A SURVEY OF THE OCCUPATIONAL THERAPIST'S PERCEIVED ROLE IN MENTAL HEALTH PROGRAMS OF THE 1970S

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We hereby recommend that the thesis prepared under our supervision by Eleanor Raffen entitled "A Survey of the Occupational Therapist's Perceived Role in Mental Health Programs of the 1970s"

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CHAPTER I

INTRODUCTION

In searching for new concepts and practices to fit in with the constantly developing mental health treatment picture, occupational therapists are reexamining their role in the mental health field.

This study is about such a reexamination. It will explore the roles we play in the field--diagnosticians, counselors, educators, supportive personnel, or rehabilitation advisors. It will also be attempting to identify the area in which we have the most to contribute.

Statement of the Problem

The purpose of this study was to bring together the thoughts of occupational therapists working in the mental health field to more clearly identify their own perception of their role in today's mental health treatment team.

Significance of Study

This is descriptive research aimed toward clarifying the role of the psychiatric occupational therapist

in current situations of today's mental health treatment field. It is felt that this survey will be of interest to occupational therapists employed in mental health facilities as well as to those who employ or wish to employ an occupational therapist in their mental health facility.

This information might be useful to those planning continuing education programs for psychiatric occupational therapists. It may also be useful in the light of licensure of occupational therapists and financial reimbursement of services by medical insurance agencies. For such purposes it presents the services of the psychiatric occupational therapist as a product of unique knowledge and skill that has an effect on the remediation of a psychiatric disorder.

This survey also traces the changes in occupational therapy from the 1950s to the 1970s. The need for this study lies in those changes through the years. As medicine advances so must occupational therapy. Occupational therapy advancements are seen going from a more diversional arts and crafts centered image of the 1950s to a more therapeutic, individualized, specialized, and professionalized type of patient treatment, using the same modalities, in the 1970s.

Limitations of Study

Limitations of this study revolve around the interpretations of the questions and the honesty of the subjects who filled out the questionnaires. Limitations also include the number of surveys that were actually returned and the number of questions on each survey that the subject answered.

CHAPTER II

REVIEW OF LITERATURE

Occupational therapy in psychiatry is based on the assumption that psychosocial dysfunction is the lack of one or more of the following: the ability to plan and carry out a task, the capacity to interact comfortably in a group, the ability to identify and to satisfy needs, the ability to express emotions in an acceptable manner, and a more or less accurate perception of self and one's relationship to the environment (Fidler 1976).

Occupational therapists use immediate action-oriented interactions to help people who have been designated as mentally ill learn to live in and be part of their community by helping them work on a value system that allows the individual to satisfy his needs without infringing upon the rights of others. They are also helped to learn skills in carrying out required activities of daily living, to learn to work at a relatively satisfying job, to enjoy avocational and recreational pursuits, and to interact comfortably with family and friends (Mosey 1973).

The subsequent headings in this review of literature are matched to those in the questionnaire of this survey. Categories considered in this study are diagnostic tasks, vocational rehabilitation tasks, tasks preparing the patient to reenter the community, as well as tasks to work with expression of feelings, treatment planning, and present and future needs of psychiatric occupational therapy.

Diagnostic Tasks

As occupational therapists respond to the health service needs of contemporary society, they begin to evolve a variety of new roles. One of these evolving roles is that of diagnostic functions. The growing thought trend among mental health professionals is that properly administered, acute, inpatient care is necessary in the rapid recovery of patients and their return to family, friends, and community. To initiate proper treatment, speedy diagnosis is essential. Evaluations performed by occupational therapists should be ones that can be easily administered and objectively scored to measure functional behavior, symptomatology, interpersonal relationships, manual dexterity, and motor responses (Bendroth and Southam 1973).

Vocational Rehabilitation Tasks

Therapists realize that their clients need goals in life and an opportunity to share the same experiences as others. They need a chance to be competent, a chance to achieve a sense of mastery, and a chance to have feelings of dignity about their lives. One way to achieve these objectives is through gainful employment (Johnson 1971).

Interest has been growing in utilizing and organizing reinforcement procedures in psychiatric hospitals and classrooms. The procedure of reinforcing a behavior rather than a completed task suggests that less emphasis should be placed on the completion of a task and more emphasis placed on the actual performance of working. High probability behaviors are considered to be rewarding and have been observed to be an integral part of a behavioral repertoire. Examples of these are television watching and playing pool. Low probability behaviors are behaviors that represent problem areas to the client because they are lacking in his repertoire. Low repertoire behaviors may be related to personal hygiene and routine tasks (Ogburn, Fast, and Tiffany 1972).

Deacon, Dunning, and Dease (1974) developed a job clinic called the Dease Procedure which they have used as a discharge procedure on single clients and groups of clients. This job clinic for psychiatric patients can be simulated in occupational therapy by any project that will provide clients with necessary work skills. Components of this job clinic must include assessing, training, placing, and sustaining client in a stable, competitive employment situation. The purpose of a job clinic is to teach clients how to market their existing skills to find suitable jobs. It is based on concepts of self help. The patient objectively evaluates his assets and skills, locates employers most likely to need those assets and skills, and approaches the chosen market with proven merchandising methods. The occupational therapist does not act as a placement agent but as a facilitator to the client who plans and controls his own job campaign. The occupational therapist needs to be knowledgeable and sensitive to the client's needs, to business customs, and to expectations of corporations.

Tasks Preparing the Patient to Reenter the Community

An increasing number of psychiatric patients are being discharged through various community placement

services. Because of years of separation from society, these people need to be reoriented into the community. Patients who have been hospitalized for a long period of time become a regimental part of an institution and have little personal responsibility for their daily functioning. Self care training, including reorientation to community experiences before leaving the hospital, could help the patient tolerate plans for discharge (Linnell, Stechman, and Watson 1975).

Providing clients with successful activity experiences in their community will reinforce and broaden their spheres of competence and the ability to interact effectively with their environment. To foster this the occupational therapy program may: (1) discover specific activities available in the client's immediate community, (2) discover the client's activity preference, his abilities, and the amount of structure and support he needs to attend these activities, (3) recommend appropriate activity choices, and (4) follow up with graduated supportive procedures (Klodner 1973).

Avocational activities are used by everyone as release mechanisms. Occupational therapy programs which use existing community resources during inpatient stay can extend into aftercare treatment in the community

helping patients to rediscover effective support mechanisms (Klodner 1973).

Occupational therapy programs which prepare patients to reenter the community are sometimes called "daily living groups." These daily living groups are very effective when performed in a "team approach" to patient treatment. The team may be composed of a psychiatric resident, nurses, social workers, aides, recreational therapists, and occupational therapists (Heine 1975).

Tasks for Expression

Life stress is a primary cause, a precipitating cause, and an exacerbating agent in specific maladaptive behaviors involving a wide range of physical and mental disorders. Essentially, stress refers to the adjustive demands made upon the individual to the problems in living with which he must cope if he is to meet his needs. Typically, one thinks in terms of three types of stress: frustration, conflict, and pressure. Frustration occurs when the ability to achieve a desired goal is impeded. Conflict occurs not from a single obstacle but when a choice must be made between two or more goals. Pressure involves demands that force one to speed up or intensify

his efforts and often stem from his own aspirations (Coleman 1973).

Stress tolerance refers to the degree of stress the individual can tolerate without undergoing disorganization or decompensation. Severity of stress refers to the degree of disruption in the system that will occur if the individual fails to cope with the adjustive demands. The severity of stress is determined primarily by three factors: the characteristics of the individual, the external resources, and the support available to him (Coleman 1973).

Occupational therapists often find themselves faced with clients who have not only mental problems but personal, social, and family problems. Occupational therapists have a particular challenge in that they must not only understand and analyze their clients' behavior but also the needs of the clients. The client must be provided opportunities to work through his feelings of anger, aggression, isolation, loneliness, and guilt, as well as his ego and superego problems. Rather than terminating treatment when patients act out in anger, patients should be engaged in situations that speak to that anger (DeAngelis 1976).

Clients identified as possessing poor ego and superego structures should be provided with nonthreatening ways to regress to earlier fixation points where they feel more comfortable. Isolation and loneliness can be addressed in part by structuring ways, nuturing treatment, and environments that allow the client to experience trust and purpose (DeAngelis 1976).

When the primary goal of self expression activities is group development, a subject oriented theme such as holidays, sports, or story topics is effective. Skills of self expression and group interaction can be practiced with such themes. However, to develop interpersonal skills, the emphasis on individual expression must be reduced. To concentrate on a feeling level, decision making should be lessened. In a group task, interaction of members is required in the sharing of media, ideas, and feelings (Osborne 1974).

An increasing number of therapists are becoming involved in encounter group experiences. The task of the therapist as a leader in an encounter group includes guidance, advice, confrontation, empathy, understanding, and an obligation to become aware of many aspects of self. Too often the professional participant in encounter groups

seeks to play the role of psychiatrist or counselor instead of a group member. He can also become so enamored of the process of self awareness that he neglects the role of advisor and teacher. The task of the therapist is one in which he manipulates interpersonal and intropsychic process to bring about a healthier and happier adaptation to reality. To do this effectively, the therapist must take his understanding of psychological principles into account (Steiner 1972).

A developmental approach toward helping a patient express attitudes is movement therapy. Movement activities can be adapted to assume a role in the preliminary stages of psychiatric rehabilitation based on the developmental learning theory of Piaget. Many good ideas in this area can be learned from dance therapists and recreational therapists (Levy 1974).

Treatment Planning

There has been increasing emphasis on the importance of fitting the task to the needs of the individual. Program planning suggests that some occupational therapy services are more therapeutic than others and that specific kinds of work are specifically therapeutic for different diagnostic categories. If so, the product of the planned

approach would be the occupational therapy prescription. However, some occupational therapists suggest that we depart from the treatment plan and the prescription and let the patient structure his own work program so that the psychiatrist may use this for diagnoses and information about the patient's problems (Linn, Shamah, and Weinroth 1962).

Day (1973) wrote an article in the American Journal of Occupational Therapy on treatment planning as the core of teaching our occupational therapy students. She feels that treatment planning is a good learning tool which helps the student to organize his treatment goals for each individual patient. It is also a good learning tool because it requires decision making based on scientific principles, experience, and judgement.

Lehmann (1973) interviewed 103 occupational therapists who all agreed that occupational therapists should generally function more independently. However, most agreed that the physician's referral or prescription should be required for delivery of occupational therapy services. Lehmann suggests that the prescription by physician is intertwined with decisions the occupational therapy community must make on independence of role in

such areas as assuming more responsibilities, clarifying technical competencies, and in institutional power relationships.

Occupational therapy activities may aid the patient in the development of interpersonal and adaptive skills as well as the more obvious task oriented skills but to take advantage of this, the patient must attend occupational therapy. All means of encouragement and persuasion have been employed to move the patient to participate in occupational therapy. Little data exists on the effectiveness of any particular method to increase patient attendance. A team of researchers (Zschokhe, Freeburg, and Erickson 1975) reported on a study done with disturbed soldiers. It was found that a system combining patient leadership, staff-patient decision making, objective pay schedule, social reinforcement, and competition was most effective in increasing attendance. They also reported that attendance was improved by positive reinforcement such as patient leadership and staff-patient decision making. Objective pay schedules, competition, bonus points, and public charting also tend to increase occupational therapy attendance (Zschokhe, Freeburg, and Erickson 1975).

Heine (1975) found that patients with an investment in making behavioral changes respond well even if coerced. Those with no investment lower the morale of the group when coerced into attending.

Present and Future Needs of Psychiatric Occupational Therapy

The change in the last ten years in the field of mental health is one of the great social revolutions in history and occupational therapists have been involved in it. The community mental health movement has gained momentum since the federal legislation of 1963-1965 for the developing and financing of local mental health services. The state hospital staff rather than declining with the stress on community mental health has instead doubled. This has lead to treatment for more patients with a shorter hospital stay. Average hospital stays now may be as little as two weeks (Ethridge 1976).

New laws have been passed such as the right to expect treatment of a reasonable adequacy that meets an acceptable level of standards. Without providing treatment it is unconstitutional to confine a mentally ill person not dangerous to himself or others and able to attend to his basic physical needs no matter how psychotic he may be (Ethridge 1976).

Under The Due Process Law, mental health professionals are constrained from treating an involuntarily admitted mentally ill person until the court process is completed and that person is labeled as needing treatment. Exceptions are made for individuals who might harm themselves or others (Ethridge 1976).

Private and general hospitals sometimes now refuse to accept involuntary patients because by law they cannot provide acute treatment for fourteen days. Also, they may never be reimbursed if the patient's insurance does not include third party payment. State hospitals have to accept anyone and state employed psychiatrists are required to sign commitment papers, whereas psychiatrists in private practice hesitate to do this because of malpractice laws and legal implications. The result is that state hospitals are getting patients who are acutely psychotic and suicidal who are brought to the hospital by police on a court order. This court order may include participation in community health treatment programs after hospital treatment (Ethridge 1976).

Thus, state hospitals do the acute treatment and local hospitals do the long term follow up treatment. Under these conditions, it seems likely that hospital

stays will become shorter and the majority of mental health patients will be treated as outpatients (Ethridge 1976).

Ethridge (1976) feels that occupational therapy must redefine its role according to the implied changes. He feels a new occupational therapy image is necessary as in the past we have been noted for our role in institutional chronic care. There may be opportunity to become experts in the field of psychiatric programming for long term clients in a community setting. We may become community organizers or therapist administrators. It will not be useful to sit complacently and wait for our role to be spelled out. To do so would be to invite the possibility of becoming one of the casualties of the mental health revolution. Occupational therapists should get some training in individual counseling, community development, budgeting and finance, administration and management, adult education, and problem solving (Ethridge 1976).

In the new environment of community oriented health care, a therapist's role often includes problem solving related to patient programming. It may also involve communicating the role of the occupational

therapist to representatives of other disciplines, administration, and community agencies (Llorens 1972).

As occupational therapists respond to the health services needed for contemporary society, they begin to evolve a variety of new role functions. One of these emerging is counseling. If one generates a theory that a counselor is a person who is available, capable of interest in another person, open to encounter and confrontation, helpful in revealing alternate ways of being, and makes possible the choice of a more viable way, then occupational therapists may say the role of counseling is one of their functions (Drenning 1973).

To fit into the mental health picture of today, occupational therapists need to expand. But to expand too far could also present problems. There are some roles in which occupational therapists could model their future to be involved in the present day mental health picture which utilize their present skills, knowledge, and traditional setting. One of those such roles presented in a traditional setting might be a therapeutic social club. The therapeutic social club has been in existence since 1938. It provides activities in a social setting using community resources to facilitate the social rehabilitation of the patient and offers a chance for reality testing,

environmental manipulation, and ego strengthening. It offers a sense of belonging and discourages isolation, passivity, and preoccupation. The emphasis is on the social interaction of the individual and the utilization of an organized activity program for promoting social readjustment in the community. With a background in psychiatric disorders, group dynamics, activity analysis, recreational planning, and knowledge of community resources, the occupational therapist is well suited for the role (Webb 1973).

Colorado State University conducted a workshop in 1972 to prepare occupational therapy students to facilitate emotional growth in their patients, focusing on interpersonal and communication skills. Two of the most vital skills developed through this workshop were those of dealing with the giving and receiving of feedback and the process of two way communications. Workshops of this nature should help occupational therapy grow with the future mental health care trends (Delworth 1972).

Schechter (1974) reviewed the role of occupational therapy in a present day psychiatric day care institution as that of a primary therapist, group therapist, activity therapist, and supervisor of students and volunteers. She thought that things which might influence the services

an occupational therapist provided would be the philosophy of the institution where the occupational therapist worked, the average duration of hospitalization at that institution, and the financial support occupational therapy received from that institution. She saw the areas of role modeling, psychodrama, recreation, and group experiences under the role of occupational therapy in the now popular community day care center.

Two areas of concern to practicing occupational therapists in mental health specialities are identified as increasing competition in the job market and job classification (Mental Health Task Force 1976).

CHAPTER III

PROCEDURE FOR TREATING DATA

Methodology

The instrument is a questionnaire of forty-six questions (see Appendix) related to how the occupational therapist views her role in today's mental health treatment team. This questionnaire was answered by occupational therapists who are actively employed in mental health treatment facilities.

Procedure for Selecting Subjects

The subjects' names were listed in the American Occupational Therapy Association Directory of 1975-1976. Coding numbers of 21 and 22 denote the therapist is involved in an employment situation of mental health and psychology.

Preference in names selected went to therapists working as directors of departments or in a supervisory capacity. They were selected over the staff therapist because they will be more likely to have years of experience an knowledge of the psychiatric occupational therapy field which the staff therapist may not have and also

because those who are working in these positions of responsibility may not change positions of employment as frequently as a staff therapist might and may, therefore, receive the mailed questionnaire at the address listed.

One hundred survey questionnaires were sent along with a cover letter (see Appendix). A period of two months was allowed for the return of these survey questions. To insure a larger number of returns, a second mailing to remind the participants to mail back the survey was sent at the end of a one month period (see Appendix).

Each survey question must be viewed separately as each question deals with a different aspect of psychiatric occupational therapy and is important in itself to the overall picture of the occupational therapists' role in current mental health treatment centers. A table with percentage of the responses obtained will be used to report the data.

The actual number of returns for this survey was approximately 30% of those mailed to prospective subjects. Some therapists did not feel qualified to answer some questions on the survey if they were not immediately involved in such activity as the question described.

Many questionnaires returned with envelopes marked "moved, no forwarding address."

Many of the therapists checked more than one answer on some of the questions. This might indicate that in occupational therapy of this nature one of several avenues of treatment may be correctly taken and the therapist must practice her judgement according to the environmental conditions existing in this instance and according to her patient's needs. Tables showing the percentage of responses to each question are presented under their original category headings.

CHAPTER IV

RESULTS

Table 1 indicates that most therapists felt that there are specific types of activity which are more therapeutic for a specific diagnostic category than other forms of activity.

It is only a 10% margin of therapists who felt that psychiatrists use occupational therapy information for diagnostic purposes.

TABLE 1

DIAGNOSTIC TASKS

1. Are specific types of work therapeutic for specific diagnostic categories?
   30 answers — 70% yes, 30% no

2. Do psychiatrists refer to the patient's occupational therapy work for diagnostic purposes?
   29 answers — 55% yes, 45% no

Table 2 shows that the majority of therapists involved in this survey relate vocational rehabilitation, work therapy, and educational pursuits for patients to their treatment program. Industrial therapy does not seem

to be used as much and when used it seems to be on an individual basis.

The terms "O.T. room" and "O.T. shop" seem to be unpopular, being replaced by terms such as "clinic" and "treatment center."

TABLE 2

VOCATIONAL REHABILITATION TASKS

1. Is your O.T. program related to vocational rehabilitation?

32 answers	69% yes
	31% no

2. Is work therapy part of patient's O.T. treatment?

30 answers	60% yes
	40% no

3. Do you provide consultation services to patients for educational avenues?

31 answers	74% yes
	26% no

4. Is your O.T. program related to industrial therapy?

30 answers	33% yes
	67% no

If yes, in what type of situation?

18 answers	11% group situation
	50% individual situation
	28% community situation
	11% other type of situation

5. How do you refer to your place of treatment?

36 answers	17% O.T. shop
	30% O.T. clinic
	17% O.T. room
	36% other terms

As table 3 indicates, 78% of the therapists have their patients involved in community oriented programs. All of the therapists approved the idea of having their patients in community oriented programs.

TABLE 3

TASKS PREPARING PATIENT TO REENTER COMMUNITY

1. Are patients involved in community oriented programs?		
	32 answers	78% yes
		22% no
If above answer is no, do you approve of patients involved in community oriented functions?		
	10 answers	100% yes
2. Are special interest groups included in O.T. programs?		
	32 answers	53% yes
		47% no
If yes, indicate interest groups.		
	34 answers	29.4% newspaper
		29.4% gardening
		3.0% bridge
		0% book reviews
		38.2% other groups
Amount of success encountered in these groups.		
	17 answers	18% excellent
		70% moderate
		12% poor
3. Importance of keeping psychiatric patients aware of holidays and seasons.		
	29 answers	93% yes
		7% no
If yes, should this be part of occupational therapy?		
	33 answers	70% yes
		30% no

Over one-half of the therapists answering this questionnaire use special interest groups of a wide variety in their treatment activities for patients with moderate success.

Almost all of the therapists involved in this survey felt that it was important for the mentally ill patient to be aware of holidays and seasons and that this should be a goal of the occupational therapist.

According to table 4, 72% of the occupational therapy programs are related to recreation.

In activities for group interaction the therapist is primarily seen acting as a catalyst.

TABLE 4

TASKS WHICH ALLOW PATIENT AN AVENUE OF EXPRESSION

1. Is your O.T. program related to recreation?
   29 answers
   72% yes
   28% no

2. In group interaction activity, how does therapist most frequently act?
   53 answers
   45.28% catalyst
   13.20% observer
   15.09% part of group
   26.41% leader

Table 5 indicates that the structured treatment program seems to be used by most therapists with the maximum emphasis on fitting the task to the patient's needs. Of the twenty-nine therapists who answered "yes" on number 3, over one-half of them said their programs were very successful and they used a variety of controls. None indicated that volunteers were used to control and male aides were used only 28% of the time to control.

Table 6 shows that most therapists felt that a patient's refusal to attend O.T. did not diminish the value of their program. Only 11% felt that it did. Seventy-three percent of the therapists participating in this survey thought that the interactions between therapist and patient were very important.

The referred prescription from a professional source, on question 3, was preferred by 35% and an added 22% specified that it come from the psychiatrist.

An overwhelming majority of occupational therapists felt that a psychiatric O.T. experience should be referred to as treatment.

TABLE 5

TREATMENT PLANNING

1. Type of treatment program contributing most to therapeutic occupational therapy.

33 answers	88% structured program
	12% nonstructured program

2. Amount of emphasis placed on fitting task to patients' needs.

31 answers	97% yes
	3% no

If yes, how important?

30 answers	67% maximum
	33% moderate
	0% minimum

3. Are short term programs used in group treatment situations for expression of aggressive and hostile feelings?

29 answers	52% yes
	48% no

If yes, how successful are they?

17 answers	6% poor
	41% moderate
	53% very

If yes, what controls are used?

18 answers	28% male aide
	0% volunteer help
	33% allied services
	39% other controls

TABLE 6

TREATMENT IMPLICATIONS

1. Do most occupational therapists feel their program has no value when a patient refuses it?

28 answers	11% yes
	89% no

2. Importance of emphasis placed on interaction between therapist and patient.

30 answers	73% very important
	0% sometimes important
	10% moderately important
	0% important
	17% unimportant

3. Type of administrative policy providing the O.T. with most meaningful method of operation.

37 answers	16% blanket prescription
	35% referred prescription from professional source
	27% referred prescription from a psychiatrist
	22% open door policy where no prescription is required

4. Should a psychiatric O.T. experience be referred to as treatment?

31 answers	90% yes
	10% no

On table 7, 68% of the therapists are shown to be using problem oriented charting. The majority of these therapists preferred it to the progress note.

Seventy-seven percent of the thirty therapists participating in this survey said that the evaluations and diagnostic tests done in occupational therapy are used by other services treating the patient.

TABLE 7

DATA GATHERING

1. Do you use problem oriented charting?

31 answers	68% yes
	32% no

If yes, do you prefer problem oriented charting to the progress note?

24 answers	79.2% yes
	20.8% no

2. Are patient's O.T. evaluations and diagnostic materials used by other services related to patient care?

30 answers	77% yes
	23% no

Table 8 indicates that 53% of the therapists answering this questionnaire felt that related health care fields recognize the value of occupational therapy. Nurses were indicated to be the most aware and administrators to be the least aware.

Ninety-three percent of the participating survey subjects said that hospital personnel observe the patient at tasks in an O.T. setting. Nurses were the most frequent visitors to the O.T. clinic and doctors were the least frequent visitors.

TABLE 8

COORDINATION BETWEEN O.T. AND OTHER MENTAL HEALTH CARE SERVICES

1. Do related health care services realize impact of O.T. on patient's rehabilitation?

30 answers	53% yes
	47% no

Percentage of related services most aware of O.T. benefits.

133 answers	8% doctors
	15% nurses
	10% aides
	9% administrators
	9% social workers
	12% allied therapies

Percentage of related services least aware of O.T. benefits.

133 answers	9% doctors
	2% nurses
	7% aides
	10% administrators
	5% social workers
	3% allied therapies

2. Do hospital personnel observe patients at their tasks in an occupational therapy setting?

28 answers	93% yes
	7% no

If yes, who?

77 answers	30% said nurses visit most
	18% said doctors visit most
	26% said aides visit most
	26% said other disciplines visit more than above

On table 9, 90% of the therapists are shown to be working under the team approach. The 10% who do not work under the team approach would like to. All of the therapists working under the team approach feel that O.T. is a contributing member to this method of patient treatment in psychiatry. They see occupational therapy services contributing most to avocational experiences and expressions of attitude. Next in importance they see O.T. contributing to role modeling experiences for the patient. Counseling and diagnostic services ranked third in O.T.'s contribution to team treatment and vocational training and placement ranked fourth. The occupational therapists saw themselves as least involved in the role of family counseling.

Occupational therapists not involved in the team approach communicate treatment goals most of the time by means of informal discussion. An additional 25% communicate treatment goals in staff meetings.

TABLE 9

TEAM APPROACH

3. Occupational therapists working under the "team approach."

31 answers — 90% of O.T.'s do
10% of O.T.'s do not

Those of the 10% that would like to work under the "team approach."

4 answers — 100% would like to

Those who feel O.T. is a contributing member of the "team approach."

28 answers — 100% yes

Areas where O.T.'s see their services contributing to the team approach.

308 answers

(1) first contribution rated by 9% of population
    - charting
    - avocational experiences
    - expression of attitude
    - group O.T.

(2) second contribution by O.T.'s to the processes of the team approach by 8% of sample
    - individual O.T.
    - role modeling

(3) next in rank by 7%
    - counseling
    - diagnostic services
    - recreation

(4) 6% of the population found these services to be a contribution to team approach
    - vocational training
    - vocational placement
    - education
    - post hospital treatment

(5) only 3% of O.T.'s answering this question were involved in family counseling in the "team approach"

TABLE 9--Continued

How O.T.'s who are not employed in a team approach environment communicate O.T. treatment goals to related hospital services.		
	16 answers	25% inservice training sessions
		25% staff meetings
		31% informal discussion
		19% other means

Table 10 shows that occupational therapists felt that occupational therapy should be part of the admission procedure. Over one-half of them felt we should not minimize the use of handcraft skills in O.T. treatment. Seventy-one percent of the therapists liked the idea of using the patient's project as a basis for verbal communication.

Eighty-four percent of the therapists in this survey use group activities in their patient treatment. Sixteen percent of the therapists do not use a form of group activities in patient treatment. Ten percent of all therapists involved in this survey use only individual projects when treating their patients. Most of the therapists however use individual projects with moderation. Most therapists feel that patients should be instructed to attend occupational therapy.

TABLE 10

PRESENT AND FUTURE NEEDS OF PSYCHIATRIC OCCUPATIONAL THERAPY

1. Including O.T. as part of patient admission procedure.	32 answers	84% yes 16% no
2. Minimizing use of handcraft skills in treatment plans.	32 answers	44% yes 56% no
3. Using the patient's project as a basis for verbal communication with him.	31 answers	71% yes 29% no
4. Frequency in which individual O.T. projects are used.	31 answers	10% completely 74% moderately 16% not at all
5. Use of group O.T. activities.	31 answers	84% yes 16% no
6. Should patients be invited to O.T.?	28 answers	46% yes 54% no
7. Should patients be instructed to attend O.T.?	29 answers	76% yes 24% no

The rating scale in table 11 shows that therapists would like more training in behavior modification, transference and countertransference, transactional analysis, role modeling, psychopharmacology, psychotherapy, and

psychodrama. The rating scale shows that most therapists felt that they had enough training in psychoanalytic concepts.

TABLE 11

RATING SCALE

Rating Scale: Rating the need seen for more academic training for occupational therapists working in mental health. Percentages are given according to number of therapists.

Scale Key: Has enough training (1) to needs more training (5).

Area of Learning	1	2	3	4	5
Behavior Modification	0%	7%	27%	33%	33%
		(30 answers)			
Psychoanalytic Concepts	31%	13%	31%	6%	19%
		(32 answers)			
Transference and Countertransference	7%	13%	30%	13%	37%
		(30 answers)			
Transactional Analysis	0%	17%	17%	35%	31%
		(29 answers)			
Role Modeling	10%	10%	30%	23%	27%
		(30 answers)			
Psychopharmacology	3%	13%	29%	23%	32%
		(31 answers)			
Psychotherapy	6%	10%	25%	31%	28%
		(32 answers)			
Psychodrama	3%	3%	31%	35%	28%

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

It is interesting to note in the survey that the therapists agreed 100% that the patient should get back into the community through community oriented functions while still under medical treatment. Eighty-eight percent felt they would rather work with a more structured program in treating patients' needs and 90% of the occupational therapists answering the survey work under the "team approach." One hundred percent of the therapists involved in this survey felt occupational therapy contributed a great deal to the team approach concept of total patient care.

Somewhat distressing is the report that only a slim margin of occupational therapists felt that the psychiatrists use occupational therapy information for diagnostic purposes.

The therapists report that they relate their programs to vocational rehabilitation, to work therapy, and to stimulating educational avenues for their patients.

Yet in the contributions of occupational therapy to the team approach, vocational training and placement were not scored as receiving outstanding assistance from O.T.

The new mental health trend to get the mentally ill person back on his feet and out into the community as soon as possible certainly has O.T. support as 78% of the O.T.'s indicated they are treating patients in community oriented activities. All of the therapists in this survey seemed to like the idea of reaching out into the community for treatment. This may show that we have made the transition from chronic institutional care specialists to community oriented specialists.

O.T.'s still like to have structure in their treatment programs and strongly believe the task should be fit to the patient's needs. Some of these needs, such as the expression of feelings, are handled by the present day therapist in the now popular group treatment programs which have proven to be very successful with many.

In keeping with the fact that therapists prefer structured treatment programs, three-fourths of the therapists answering the survey preferred to work under a referred prescription from a professional source. It may be that O.T.'s maintain their professionalism by sticking to such guidelines.

Occupational therapists seem to have done a good public relations job on getting the message of their profession across to doctors and nurses, but many administrators still seem to be unaware of the benefits their patients can derive from O.T.

The team approach is definitely the preferred method of treatment in psychiatry. It is being used almost totally in the occupational therapy settings of today. In this approach O.T. is setting its new image by contributing to the total patient care in avocational experiences, expression of attitude experiences, role modeling experiences, and counseling and diagnostic services. Needed vocational training seems to be performed by another discipline.

A very interesting outcome is that the majority of occupational therapists participating in this survey do not want to minimize the use of handskills in their new professional image. They want to build the new concepts of O.T. around the handskill activities.

The rating scale on additional learning in this survey produced the fact that the majority of O.T.'s are asking for more learning in most areas of psychology. They seem to say that they know the psychoanalytic concepts, but they need to know more about how to apply the

tools of psychology such as psychodrama, psychotherapy, role modeling, behavior modification, and transactional analysis.

APPENDIX

SURVEY FORM LETTER

Dear _____,

I am a graduate student at Texas Woman's University writing a thesis on "A Survey of the Occupational Therapist's Perceived Role in Mental Health Programs of the 1970s."

As a practicing therapist in the field of psychiatric occupational therapy, I would like to ask your cooperation and opinions on the following enclosed survey questionnaire.

I would be most appreciative if you would fill it out and return it in the enclosed self-stamped, self-addressed envelope at your earliest convenience.

If you would like to receive a copy of the computed statistics of this study, please indicate on the space provided below.

Thank you for your help.

Sincerely,

Eleanor A. Raffen, O.T.R.
2225 Pembrooke
Denton, Texas 76201

_____ I would like to receive a copy of the computed survey.

SECOND MAILING POSTCARD FORM LETTER

Dear _____,

I hope you found the questionnaire for "A Survey of the Occupational Therapist's Perceived Role in the Mental Health Programs of the 1970s" of interest and that you will find a moment to complete and return it at your earliest convenience.

Your opinions are appreciated.

Sincerely,

Eleanor A. Raffen, O.T.R.
2225 Pembrooke
Denton, Texas 76201

SURVEY QUESTIONS

Instructions: Please answer as indicated for each question.

Categories:

1. Description of specific tasks that might be performed by an occupational therapist working in a mental health treatment center.
2. Treatment planning.
3. Treatment implications.
4. Data gathering.
5. Coordination between O.T. and other services in mental health centers.
6. Determining present and future needs of psychiatric occupational therapy.

Category One: Description of specific tasks that might be performed by an occupational therapist working in a mental health treatment center.

1. Diagnostic tasks:

   a. In your working experience are specific kinds of work specifically therapeutic for specific diagnostic categories?
   Check one: Yes _____ No _____

   b. Do the psychiatrists in your institution refer to the patient's occupational therapy work for diagnostic purposes?
   Check one: Yes _____ No _____

2. Vocational rehabilitation tasks:

   a. Does your occupational therapy program have any relationship to vocational rehabilitation?
   Check one: Yes _____ No _____

   b. Do you introduce work therapy as part of the patient's O.T. treatment?
   Check one: Yes _____ No _____

   c. Do you ever provide consultation services for educational avenues that are being considered for any patients you see in your occupational therapy program?
   Check one: Yes _____ No _____

   d. Is your occupational therapy program related in any way to industrial therapy?
   Check one: Yes _____ No _____

      (i) If yes, it is (check any pertaining to your situation).

      _____ group situation
      _____ individual jobs
      _____ community service
      _____ other (please specify) _____

e. Do you refer to your place of treatment as:

_____ the O.T. shop
_____ the O.T. clinic
_____ the O.T. room
_____ other (please specify) _____

3. Tasks which prepare the patient to reenter the community society:

a. Do you involve your patients in any community oriented programs as part of the institution's occupational therapy treatment?
Check one: Yes _____ No _____

(i) If your answer to the above is no, would you approve of occupational therapy programs which involve their patients in community oriented functions? Check one:

_____ Yes, it would aid the patient's recovery
_____ No, I feel it has no place in the patient's treatment program

b. Do you have any special interest groups connected to your occupational therapy program?
Check one: Yes _____ No _____

(i) If yes, indicate the interest groups by a check in the blank provided.

_____ newspaper or journalism clubs
_____ gardening clubs
_____ bridge clubs
_____ book review clubs
_____ other (please specify) _____

(ii) What amount of success have you encountered with your special interest groups? Check one:

_____ excellent success
_____ moderate success
_____ poor success

c. Do you agree that it is important to keep psychiatric patients aware of the seasons and holidays in each season by festive occasions?
Check one: Yes _____ No _____

(i) Do you agree that this function should logically be included as a part of the occupational therapy program?
Check one: Yes _____ No _____

4. Tasks which allow the patient an avenue of expression:

a. Is the occupational therapy you provide related in a dynamic manner to recreation?
Check one: Yes _____ No _____

b. In working with group interaction processes in activity, do you most frequently act as a:

_____ catalyst
_____ observer
_____ part of the group
_____ leader

Category Two: Treatment planning.

1. Which type of treatment program contributes most to make occupational therapy services therapeutic?

   _____ A structured program
   _____ A nonstructured program

2. Do you place emphasis on the importance of fitting the task to the needs of the individual?
   Check one: Yes _____ No _____

   a. If so, how much importance do you place on this?

      _____ maximum
      _____ moderate
      _____ minimum

3. Do you insert any special short term programs into your group treatment plans in occupational therapy for specific expression of aggressive and hostile feelings?
   Check one: Yes _____ No _____

   a. If yes, how successful are they?

      _____ poor
      _____ moderately successful
      _____ very successful

   b. What controls do you have for this program?

      _____ a male aide
      _____ volunteer helpers
      _____ allied services with strength and authority
      _____ other (please specify) _____

Category Three: Treatment implications.

1. Do you think that most occupational therapists feel their program has no therapeutic value when a patient refuses to use occupational therapy as part of his treatment program?
   Check one: Yes _____ No _____

2. How much therapeutic emphasis do you place on the interaction between therapist and patient? Circle one:

   Very important — Sometimes useful

   Moderately important — Unimportant

   Important

3. Check the type of administrative policy which provides the O.T. with the most meaningful and practical method of operation.

   _____ blanket prescriptions
   _____ referred prescriptions from a professional source
   _____ referred prescriptions from a psychiatrist who will prescribe the type treatment he feels will be of benefit to the patient
   _____ open door policy with no prescriptions required

4. Do you feel that a patient's psychiatric occupational therapy experience should be referred to as a "treatment"?
   Check one: Yes _____ No _____

Category Four: Data gathering.

1. Have you ever been employed in an institution which uses problem oriented charting?
   Check one: Yes _____ No _____

   a. Do you prefer problem oriented charting to the progress notes?
      Check one: Yes _____ No _____

2. Are the patient's occupational therapy evaluation and diagnostic materials used by other services related to patient care?
   Check one: Yes _____ No _____

Category Five: Coordination between O.T. and other services in mental health centers.

1. Do you feel that hospital personnel do not realize the impact of occupational therapy on a patient's rehabilitation progress?
   Check one: Yes _____ No _____

   a. Of the list below, who do you feel is the least aware of this and who do you feel is the most aware of the impact O.T. can play on a patient's rehabilitation progress?

Doctors:	most aware ___	least aware ___
Nurses:	most aware ___	least aware ___
Aides:	most aware ___	least aware ___
Administrators:	most aware ___	least aware ___
Social workers:	most aware ___	least aware ___
Allied therapies:	most aware ___	least aware ___

2. Do hospital personnel come into the occupational therapy setting to observe patients at their tasks?
   Check one: Yes _____ No _____

   a. If yes, who?

   Nurses? Yes ___ No ___
   Doctors? Yes ___ No ___
   Aides? Yes ___ No ___
   Others? (please list) _____
   _____

3. Is your institution working under the "team approach"?
   Check one: Yes _____ No _____

   a. If no is your answer, would you like to have the opportunity to try the team approach to patient treatment?
   Check one: Yes _____ No _____

b. If yes, check one answer for each question.

(i) Is occupational therapy a contributing member of the team approach? Yes _____ No _____

(ii) In what areas does occupational therapy contribute to the team approach?

(a) counseling?	Yes ___	No ___
(b) charting?	Yes ___	No ___
(c) diagnostic?	Yes ___	No ___
(d) vocational training?	Yes ___	No ___
(e) avocational experience?	Yes ___	No ___
(f) vocational placement?	Yes ___	No ___
(g) family counseling?	Yes ___	No ___
(h) recreation?	Yes ___	No ___
(i) education?	Yes ___	No ___
(j) role modeling?	Yes ___	No ___
(k) expression of attitude?	Yes ___	No ___
(l) group centered O.T.?	Yes ___	No ___
(m) individual O.T.?	Yes ___	No ___
(n) post hospital treatment?	Yes ___	No ___

c. If no, by what means do you let hospital services involved in patient treatment know what O.T. goals are for the individual patient?

_____ inservice training sessions
_____ staff meetings
_____ informal discussions
_____ other (please specify) _____

Category Six: Determining present and future needs of psychiatric occupational therapy.

1. Should occupational therapy be included as part of the patient's admission procedures?
   Check one: Yes _____ No _____

2. Should occupational therapists minimize the use of handcraft skills in their treatment procedures?
   Check one: Yes _____ No _____

3. Should we as occupational therapists use the patient project as a basis for our verbal communications with the patient?
   Check one: Yes _____ No _____

4. How much do you use individual occupational therapy projects today? Check one:

   _____ completely
   _____ moderately
   _____ not at all

5. Do you use group occupational therapy activities in your psychiatric occupational therapy setting? (Group occupational therapy activity being defined as: one activity with one goal and one end product that a group of patients unite to do.)
   Check one: Yes _____ No _____

6. Should the patient be <u>invited</u> to occupational therapy?
   Check one: Yes _____ No _____

7. Should the patient be instructed to attend occupational therapy?
   Check one: Yes _____ No _____

8. On a scale of 1 to 5, how would you rate the need for more academic training for occupational therapists working in mental health in the areas listed below? (Check one category for each line)

	From: has enough training			To: needs more training	
	1	2	3	4	5
a. behavior modification	____	____	____	____	____
b. psychoanalytic concepts	____	____	____	____	____
c. transference and counter-transference	____	____	____	____	____
d. transactional analysis	____	____	____	____	____
e. role modeling	____	____	____	____	____
f. psychopharmacology	____	____	____	____	____
g. psychotherapy	____	____	____	____	____
h. psychodrama	____	____	____	____	____

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