by avoiding as far as possible the detailed information of records.

Beyond this there lie certain dynamic values in the charts. Evidently in a completed chart we hope that in going down the page the entries will move to the right—as the case progresses there should be a definite tendency towards more complex and nice tasks. On the other hand an unsatisfactory case "gets into a rut"—the entries go straight down—each one being immediately under the preceding. In our conception of occupational therapy any skipping around of the entries represents a better state of affairs than one in which each entry is exactly as the one above.

**FIGHTING STAGNATION**

Fundamentally, we are fighting stagnation. As previously stated, at McLean we constructed a patient's conduct chart which, being on a number basis, sensed stagnation immediately.
Illness has been severe and of short duration. Note very pretty progress until May 13. Patient then shows that he is not ready for too rapid a recovery. Later in May he makes a spurt but goes back on June 10th. Such a chart shows an active attempt at therapy practised upon a patient as yet entirely too sick to respond well. We look upon this chart as a concise and beautiful statement of what has been happening to H. G.
A FORM OF OCCUPATIONAL THERAPY CHART

This chart attempts the same thing with occupational therapy work. Perhaps in a particular case you want stagnation. In many depressions the persistence at one task means a preservation of morale which is for the time the keystone of the therapy. Yes, but let us get something into these charts which makes us ask questions. An advertisement has its only value in arousing our desire to see the article—a chart has its sole validation in stirring us to question the source of its picture. The answer for a bad looking chart may be simple, but the answer should be elicited. Perhaps the patient is an irritable soul, chronically so, who starts a fight when not allowed to cane chairs. You are busy with “more hopeful” problems. Here, again, these charts are going to mean that each entry represents (as it goes vertically down the page) a real, irritating stimulus to do something with that patient. Of course, this assumes interest. It assumes that in a given situation stagnation in three-quarters of the population arises because the other one-quarter is “more interesting.” These charts are meant, in part, to attack the stagnation of the “uninteresting” three-quarters.

FALSIFICATION THROUGH INERTIA

Falsification of records is possible. Lazy persons are constantly making essential repetitions in records because that is easier. Every hospital is cursed with these formulae which gild inertia. Records permit this much more than do charts and especially in these charts is such a procedure attended by disastrous results. The teacher must either very actively falsify or produce a chart which will arouse embarrassing questions. If a staff has any interest in its patients it will constantly question charts where the entries are repeatedly the same. Evidently in these charts to the extent that the entries tend to arrange themselves in vertical order conditions are unsatisfactory whereas to the extent that this arrangement is horizontal there is a satisfactory state of affairs. There are all sorts of individual needs and conditions but certainly a brief résumé of these will harm no one on those occasions when apparently unsatisfactory charts raise questions.
All charts must receive the active interest of the physician in charge. These charts only represent a facile outlet for and expression of interest. When your supervising officer fails to ask to review all charts at least once every two weeks they might as well be discontinued. They are of little value as records.

LIMITATIONS OF THESE CHARTS

Therapy should be, of course, progressive. Either there is, projected from the first, a progressive plan of therapy for a given case or, without such plan, the patient himself so changes as to demand a change in therapy. These charts have their chief excuse in the fact that they so quickly and easily depict change. Where occupational work is used in teaching a vocation, these charts are of no value. There is also, unfortunately, a large group to whom occupational work represents a simplified and established life adjustment. Here again these charts are useless. Let us also cease calling this sort of occupational work “therapy.”

WHAT THESE CHARTS CAN DO

A mere glance at one of these charts gives a very beautiful, of course generalized, picture of just what the patient is doing. Where laboratory procedures are being carried on intensively these chart pictures of patients’ progress are well nigh necessary. Beyond this, the charts invite lively interest from the persons involved. The occupational therapy teacher sees in the entries a beautiful and concise picture of her labors. How pretty to see the check marks begin to move to the right side of the page—or, mayhap, even to merely waver a bit from their vertical column! Too often do her greatest labors go unheralded and in these charts lies the possibility of expressing just these efforts.

Too often the physicians know little of what is going on in the occupational therapy department. To get the detailed reports is too difficult and takes too long. These charts should stimulate questions and interest. At a glance they show rapid progress of some sort or stagnation. The questions, the interest which is the keystone of all our work, must follow.
## Chart 3. J. S., Male, Age Thirty-Two. Satisfactory Recovery in a Depression

Note that entries tend towards the right as you go down the page. Satisfactory work on part of teacher and satisfactory response from the patient. All this shows up better in such a chart than in paragraphs of written records.
Too often the therapy of the patient is forgotten. He changes about in his work until something is found in which he does well. There he is kept—it is easier—the annual "show-off" of the department must be considered—he no longer demands the painstaking effort of the unadjusted period. Of course with many patients this stage, this level, is definitely sought. However, for those who really need therapy the fact that the checks begin to arrange themselves in a vertical column represents a tell-tale picture that somewhere something is wrong.

What we have said of needs we have nowhere found contradicted. These charts represent, at present, a very crude attempt at answering these needs. For numerous very helpful criticisms and for kind assistance in this experimental phase I owe many thanks to Mr. Joy of the occupational therapy department of McLean Hospital.