OCCUPATIONAL THERAPY FOR NEURO-PSYCHIATRIC CASES

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Occupation as one of the means of treating patients was introduced in this hospital in the early part of 1918, and by the end of that year, it had become controlled by a definite organization with its individual personnel, striving toward definite purposes and accomplishing definite results. It is safe to say that there are few general hospitals in the United States, today, where the ramifications of this branch of therapy reach so intimately and persistently every type of patient as at Walter Reed. Since its introduction in 1918, occupational work has been carried out extensively with the nervous and mental cases, and its value has been recognized clearly by doctors, nurses and attendants.

The most convincing argument of the efficacy of occupation, in the management of neuropsychiatric cases, is to work with these patients in some mental hospital. There the difference is recognized easily between the confusion, disorder and regression upon wards where patients are left to their own devices and the industry, cheerfulness and order upon wards where patients spend their hours in regulated, systematized occupation and recreation. Numerous cases can be cited who have been regressed, excited or depressed, where persistent effort has succeeded in arousing some dormant spark of normal interest. This interest when encouraged by intelligent means of occupation will often lead to improvement in the severe symptoms. This factor of improvement in morale, causing a decrease of that feeling of possible impending danger in those caring for mentally ill people, is worth all the funds expended in occupational therapy. For that matter, in these days of enlightenment the expense of funds for such purposes is prac-

1 Read at meeting of the Occupational Therapy Association of the District of Columbia January 3, 1924.
tically demanded by relatives of the patients and solicitous friends.

It seems probable, however, that occupation does more than improve the general morale of wards. It is a common observation that although it may not produce cures, with its aid recoverable cases improve more rapidly or are raised a little from their regressed or depressed states and as a result can be attacked more easily by other therapeutic means.

In order to understand what we hope to accomplish at Walter Reed by occupation, it must be understood that patients are never institutionalized here, but are disposed of in various ways whenever it is decided that because of social adjustment, improvement or chronicity, they have attained maximum hospital improvement. Therefore, even if it were either possible or advisable, there is no special effort made to develop vocations in our patients.

Mental patients are encouraged to assist in the routine care and orderliness of the ward and their persons. Recreation is provided on the closed wards by indoor and outdoor games, by the regular supply of books and magazines from the library, and frequent special entertainments. Parole patients have access to all the numerous recreational activities of the hospital. It is the usual observation that the interest and cooperation of the majority of patients can be secured in occupational work. This work occupies the patient's time, diverts him to some extent from abnormal conduct, and helps train him in orderliness, self reliance and precision. Outdoor occupation, especially work in the gardens, is the best of all activities, for it promotes physical well being, it has a demonstrable result to the patient for his labor, and acts as a soporific at night.

At this time we have a ward equipped solely for occupational work. In addition to what is accomplished there the aides go upon the wards and reach patients who require special precautionary measures. During the warmer months groups are sent out daily with attendants to the gardens and are kept busy under the supervision of the aides.

The psychoneurotic cases and special paroled mental patients are permitted to work in the regular occupation shops and schools,
where opportunity is afforded to learn batik and leather work, typewriting and stenography, basketry, weaving, wood carving, cabinet making, automobile repairing, metal work and jewelry making. The more restricted patients are taught basketry, agriculture, horticulture, dyeing and weaving. Approximately 73 per cent of all our patients are kept busy at some form of occupation and practically all receive in some degree the benefit of recreational activities.

This therapy not only produces the so called diversion of mind, but it is believed that it is a factor in some cases in helping re-establish normal mental states, and that there is a fundamental reason to explain this tendency. It seems fair to assume that the nearer normal the daily life of a patient is made, the nearer normal he actually is. The jar of throwing an individual from the busy hum-drum of life into the useless, dependent existence on a mental ward, is a severe one except in very dilapidated patients.

If this is true the logical conclusion should be to ease the shock of their environmental change by imitating on the wards the outside world’s work and recreation periods of the day. Ergotherapy will at once, therefore, change the life of a patient from one of eating, sleeping and deterioration, to one of eating, sleeping, recreation and occupation. The guiding hand in this new sort of existence for the patient is the occupational aide, who becomes his constant means of contact with the outside world. The physician who is concerned with the patient’s symptoms, and the nurse who is keeping him from the things he desires most to do, and the attendants who are watching him, are not always the patient’s choice for socialized contact. The aide works several hours daily with him, talks about his interest, encourages him in his own powers and directs his mental and physical energies along normal lines and represents more nearly the kind of individual he has always known.

He can understand her for she is not a strange factor in his distorted vision. Some of the improvement as a result of occupational therapy must be credited to this association between patient and aide.