

## 1962 Eleanor Clarke Slagle Lecture

# The Challenge of the Sixties Naida Ackley, OTR

It is with feelings of trepidation and humility as well as pride that I take my place in the lengthening procession of Eleanor Clarke Slagle lecturers. Although deeply honored to be the recipient of this award, I feel you have not so much honored me as an individual as that you have chosen me as a symbol, a representative, for all the occupational therapists who have devoted their interest and professional competence to the treatment of the mentally ill.

#### **Changing Roles**

I would like to use this time to examine with you some of the current developments in psychiatry in the United States of America which have implications for us and for our future practice. Many changes are taking place in the whole field of psychiatry. Long established and accepted concepts of care and treatment are being critically evaluated; different types of in and out patient treatment facilities are being established; traditional roles are changing as professional and nonprofessional groups review their qualifications and patterns of operation in order to improve their current function or assume new roles. Social scientists and anthropologists are contributing new insights, and the role of the community in all aspects of the mental health problem is increasingly recognized.

These changes have vital implications for occupational therapists in psychiatric practice which we must recognize and act upon. The decisions we reach and the action we take during the next few years will determine the future of occupational therapy. We must finally answer the question "What is the function of occupational therapy in psychiatry?" There is no consensus today; opinion and practice range from dynamically oriented treatment programs to ones which are very broad in scope and general in application. My personal and professional conviction has always been that occupational therapy is treatment. In psychiatry it is a form of treatment which utilizes activities and the relationship developed around and

through these activities to assist the patient in finding more acceptable patterns of relating to others, and more mature ways of dealing with and solving his problems.

#### **Utilizing Occupational Therapy**

The education of the occupational therapist is designed to prepare personnel equipped to carry out this treatment function under medical direction, but many institutions do not use their occupational therapists in this capacity. This may be due to the orientation of the hospital itself. *Action for Mental Health* documents an impressive number of institutions which are not treatment oriented. It may be due to the quality and immaturity of the occupational therapists it employs. Or it may be due to the unwillingness of some physicians to accept allied medically trained personnel as co-therapists. Whatever the reason, I wonder how much longer we can persuade young occupational therapists to enter the psychiatric area if we do not demonstrate a role and function for them which is commensurate with their professional preparation. The ability to recognize and understand factors which contribute to or precipitate disability, and the acquisition of knowledge and security in using remedial techniques is the justification for the long and expensive education of the occupational therapist. Today the need for personnel with medical or medically related professional training is so acute, that it is difficult to justify the use of such personnel in any capacity which does not utilize their professional preparation to the fullest possible extent.

## **Future Responsibilities**

There are many situations where the occupational therapist is a respected member of the treatment team and where occupational therapy makes an important contribution to treatment. These include private hospitals, psychiatric services in general hospitals, state hospitals, Service and Veterans hospitals. Since my experience has been primarily in state hospitals I shall discuss treatment focused occupational therapy in that setting. Many influential people in psychiatry feel the state hospital will be superceded by other kinds of treatment facilities for all types of mental illness. Others, equally authoritative, feel the state hospital provides the best facilities for the treatment of major mental illness and will continue to do so for many years. There is general agreement that many changes will be made, but again there is a difference of opinion about the degree of these changes and the form they will take. I am no crystal gazer and can certainly make no predictions about the future size or specific function of the state hospital, but I feel safe in saying that the future of occupational therapy in psychiatry is in our hands as it has never been before.

We, in common with other professional groups, are being asked to review and evaluate our practice, to determine objectively which of our current functions could be delegated to less highly trained workers so that professionally trained personnel can devote more of their time to specific patient treatment. This request is predicated on the well-documented assumption that professional staff shortages will exist for a long time to come, and it is thus imperative that current professional staff be relieved of every duty, administrative or

treatment-focused, which could be performed by less highly trained workers. This is in no way an effort to reduce services to patients. It is rather an effort to relieve physicians and allied medical personnel of routine or administrative duties and minor responsibilities and functions which have become associated with their positions over the years, so that they will have time and energy to use their specialized skills in more meaningful patient treatment. The request to re-evaluate professional functions also takes cognizance of the development and use of volunteer groups and the services which they render, the availability of personnel with specialized activity skills, the increasing emphasis on vocational rehabilitation and after care services, and the use of ward personnel in ward activity programs.

Occupational therapists should recognize the implications in this request and should act to formulate a statement of role and function which will justify the continued inclusion of occupational therapy as one of the allied medical services of the hospital. If we want the recognition and status of professional personnel we must function on that level. We must be prepared to participate actively in patient evaluation, treatment planning and disposition conferences. We must understand the concepts and terminology of the psychiatrist, psychologist and social worker, and we must be able to discuss the contribution of occupational therapy in terms that are meaningful to them. Our treatment objectives must be carefully formulated and psychiatrically meaningful if we wish to have them incorporated in the overall treatment plan for the patient. If individual occupational therapists do not feel adequately prepared to function at this level or if their institutions want to use the program for diversional activity or as a management device, the program should not be called occupational therapy but should be given another designation which does not carry treatment implications.

The continuing shortage of qualified occupational therapists makes it almost mandatory that we relinquish all activity functions which can be performed by other personnel who are more readily available. To do so will permit us to fulfill treatment responsibilities which have been too often curtailed or neglected in the effort to supply activity programs for large numbers of patients. At one time occupational therapists were almost the only group able to meet activity needs, but today this is not true. There are trained personnel in the areas of recreation, music and library; volunteers conduct many activities and make available community contacts and cultural and diversional opportunities which institutional personnel could not duplicate. The increasing recognition of the importance of an attractive stimulating ward atmosphere has emphasized the need for activity programs conducted by ward personnel. These developments should be welcomed and supported by occupational therapists as each allows us to assume more of the treatment functions for which we are prepared.

This is important as the number of qualified personnel in mental health professions is not increasing. An extensive study of man power trends, made by Dr. George W. Albee for the Joint Commission, presents a discouraging picture. He is not optimistic about solving personnel problems through increased recruitment efforts, as he relates the shortage of candidates for all mental health careers to the shortages in other categories of professional man power. He documents the fact that there are not enough candidates to begin to meet the needs of the various professions.<sup>2</sup> One might say we are all fishing in an inadequately stocked pool. Those of us who hoped the population bulge would solve our staffing problems have

apparently been entertaining an illusion. There may be more personnel but there will be more patients who are also part of the bulge. Since we cannot realistically expect to expand professional staff to any marked degree we must utilize those we have to the greatest advantage.

#### **Changing Treatment Goals**

Today occupational therapy has to be geared to the concepts and tempo of contemporary psychiatry. Modern treatments have radically changed the character of the mental hospital which now has a quieter, more purposeful atmosphere. More patients are receiving active treatment and many more are now accessible to and can profit from psychotherapy. The goal of a short period of hospitalization is stressed and patients are encouraged to maintain their interest in and contact with the community. Techniques and procedures which alleviate acute symptoms and promote control and the ability to function are given priority while ones based on long periods of hospitalization are being used less frequently. Generally speaking there is less emphasis on individual analytical psychotherapy but much more emphasis on group techniques of treatment. These procedures utilize the attributes of group identification and interaction to develop a degree of insight which will permit the patient once again to adjust in the community. Similarly where individual psychotherapy is used, it is often short term in nature and directed toward assisting the patient in reintegration of ego functions and the development of a sufficient degree of insight to facilitate social and work adjustment in the community.

The insidious factors in hospitalization are being identified and the more noxious are being removed or ameliorated as rapidly as possible. It is interesting to note that many of these factors are ones which occupational therapists have long recognized as being undesirable and have tried to counteract in their work with patients. They have seen the development of apathy and loss of self-respect as the patient succumbed to ward and hospital procedures which stifled him in routine and protected him from all decision-making. They have observed disturbed behavior subside in the permissive atmosphere of the occupational therapy clinic and they have fostered and nurtured any sparks of initiative and creativity which could be awakened. They have encouraged patients to accept responsibility for their own work and they have trusted them with dangerous tools and expensive equipment. These few examples among many possible ones are not recent developments in occupational therapy. They are based on insights which the occupational therapist has utilized for many years. The occupational therapist has had little difficulty in accepting the idea of a therapeutic community—in many aspects it is only an extension to the hospital as a whole of attitudes and concepts which are traditional in our clinics.

## **Correlating Treatment**

Contemporary occupational therapy cannot exist in a vacuum or on the outskirts of medical awareness. To make an effective contribution in today's intensive treatment schedules it must correlate its treatment skills with other treatment effort, and it must contribute its

observations and insight for the use of all team members. The organization of professional staff to achieve this focusing of treatment resources and knowledge will vary with the type of service but the importance of good communication in good treatment is universally recognized. Today the psychologist, social worker, psychiatric nurse and occupational therapist under the leadership of the psychiatrist, pool their collective knowledge to work out and implement effective treatment for patients assigned to their care.

The functions of occupational therapy in a dynamically oriented center are determined by the needs of the patient and the other treatments he is receiving. It may be used as a form of psychotherapy to augment psychotherapy or it may be used to facilitate the process of repression and restitution of ego functions. It may be evaluation, either initial or ongoing, used by itself or in conjunction with other diagnostic procedures, or it may be used to determine a patient's response to special treatment procedures or over-all therapy. The patient may be referred for occupational therapy upon admission, at any stage of treatment or for evaluation for readiness and suitability for vocation rehabilitation, community placement or intrahospital transfer.

If occupational therapy is to discharge these functions, adjustments must be made by other services and divisions of the hospital. Large numbers of patients needing supportive activity cannot be included in occupational therapy groups where therapists are trying to establish meaningful interpersonal relationships and provide corrective emotional experiences for the active treatment of patients. The size of the occupational therapy groups has to be determined in accordance with the severity of the patients' symptoms and the goals of the treatment, and usually comprises from 6 to 15 patients per therapist. The occupational therapy department has to have an adequate budget. It cannot rely on a revolving fund supported by the sale of projects, and the department should not be expected to function as an interior decorating service or the source for small items of equipment or furniture for the hospital. These functions are generally not compatible with the needs of the patients, and might be considered as a continuation into the present of the era when patient labor was basically for the benefit of the institution.

## **Intensive Treatment Program**

Many hospitals consider the primary function of occupational therapy as work with the nonverbal, regressed patient who cannot be reached by treatments which are based on group participation or words. It is true that occupational therapists are often very effective with these patients, but I cannot agree that this is our primary function. Such patients are only one of a number of types of patients who are included in an intensive treatment program. When these regressed, withdrawn patients are referred to occupational therapy they are assigned to clinics where a small number of patients (usually 6 to 8 at one time) are treated in an atmosphere that is warm, friendly and undemanding. A limited number of activities are available but these include both those that are structured and can be used to give support and security, and those which are unstructured and projective in nature and may be used by the patient to express his problems and anxieties. Interpersonal demands

are kept at a minimum, but at all times the therapist provides support, reassurance and acceptance. The patient is encouraged to participate in an activity which may provide the staff with insight into his problem, but often the complete freedom of projective techniques is too threatening. In that event structured activity is substituted. This permits guidance from the therapist and may be the first step in a meaningful relationship which the patient could not tolerate without the activity to provide the justification for instruction and guidance. If the therapist has been sufficiently accepting and undemanding, and has tried to understand the non-verbal communication, the patient will generally become more relaxed and less frightened. As this occurs he can relinquish some of his more extreme defenses and may begin slowly to establish verbal contact with the therapist. This should be quietly accepted and unobtrusively utilized to deepen the relationship. When the patient can tolerate awareness of the others in the group, or when he begins to show any interest in them, the therapist will then try to encourage a relationship with another patient or patients.

#### **Observation and Evaluation**

As the process of re-integration continues, the team may decide on other forms of therapy which may either take the place of or supplement occupational therapy. This illustrates another point in the team concept of treatment. Although all disciplines are represented, under the supervision and direction of the psychiatrist, any member of the treatment team may become the dominant therapist. This role will pass from one discipline to another as the patient is able to utilize the special skills of each. This approach provides a continuous, coordinated but flexible program under medical direction which can be adjusted to meet the changing needs of the patient during his period of treatment.

Newly admitted patients are often referred to occupational therapy for observation and evaluation. The rationale for this procedure is based on the concept that all of a patient's behavior and reactions are significant and are directly related to the problems which cause his illness. Occupational therapy is one of the most normal situations which the hospital provides in which to observe characteristic behavior and patterns of defense, and the observation which the occupational therapist can supply for the use of the psychiatrist or the team in evaluating the patient's condition and determining procedures of treatment will become an increasingly important function of occupational therapy. Current emphasis on the desirability of psychotherapy for increasing numbers of patients has meant that psychologists, as one of the groups best able to meet this need, are devoting more and more time to this function, with a corresponding decrease in the number of psychological evaluations which they can provide. I do not mean to imply that information which the occupational therapist can supply is a substitute for the psychologist's evaluations which are based on standardized test procedures and protocols. Rather it is a means of evaluating the functioning level of the patient in a reality oriented situation where he can be as active or passive in participation in activities and relationships as he chooses.

The occupational therapy clinic looks like a well-equipped home workshop, a familiar kitchen, a hobby shop or a pleasant club room such as one finds in various community centers. The atmosphere is relaxed and there is little to remind one of a hospital. In this environment the patient is invited to select and participate in an activity. The type of activity he chooses, the way he goes about the task, the nature and degree of help he seeks and his movement towards completion all indicate his habitual approach to problems and their solution.3 Since observation and reporting of characteristic patterns of behavior is the objective of the referral, the occupational therapist cannot interfere in the situation in any way except to protect the patient or other patients in the groups from serious physical injury. He cannot offer guidance (unless the patient requests it,) he cannot protect the patient from the results of faulty judgment or patterns of behavior, for to do so would influence the patient's choice and/or normal pattern of behavior and thus invalidate the information obtained. In this type of situation the patient is exposed to the personnel, patients and available activities and allowed to proceed on his own initiative. The way he reacts in the situation usually reflects his patterns before hospitalization. If these patterns have been such as to court or insure failure, this will be demonstrated. If his behavior has been such as to invite rejection or retaliation, this will probably be forthcoming from other patients, or the occupational therapist may recognize the wish to reject or retaliate in his own feelings. Through such observations the occupational therapist will gain concrete, "on the spot" examples of the patient's usual behavior and reactions which will clarify his problems. The occupational therapist has an advantage when evaluating not generally shared by the psychiatrist, social worker or psychologist, who more frequently evaluate through interview or other techniques in a one-to-one situation. The occupational therapist, on the other hand, generally evaluates the patient in a situation where other patients are present. This permits observation of the patient's responses in situations which can generate sibling rivalry, dependence or other characteristic behavior in relating to people.

## **Evaluating Purpose**

It is desirable to distinguish between evaluation, which is a preliminary to planning treatment, readability and the ongoing evaluative process, which is an integral part of treatment. It is advisable to differentiate when occupational therapy is to be used as an instrument of evaluation and when it is to be used as treatment. When occupational therapy is used as an evaluation procedure, the therapist is as passive and non-intervening as possible. No effort is made to inhibit self-defeating behavior. The faulty patterns of relationship or performance which have created difficulties for the patient prior to hospitalization tend to be repeated within the occupational therapy setting. This repetition of destructive or inappropriate behavior may be a detriment to later treatment, but this is not the case if the patient is placed on a type of psychotherapy designed to uncover unconscious motivations and to foster the development of insight. Patients who are receiving other forms of therapy usually appear to derive more benefit in occupational therapy from activities and techniques which permit the therapist to give

them a great deal of personal attention with enough firmness and control to provide support and security in the situation.

The period of observation and evaluation is followed by the initiation of an individual program of treatment. Should this program include any of the somatic therapies it is very helpful if the occupational therapist has had an opportunity to observe the patient's pretreatment reactions, since somatic therapies tend to have a repressive effect which masks psychotic symptoms. In addition there may be organic reactions directly related to these therapies which affect the patient's response in occupational therapy. Immediate treatment objectives are limited, being directed primarily to the relief of confusion, strengthening contact with reality and assisting the patient to regain self-confidence and security. Treatment procedures and activities are simple, structured and of a nature which permits and encourages frequent contact with the occupational therapist to supply the support and reassurance which the patient needs. Later the goal should be to facilitate restitution of ego function and the satisfaction of emotional needs, with no specific attempt to provide insight, since somatic therapies are not primarily designed to uncover underlying or unconscious material. This approach requires just as much psychiatric knowledge on the part of the occupational therapist as one involving the development of insight, since he must be able to recognize the dynamics which underlie symptoms, the importance of different patterns of relationship, and the way in which activities may be used to satisfy unconscious emotional needs.

If the patient is assigned to a treatment program emphasizing the development of insight, the function of occupational therapy will be quite different. I should like briefly to describe two such programs, one designed for residents of a hospital and the other for day hospital patients.

The residential program is focused around an open ward in the men's division of the hospital which is made as attractive and home-like as possible. Treatment includes group psychotherapy and occupational therapy and is supplemented by industrial assignments. Adequate library and recreational facilities are available. The psychotherapist and the social worker, who have their offices on the ward, and the ward personnel offer support and encouragement, but responsibility for planning diversional activities, meeting individual assignments and ward housekeeping are delegated to the patients. In order to maintain or develop normal social interaction, the men go for lunch each day to the comparable women's ward. At least once a week these women spend the evening on the men's ward where they play cards or converse and there are frequent dances. Activities away from the hospital are sponsored by volunteers.

# **Coordinating Program**

Occupational therapy and group psychotherapy are closely coordinated. The psychotherapist meets once a week with the occupational therapy personnel in the occupational therapy clinic, to examine the patient's work and discuss all significant developments which have occurred in either locale. In addition a weekly meeting is held with the social worker, ward personnel and occupational therapist to share information, review and revise treatment goals and

evaluate new developments. Occupational therapy is directed toward providing both individual and group experiences for the patient and facilitating his ability to appraise more accurately the demands of, and react appropriately in, both types of situations. Since the majority of these patients are psychotics with considerable variation in age and background, it is sometimes difficult to find group activities which are generally acceptable, but wherever possible they are selected by the group and worked out with the guidance of the occupational therapist.

The day hospital group is composed of patients who are primarily neurotic or borderline psychotics. The majority come from the community each day, although some inpatients are assigned for a transitional experience before complete separation from the hospital. All patients have group psychotherapy daily and most are seen in individual therapy sessions. These patients attend occupational therapy as a group and often use part or all of the session as an extension of their psychotherapy hour. In order to facilitate appropriate identification and to provide as nearly a normal situation as possible there are both a woman occupational therapist and a man who is a certified industrial arts instructor in the clinic. The personnel have to play many roles and assume many responsibilities, perhaps the most difficult being to keep the group active and therapeutically effective. The personnel must have confidence in the value of dynamic group interaction and they must not impede the group process with their opinions, advice or interpretations. There must be meaningful communication and correlation of effort between the occupational therapists and the day hospital nurse and psychotherapist. Personnel in both situations must be informed about all developments and reactions as they occur in order to maintain consistency in attitude and to frustrate the patients' efforts to manipulate the situation and embroil the personnel in dissension. Where good correlation exists, each group experience (psychotherapy or occupational therapy) enhances and strengthens the effectiveness of the other. Occupational therapy provides an opportunity for reinforcement and testing of insight, release of tension created but not expressed in the psychotherapy session, and stimulation of enough tension and anxiety to keep the patients working and talking in group therapy. The occupational therapist must frustrate the group's dependency, which is expressed by trying to force her into a position of leadership, consistently handing all responsibility for insight, opinions, judgments and solution of problems back to them as individuals or as a group.

However the occupational therapist cannot therapeutically ignore all dependency needs. Activities provide one area where the patient is justified in seeking assistance and instruction and where the occupational therapist can accept and fulfill the dependency needs, symbolically, through concern and attention expressed in her instruction and supervision. A good variety of activity should be available but there should be no overt pressure to participate. The atmosphere of the clinic and the example of other patients is usually enough to motivate the patient to start a project. Once started, the patients soon utilize the activities in the clinic to externalize and express unconscious material. The atmosphere is one of controlled permissiveness with sufficiently defined limits to protect the patients from unrestrained acting-out. For example, patients may be verbally aggressive but they are not permitted to indulge in

assaultive acting-out. They can destroy their own projects but they may not destroy other patients' work or clinic property.

#### **Developing Insights**

The occupational therapist must be constantly aware of transference reactions, interpersonal relationships and the way the patient uses, or does not use, the group and activity. The response by occupational therapy personnel to the misconceptions and distortions expressed in behavior and verbalization are determined by the patient's needs and his treatment plan. For one this might be an interpretive statement, "This is the way you would like to treat your father." Another may need to be confronted with reality, as, "But I am not your sister," while in many instances the group itself will confront the patient with an interpretation. The patient uses the clinic, the activities, the personnel and the group to work through and test developing insights, to practice new patterns of relating to people and reacting to frustration and pleasure, and to demonstrate to himself the greater satisfaction derived from more mature and objective ways of facing and solving his problems.

#### **Evaluation Service**

Following completion of formal treatment and during the state of consolidation and convalescence, occupational therapy is called upon to supply another type of service. This relates to preparing the patient for his return to work and the community. Since the "work" of most women patients is still home-making, a unit is provided utilizing skills such as food shopping, cooking, cleaning, laundry and sewing for the home as modalities. The patients receive instruction and practical experience in such activities as budgeting and efficient home management, menu planning and food service, home decorating and personal grooming. This program has demonstrated its value in helping the patient make the transition from hospital to home duties without undue anxiety and often with increased security and competence.

This period of the patient's hospitalization is also used to evaluate suitability for vocational rehabilitation if this is needed. Occupational therapy does not provide vocational rehabilitation services but it does provide a preliminary evaluation and screening service for the vocational rehabilitation counselor which is not available from other hospital services.

# **Supportive Activity**

I have talked about the functions of a treatment focused occupational therapy program in a dynamically oriented state hospital, but I have not mentioned two groups of patients who must receive attention, the chronic and the geriatric. I have purposely left these groups until now as I believe they need a program of supportive activity rather than specific treatment. The chronic patients have generally received all appropriate treatment which the hospital provides without evidencing sufficient improvement to permit their return to the community. Occupational therapy for these patients should be directed toward maintaining the level

of improvement which has been achieved, providing the support and reassurance which encourages further progress, and preparing them to function at their maximum level of adjustment within the hospital community. The same goals apply to the geriatric patient, except that ability to function in the hospital community is often more limited.

Many occupational therapists consider that this type of program is also treatment. I cannot agree. I believe that a program can be valuable and perform an essential function within the hospital structure without having to bear the label "treatment." In fact I feel that the indiscriminate labeling of everything which occurs within the hospital as "therapy" or "treatment" has devalued the term, and has made the thoughtful physician sceptical about most nonmedical so-called "therapies." It is commonly said that we treat the whole man and that we want to return him to his community as a functioning individual with the insights gained through treatment enriching his capacity to live. Do we want to send him back to the community with the concept that his work is a treatment, his recreation a treatment, if he reads a book or attends a concert he is engaged in a form of treatment? I am of the opinion that the provision of components of normal life situations within a hospital is no more a part of specific treatment than is the provision of an adequate diet or heat in the winter time. The fact that recreation, library and music enrich our lives, and that work is an essential activity in our culture, does not make participation in them treatment per se. I am in favor of providing as many types of activity as we can for patients; all I ask is that we do not slip into the fallacy of labeling activity "treatment" just because it is carried on within the hospital boundaries.

#### Re-evaluation

I called this paper "The Challenge of the Sixties" and I should like to restate the challenge as I see it. We, along with other mental health professions, need to re-evaluate our role and function in the care and treatment of patients suffering from mental illness. We need to undertake this re-evaluation in the interests of providing better treatment for more patients. Can we as a professional group meet these needs? In order to re-evaluate the role and function of occupational therapy in psychiatry, we should reach a broad agreement on what our role and function is. Certainly re-evaluation can be carried out on a departmental basis, but this is not resolving the confusion which exists concerning the role of occupational therapy as a professional entity. Vacillation in coming to grips with this problem and in working out a solution has in turn inhibited our ability to work towards the solution of related problems which call for action. We have all expressed the feeling that physicians should receive more orientation to occupational therapy in medical schools. Even if time were made for it in their crowded curriculum, whose concepts should be presented? We look forward to the day when we can have accreditation of clinical centers, but what will form the basis of accreditation? We wish students were better prepared for practice in the clinical area, but for which type of program should they be prepared?

Professional roles are changing. Social workers, nurses and psychologists have been engaged in studies of their role and function for some time and already changes are in evidence. Some of these came about rapidly; others have occurred almost imperceptibly. Think

for a moment of nursing and what seems to have happened in the last five years. Practical nurses now perform most of the bedside functions which registered nurses used to carry out, registered nurses now perform some procedures previously restricted to physicians, and a whole new category of workers has come onto the scene as ward secretaries, cleaners, porters, food servers, and so forth.

Changes are also occurring in the physician's role. In order to meet the needs of patients who could benefit from psychotherapy there has been a rapid increase in the use of group therapy techniques and the utilization by the physician of allied personnel as co-therapists, group leaders or as primary therapists. In the capacity of team leader the physician functions as a consultant and adviser who supports his team in their work with patients. While medical responsibility for diagnosis and treatment is vested in the physician, he uses the specialized training and competence of his team to assist him in both functions, and through the team's effort more patients are treated than could be reached through the physician's efforts alone.

The greatest challenge for occupational therapy is to define our own role in terms of present day psychiatry, and to determine which of our current functions actually require professional preparation and which could be adequately performed by less expensively prepared personnel. If the function does not require professional preparation it should be relinquished. This is not going to be easy, but if we do not accept this responsibility we shall not long retain our identity as members of the institution's professional staff. Today the graduate occupational therapist is considered part of the professional medical staff in many treatment oriented centers and service at this level should be the goal of all occupational therapists in psychiatric practice. We should utilize our training in the medical aspects of treatment and remember that at this time we are one of the few groups which have such qualification. Many psychiatrists recognize and value the contribution which occupational therapy currently makes to patient treatment and are willing to provide guidance and support if we demonstrate our readiness to accept increased responsibility. When the psychiatrist is willing and prepared to use the occupational therapist to the extent of his education and ability to assist in treating patients, there remains the problem of supplying therapists to use in this manner. If occupational therapy is to be a significant part of psychiatric treatment, we must attract with some degree of consistency competent and enthusiastic recent graduates to our centers. This can be accomplished only if we provide challenging opportunities for them to work in treatment situations which demand all of their professional knowledge. Recent graduates are not interested in nor attracted to positions which require primarily activity or even administrative skills.

# **Student Training**

It is more than possible that disinterest or lack of attraction has its roots in the clinical affiliation in psychiatry, and what has just been said of the recent graduate is equally applicable to the student in affiliation. Indeed it is my belief, that if a student's clinical experience in psychiatry takes place in a department where occupational therapy is an activity program and where the graduate occupational therapists function only as administrators, the future

graduate is already lost to psychiatric practice. The student in affiliation who has had an unfavorable experience in one clinical area generally avoids undergoing a corrective experience as a staff member in the same area.

Fortunately it should be easier to provide the affiliating student with an effective experience of occupational therapy used as treatment in a psychiatric program than it is to provide this same experience for a young staff member. The students, performing directly under close supervision by a qualified occupational therapist who serves as preceptor, desirably will observe, comprehend and practice occupational therapy as treatment through the example, discussion and constructive criticism of the occupational therapist. The staff member, on the other hand, does not often enjoy such immediate guidance and may be said to have to light his own way.

All students in psychiatric affiliation are entitled to the following positive experiences. (1) They should be shown the different ways that patients use activity to satisfy their emotional needs. (2) They should be shown how the occupational therapist not only facilitates this use of activity by the patient but can also help the patient gain insight into his feelings and behavior through his reaction to activity. (3) Students should be shown the various patterns of relationship which the occupational therapist uses to achieve treatment goals for individual patients or for the functioning group. (4) Finally students should be shown how to observe, analyze, evaluate and formulate appropriately the factors pertinent to planning or reporting treatment for a psychiatric patient.

These experiences should not be left to chance and the native awareness and skill of the student. The supervising occupational therapist should make certain that the student observes accurately the actual patients in the clinic, understands the significance of what he sees and his own reactions to it, can set realistic goals in occupational therapy for the patient and arrive at a feasible program to achieve them. The student should progress from the role of observer (by way of discussion and practice) to active participant in the therapeutic situation and finally to that of therapist, with all the responsibility that this implies. A student who has had this type of experience during the psychiatric affiliation becomes a young staff member who is prepared to administer treatment and who will continue to grow in professional skill through constant self-evaluation of his practice.

Specific mention must also be made of one other experience which is of great value to the young staff occupational therapist, which should also be shared by the affiliating student wherever possible. This is participation in conferences of the psychiatric treatment team. In this situation the occupational therapist has an opportunity to judge for himself the significance of occupational therapy's contribution as it is seen by other disciplines. Moreover, there is no better preservative or restorative of the sense of proportion than genuinely working with members of other professions in treating the same patient or group of patients.

#### Conclusion

My summary is not lengthy but it is as sincere and heartfelt as anything I have ever said in my lifetime as an occupational therapist in psychiatric practice. We occupational therapists

in psychiatry must now make a decision as to our future course. On one hand we can strive to turn out many occupational therapists to be the personnel responsible for carrying out or supervising programs of activity for large numbers of patients as an instrument of patient management. Unfortunately it does not seem realistic to anticipate the necessary numbers of these personnel resulting from the current educational pattern of the registered occupational therapist. On the other hand we may work to produce a more limited number of occupational therapists who will perform a strictly treatment role for selected patients, having relinquished non-treatment or routine treatment aspects of previous occupational therapy functions to other personnel (even including supervision of non-occupational therapists). These specialists will find that their practice utilizes all their professional preparation and indeed demands continually increasing competence. Young persons who are considering a career of service in a health-related profession respond to challenge, and it is with confidence that I predict an adequate, although always limited, supply of good students and recent graduates to meet the demands of the psychiatrist who uses occupational therapy as treatment. In the last analysis, continuance of a profession depends upon the generation to come. So long as occupational therapy in psychiatric practice continues to attract vital recruits, so long will it maintain the worthy tradition of service to patients laid down by pioneers like Eleanor Clarke Slagle.

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