OCCUPATIONAL THERAPY.

By ELIZABETH CASSON, M.D., D.P.M.
Medical Director, Dorset House School of Occupational Therapy.

Reprinted from Report of Conference on "Welfare of Cripples and Invalid Children" held at the Drapers' Hall, London, on November 7th and 8th, 1935.

THE task given me this morning is that of speaking on Occupational Therapy as applied to recovery from accidents in children.

Occupational Therapy is any activity, mental or physical, prescribed and guided for the definite purposes of contributing to, and hastening recovery from, disease or injury. An Occupational Therapist is one who has gone through a specific and strenuous professional training such as has a masseuse, a dispenser, or a nurse, and who is ready to be given a doctor's prescription and carry out that treatment with all the skill it requires. To take an example. I once fell on my elbow, and knocked off the tip of my olecranon. A surgeon wired it together and the elbow healed rapidly, but complete flexion and extension did not return at once. All the combined treatment of massage, radiant heat, passive movement, and voluntary exercise helped. Then a month after the operation I was allowed to drive my car, and completed the cure. My left arm did most of the work steering, but my right arm was also on the wheel, and the muscles began at once to regain their tone, constant movement improved the joint, a sharp corner suddenly pulled at the slight adhesions that remained. Its occupation completed the cure of my arm.

You all know how much afraid we are of moving a limb after any injury. It is a necessary provision of Nature to desire to rest a painful joint. In the ordinary course of events our work begins again and we forget the injury because our attention is fixed on something else and constant messages reach the brain that cause the joint to move unconsciously. Careful treatment however often fixes our attention on an injury and fear prevents movement after it is quite safe: We all saw soldiers during the War who came up to hospital for massage and their mental attitude prevented their recovery —"If my leg still needs daily massage it just shows that the doctor knows it is not well" is what he believed consciously or unconsciously. In such cases as this occupation completed the cure much quicker than any other treatment—often a

ward dance, a game of football, or, if it was available, a treadle fretsaw was all that was needed.

A few principles in occupational therapy must be remembered. First and foremost, the psychological principle that every action depends on a stimulus.

For the purpose of this paper I will take " accident " with rather a wide meaning. Many of you deal with cases of spastic paraplegia, some at least of whom are caused by birth injury. Here as you know stimuli do not pass over to muscle action as easily as in the normal child. Heat, such as in the hot pool at Bath, increases the ease with which the reaction takes place. The child will improve very much more rapidly if an occupation accompanies and provides motive for the reaction. A game of getting a sponge out of the bath by squeezing it under the hot water—catching a toy fish with the toes, or a race with another child to pick up the toys sends up a message far more effectively to the slow brain and all sorts of conditioned reflex muscular actions result. In heart cases a set of toy reins can be plaited with the strings so arranged that only a slight movement of the fingers is needed to work. The stimulus reaches the brain, the little fingers move in ordered rhythm. As the child improves, the strings can be lengthened or the work raised so that muscular effort can be measured to a nicety to suit the amount of movement that the doctor has ordered. Being busy with its hands, the child ignores the stimuli to general restlessness that reach its brain from its illness.

The second great principle in Occupational Therapy is to arouse specific emotions that result in the desire to use muscles and thereby to return to health. One of the most powerful motives we have is curiosity. It is so universally active that we often forget it. The whole audience has come here to-day because it is drawn here by its curiosity to hear what is said. The well-trained occupational therapist uses this active motive in her patients continually, and a new patient's first desire for occupation comes from curiosity as to what the next patient is doing with bits of wool or string she is using, or the block of soap she is carving.

Not long ago Miss Forrester Brown invited one of my Occupational Therapy staff to work under her at the Bath Orthopædic Hospital, and prescribed occupations for a man with an injured spine. Lying near him were two boys who had lately come to the Hospital from remote farms. They had had infantile paralysis when quite young. Their families had settled down to the fact they were cripples. They had been washed and fed quite kindly, and that was all. During

the long years they had become completely apathetic and seemingly feeble-minded. They lay in bed in Hospital and watched the man in the next bed. Gradually curiosity was stimulated by what they saw and heard and they began to want to do something too. One boy asked for a pencil, and when he saw his drawing and felt his muscles producing his drawing, a whole new life came to him. Both boys are now working well, and quickly showed that their intelligence is excellent.

Following on the instinct of curiosity comes the desire to achieve. Every child loves to make something that he has made himself, and the pleasure is even greater if he can send something home that he has made and that earns the praise of his family.

Then again we must remember to arouse the gregarious emotions in our patients. We all like to feel that we are one of a group with common interests, and many patients work better if doing the same work as others. In an occupation department one must allow for the seasonable rhythm that brings out tops, hoops and marbles as the prevailing rage. Patients all like to make baskets, then they all want to paint boxes or weave, &c., and this tendency must be used if you want enthusiasm.

There is an important point I must stress and that is the difference between occupation as such, and occupational therapy.

Children in orthopædic hospitals do school work and many learn crafts by which they may afterwards earn their living. An injured child in a general hospital may be made happy by dressing a doll, but unless that bit of sewing is prescribed to help to cure the particular disability that is needing treatment it is occupation only and not occupational therapy.

I remember well seeing a mentally deficient girl with a spastic condition. She had been taught to knit with one long needle held down by a rigid arm to her side and the other slipped down into an equally rigid flexed hand. Occupational therapy would have meant putting her on to a simple loom made by threads of string on an old picture frame. She would then have wanted to use her arms more freely and her flexed hand would have had to be extended to beat down the weft.

I think I have told you enough to show what a fascination lies in the development of Occupational Therapy and the joy that comes from giving it. There are opportunities for good professional posts for those who need to earn their livings by it, and there are even more for those who can afford to train

and then work voluntarily until the English hospitals have learnt to pay for this work as all the American hospitals do. In the meantime salaries at £200 are available in mental hospitals, and splendid work is being done and is waiting to be done there.

The training takes two years, during which the student studies anatomy, physiology, psychology and many crafts with the necessary knowledge as to their application to various conditions to be treated.

4 pages