

1939

Study of occupational therapy and its function in the children's mission to children: an analysis of thirty-one cases

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Thesis
Wilding

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Boston University
School of Religious and Social Work
Division of Social Work

A STUDY OF OCCUPATIONAL THERAPY AND ITS FUNCTION
IN THE CHILDREN'S MISSION TO CHILDREN

An Analysis of Thirty-One Cases

A Thesis

submitted by

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(A.B., Albion College, 1937)

in partial fulfilment of requirements for
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1939

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INTRODUCTION

I

INTRODUCTION

A. Purpose of the study

Children's Mission to Children is a children's agency specializing in caring for children who need convalescent medical care. About eighty per cent of the total case load is composed of medical cases, and of these about eighty-six per cent are cardiac children.¹ The most effective treatment of the illnesses causing cardiac involvement is complete bed rest, but such treatment is often difficult to provide. During the first few weeks of field work experience, the writer was impressed with the frequency with which mothers complained, "I can't keep my child in bed. There is nothing for him to do." Occupational therapy was being used to some extent in some of the medical foster homes as a means of keeping the children happy and occupied. If occupational therapy could aid in making a child satisfied to stay in bed, the only treatment which would produce effective cure, it was a tool about which the case worker should know more.

The purpose of this study is three-fold.

1. To survey the new but rapidly developing profession of occupational therapy and learn something

¹

These figures represent the average of the per cents taken from the Children's Mission statistical reports for months Jan. 1939 through May 1939. For exact figures see Table I.

TABLE I
PER CENT OF MEDICAL AND CARDIAC
CASES IN TOTAL CASE LOAD OF AGENCY

1939	Of whole load are medicals	Of whole load are cardiacs	Of whole medical load are cardiacs
January 31	78	67	85
February 28	79	68	86
March 31	79	68	86
April 30	80	70	88
May 31	82	71	88
Average of per cents for Jan. through May	79.6	68.8	86.6

of its history, its philosophy, and its purposes and values.

2. To study occupational therapy as it has been in effect in the Children's Mission to Children, with special attention being given to the work done with thirty-one children in the period of time, October 1938 to June 1939.
3. To make any conclusions based upon the survey of the field, the general observations and specific study of occupational therapy in the agency, that may be helpful in guiding the agency's policy toward the future occupational therapy program.

B. Method used in the study

The method used in making this study has changed considerably during the time that the study was being made. The writer is taking space to point out this change because she believes it is a means of showing the progress that has been made in the Occupational Therapy Department of the Children's Mission to Children within the brief time during which the material was being gathered for this study.

When the study was first contemplated, the material included the attendance record book in which the patient's name was listed and where the occupational therapist checked her meetings with the patient, the Occupational Therapy Recommendations slip which was to be filled out by the doctor who examined the child before placement, and the social case record kept by the social case worker. In addition, there was a form card on which the therapist was to keep a record of her visits and work done. This record was for the Occupational Therapy Department. There was a form sheet Progress Report to be

filled out by the therapist at the end of her contacts and included in the social case work file. These two forms were to be filled out during the year. With only the attendance book and the recommendations slips available at the beginning of the study, it is obvious that the material was limited. Consequently, the writer thought it wise to include spaces for considerable social information on the schedules.

In January, 1939, comparatively few of the card records for the cases selected had been completed. Of the thirty-one cases being studied, fourteen, slightly less than half, had Occupational Therapy Progress Reports filed in the case work records. However, in June, 1939, the outlook had changed. All but five of the thirty-one cases had card records filed in the Occupational Therapy Office; and twenty of the thirty-one had Progress Reports deposited in the case work records. This meant that the writer could shift the emphasis of the study from the social aspects to a more complete consideration of the occupational therapy aspects--an emphasis which she hoped would be possible for the study. (See Table II).

C. Selection of cases

Originally the writer intended to study the cases of all children receiving occupational therapy. They numbered about forty at the time. As the year advanced more names were added to the Occupational Therapy Attendance Book. Then it was realized that the list would be constantly changing because of

TABLE II
NUMBER OF SOCIAL CASE RECORDS
CONTAINING
OCCUPATIONAL THERAPY PROGRESS REPORTS

	Number with no O. T. Report	Number with one O. T. Report	Number with two O. T. Reports	Total
January, 1939	17	14	0	31
June, 1939	11	16	4	31

the discharging of the old patients and the coming of new ones. It was then decided to confine the study of cases to thirty-one, about half of the number of children then receiving occupational therapy. The cases were taken from the original list of patients. They represent a variety of ages of children, children of several workers, and children placed in several foster homes as well as in their own private homes. The writer feels the cases selected to be fairly representative of the cases handled by the agency and of those being assigned to the Occupational Therapy Department for treatment. (See Tables III - VII).

D. Limitations of the study

This study is by no means a comprehensive one. The number of cases studied offers a limitation. It is thought they are fairly representative. However, they were all cases in which the patients were enrolled in the Occupational Therapy Department early in the period of the study. If a group of cases in which all the patients were enrolled later in the year had been studied, the findings in regard to the Occupational Therapy Recommendations slips and records might have been different due to the education of the doctors and social workers and the increased experience of the student therapists. There might have been fewer discharges and so treatment could have continued for a longer period. However, the analysis has been made of various phases in this specific group of cases, and

TABLE III
SEX DISTRIBUTION OF THIRTY-ONE CASES

Sex	Number
Male	16
Female	15
Total	31

TABLE IV
AGE DISTRIBUTION OF THE
THIRTY-ONE CHILDREN
WHOSE CASES WERE STUDIED

Ages	Number of Children
3	1
4	1
5	0
6	7
7	3
8	4
9	3
10	5
11	1
12	5
13	0
14	1
Total	31

TABLE V
RACIAL DISTRIBUTION OF THIRTY-ONE CASES

Race	Number
Caucasian	29
Negro	2
Total	31

TABLE VI
DISTRIBUTION OF RELIGION OF
THIRTY-ONE CHILDREN STUDIED

Religion	Number
Roman Catholic	22
Protestant	9
Total	31

TABLE VII

WEEKLY INCOME OF FAMILIES OF THIRTY-ONE CHILDREN

Dollars	Independent	Dependent	Partially Dependent	Total
5 - 9.99	0	1	0	1
10 - 14.99	2	3	1	6
15 - 19.99	2	7	1	10
20 - 24.99	2	0	0	2
25 - 29.99	3	0	2	5
30 - 34.99	2	0	1	3
35 - 39.99	1	0	0	1
Unknown	1	1	1	3
Total	13	12	6	31

the findings are recorded for whatever they are worth.

It may be that too much emphasis has been placed on the technical phases, such as the filling out of the Occupational Therapy Recommendations slips. Yet occupational therapy treatment, if it is to be effective, must start with a medical recommendation. If occupational therapy is to develop skills and knowledge in relation to treatment for specific diseases, it must keep records. If occupational therapy is to be a part of a children's social agency, it has certain responsibilities to those doing the social case work. Study could be made of these technical phases because there were records available. It would have been difficult to include a study of the more subtle values of occupational therapy that do not get into the records--such things as the effects of the therapist's personality, her remarks, and her mannerisms on the patient; or the children's enthusiasm over a newly created toy.

Not all of the analysis can be reduced to statistical summaries. The section on the types of projects used for treatment is an example where figures are interesting but where their scientific accuracy and value is negligible. The writer purposely limited the analysis of the social findings. Only enough was included to give a sketchy idea of the type of children who were being studied. The findings are limited, but they are presented as fairly as possible in an attempt to reveal the work of the Occupational Therapy Department as it has actually functioned. Interpretation has been added when

it seemed warranted. None of the statements have been written in a critical spirit but in a spirit of truth tempered with sympathetic understanding of the difficulties confronting the Occupational Therapy Department of the Children's Mission to Children.

THE HISTORY OF OCCUPATIONAL THERAPY

II

THE HISTORY OF OCCUPATIONAL THERAPY

A. Early ideas of occupational therapy

It was in 172 A. D. that the Greek physician and philosopher, Claudius Galen, wrote that "Employment is nature's best physician and is essential to human happiness." Long before this date the Egyptians of about 2000 B. C. recognized the curative value that was embodied in work. Throughout the ages there have been varying concepts of work therapy and varying degrees of value attached to it.

B. Occupational therapy in United States

1. Beginnings and growth.

The conception of occupational therapy in the United States can be traced back to the early part of the nineteenth century. About 1815 Thomas Eddy, a member of the board of governors of the society of the New York Hospital, was interested in and studied the value of employment as a therapeutic agency. Other important influences of this period were exerted by Creighton, Arnold, and Rush. It was about this same time that Samuel Tuke of the York Retreat, near York, England, was studying employment for the mentally ill.

Even though occupational therapy made its beginning in this country over one hundred years ago, the real constructive

efforts to think of occupations as therapy, in a concept approaching the one we now have of therapy, was organized about seventy-five or eighty years later. It is interesting to note that the history of occupational therapy could be studied fairly accurately by tracing its development in the mental hospitals. Yet the field as it now exists encompasses much more than its use in the treatment of the mentally ill. As late as 1910 there was practically nothing written on the subject of occupational therapy. The written material which did exist was in the form of brief statements. The year 1910 also marked the beginning of an attempt to differentiate types of occupational therapy for special conditions.

2. Twentieth century influences.

The World War was a sudden impetus for this profession as it was for many professions and businesses. The war-time stories and press articles served to help educate the public to the needs which occupational therapy could meet. This type of therapy had much to offer the disabled soldier. It might be a means of exercise; it might give him confidence in the possibility that function could be restored to the disabled part of his body; it could divert his attention from his illness to wholesome and objective interests and activities. A special interest was stimulated in the application of occupational therapy to orthopedic cases. It was hoped that this interest would be carried over to civil life, but it was not. Fortunately, even though it was not carried over to civil life,

the occupational therapy movement did not suffer as so many movements do during a period of sudden growth by the well-meant enthusiasm of poorly informed disciples. Those people who are concerned about the development of this new profession believe that its slow beginning has insured a healthy growth. The next need was for a study of the development of the techniques used by the profession.

Another influential factor in the modern history of occupational therapy helped to meet this very need. There has been an introduction or revival in the United States of the fine handicrafts, and training in the arts and crafts is being offered more widely in both general and specialized educational institutions. The skilled workers resulting from increased interest and training are the only ones who will be able to build up a body of knowledge and organize information regarding technical skill and equipment--both vital in the shaping of the future of occupational therapy.

However, it is thought "that a more general use of this form of treatment will not be attained in United States until the physicians are taught more concerning it and until they know how properly to prescribe its use." Information regarding occupational therapy is not included in the curriculum of the medical schools and few teachers give the subject more than a passing interest. Occupational therapists are attempting to lessen this handicap by informing the public as well as the

¹
Dunton, Wm. R.: Prescribing Occupational Therapy, p. v.

physicians concerning the values of occupational therapy as treatment.

C. Philosophy of occupational therapy

1. Early concepts.

The history of this movement like that of so many others reveals that the conceptions of its purposes, aims, and objectives have changed as the movement has developed. It has long been observed that the natural recuperative powers of the human organism can be stimulated and strengthened by the use of regulated exercise of the mind and body and that such exercise, therefore, may be beneficially employed as a means of restoring health. Neither is the concept commonly expressed by the phrase "Mind over matter" of recent development. In writing "The Value of Occupational Therapy from a Medical Inspector's Standpoint," P. Smith has expressed this idea a little differently when he says that no two mental ideas can occupy and be carried by the mind at the same time.¹ Either one or the other will gain ascendancy and the stronger one becomes the less will be the effect of the other. These statements should make clear to us the importance of replacing the morbid, unhappy, worried thoughts by others of a more normal and healthy character. For a period the principal measures relied on for the purpose of exercising the body and replacing morbid

¹ Smith, P.: "The Value of Occupational Therapy from a Medical Inspector's Standpoint," Hospital Social Service, XXI, pp. 362-63.

thoughts were exercises, games, and other indoor and outdoor pursuits of a diversional nature. At this time the more substantial and lasting effects of productive work were given less attention and consideration than the immediate effects of the diversional activity.

2. The modern definition of occupational therapy.

Later it was realized that mere activity, just being busy, was not necessarily therapeutic. To be therapeutic the activity had to meet some physical or mental need. The definition of occupational therapy given by Dr. Pattison and quoted by William Rush Dunton, Jr., is conceded to be one of the best and is used widely by the professionally trained occupational therapists. This definition states that occupational therapy is "any activity, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to hastening recovery from disease or injury."¹

3. Interpretation of the definition.

The definition makes clear, in a brief way, the general purpose of occupational therapy. It also is stated so that there is no limit to the type of activity that can be used as long as it is an aid in attaining the objective. The therapy is to be "prescribed and guided." This implies that a doctor's advice is sought and followed regarding recommendations for the type of activity which would be advisable for the patient and regarding changes in the activity necessitated by

¹

Dunton, op. cit., p.3.

a change in the patient's health. It is the belief of William Rush Dunton, Jr., that practically every patient who is in a recoverable condition will benefit from prescribed therapy.

Occupational therapy can be used to make the chronically ill more comfortable and to make the patient requiring long time convalescence happier, or it can be used as a pastime for the patient who is ill for a short time. A. M. Coe, in writing about the value of occupational therapy in a general hospital, expresses the thought that even the patient who is hospitalized for a short time may need some solace of work, or what might be called "courage therapy." On the other hand, occupational therapy may have rehabilitation as its aim and the plan may be a constructive program which carries the patient from the first days of his illness to his maximum recovery and a readjustment to as much independency as is possible. Crippling disease may cause a shock to the nervous system that makes for more suffering than the physical disability itself. The therapist must know the patient's ambitions, attitudes, and fears in order to counteract the feelings of inferiority and incompetence by causing a feeling of capability and accomplishment. Occupational therapy can often give the interest and impetus needed to accomplish something; the sense of achievement, in turn, stimulates mental and physical activity. For example, a patient might be required to exercise his elbow but might abhor

¹
Coe, A. M.: "Occupational Therapy in a General Hospital,"
Hospital Social Service, XVIII, p. 424.

exercise as such. The prescription of weaving finds the patient interested in a creative art. The impetus of doing supercedes the task of exercising the elbow and the activity becomes pleasant and worthwhile.

The patient must not be allowed to stick to one type of work because he finds it profitable. Neither is the aim to turn out good products and only slightly improved patients. The occupation must have value as therapeutic treatment. As Marjorie Taylor has stated, "The true economic factor in occupational therapy is the functional restoration which makes possible the return of the disabled person to independency."¹

As has previously been stated, Dr. Pattison's definition of occupational therapy is a concise statement and yet allows for the interpretation needed to make it a workable definition. The Boston School of Occupational Therapy, in addition to using Dr. Pattison's definition, has composed a series of statements which tell more specifically what is the general idea involved in occupational therapy. "Occupational therapy aims to furnish a scheme of scientifically arranged activities which will give to any set of muscles or related parts of the body in cases of disease or injury, just the degree of movement and exercise that may be directed by a competent physician or surgeon. Stimulating heart action, respiration, and blood circulation accurately as prescribed and at the same time yielding some of the joy and

¹

Taylor, Marjorie: "Rehabilitation of the Disabled through Occupational Therapy," Hospital Social Service, XXII, p. 56.

satisfaction that wisely selected wholesome occupation provides in normal life, it thus takes its place with nursing, medicine, and surgery as one of the important departments of medical art."¹

The above statements of the Boston School of Occupational Therapy are in no way contradictory to Dr. Pattison's definition.

In fact, the fundamental meaning is the same, even though a different way of expressing it has been used. It would seem wise, therefore, for the purposes of this paper, to accept the views of occupational therapy as expressed by Dr. Pattison and the Boston School of Occupational Therapy as the approved modern concept that has resulted from the evolution of work therapy.

¹
Dunton: op. cit., pp. 3-4.

THE PURPOSES AND VALUES OF
OCCUPATIONAL THERAPY

III

THE PURPOSES AND VALUES OF
OCCUPATIONAL THERAPY

A. Purposes of occupational therapy

1. General purposes.

The two major divisions of this chapter are very closely related. The purposes, aims, and objectives of the profession of occupational therapy are set up to meet the general and specific needs of the patients receiving treatment. The values of greatest importance are, logically, those resulting from the needs having been met. Perhaps it is an encouraging sign to find that different writers concede similar purposes and values. There is some repetition in this chapter and yet the writer thinks it necessary to clarify the thinking and logic which should be aided by dividing the chapter into the two divisions of objective purposes and resulting values.

From personal experience or observation it can readily be understood that the individual who is ill has a feeling of being "let-down", feels below the state of mind of the normal individual and feels the absence of a daily routine. The physical inactivity reacts upon the individual mentally and makes him feel discontented. The inactivity interferes with his appetite, digestion, and other physical processes. The discontent and unhappiness resulting from inactivity in turn cause other

physiological changes. Hence a vicious circle is formed. Outside interests aid in bringing about happiness and contentment and thus aid in physical recovery.

Perhaps the above explanation makes it easier to understand why the basis for successful occupational therapy treatment is to create a pleasant mental state or emotion as well as to stimulate interest. Another essential to recovery is the development of resistance. The developing of resistance is one of the objects of curative work, and occupational therapy strives toward this goal through carefully selected and graded work.

J. F. Sands has pointed out three purposes of curative work and has classified them as the spiritual, the mental, and the physical.¹ Spiritually, occupational therapy should keep up the individual's self-respect and develop ambition and initiative. Mentally, it should develop coordination and mental poise. Physically, it should develop weak muscles through adapted occupation.

In Prescribing Occupational Therapy, William Rush Dunton has divided the objectives of occupational therapy into the mental and physical, even though he recognizes the fact that the two elements cannot be divorced and considered as separate entities. Physically, the goal is recovery. Mentally, the first objective is improvement of the patient's mental at-

¹Sands, J. F.: "When is Occupation Curative?" Hospital Social Service, XVIII, p. 263.

titude or morale. It is the contented, happy patient and not the depressed, apprehensive, or apathetic patient who has the better chance of recovery. Perhaps this writer would include in his mental objective what J. F. Sands incorporates under the heading of spiritual. For convenience then, these two or three headings can be accepted as inclusive classifications. However, there are certain other guiding principles and factors to be considered which, although they are included in the above groups, can be elaborated upon and in this way the reader can see more specifically how some of the above aims can be attained.

In selecting an activity for a patient the occupational therapists should think of what rate of heart action and blood circulation is best for building new tissue or helping recovery in a particular case, what the rate and depth of respiration should be, the specific muscles to be exercised and the character and extent of the movement, the joints to be flexed, the motor nerves to be used. In addition, the occupational therapists must consider the mental processes which should be stimulated--processes such as attention, observation, memory, creation, balance, restraint, interest. Occupational therapy may also be a means of training the individual in orderly habits of thought, in concentration, and may cause a better contact with reality by lessening day dreaming. Furthermore, seven principles for selecting the occupational activity have been noted and these principles also tend to show some of

the underlying theories of occupational therapy.

1. Occupational therapy should be prescribed and administered under constant medical advice and supervision, and correlated with the other treatment of the patient.
2. Systematic methods and precision is important. Dosage should be exact and the object to be attained should be kept in mind constantly.
3. Treatment should be specifically directed to meet the need of the patient.
4. The occupation should vary as the patient's strength and capability increase.
5. The only reliable measure of the results of the treatment is the effect on the patient.
6. The occupation should be within the patient's interest and capacity.
7. Employment in a group is usually the best. The accomplishment of a well made useful product enhances the satisfaction and adds to the good results.

2. Specific purposes.

Now that the purposes of occupational therapy in relation to illness as a whole have been considered, it might be worthwhile to see briefly what occupational therapy can do for specific types of sicknesses and handicaps.

Two authors writing from their experiences in the Mayo Clinic have stated that there are three objectives to be considered in selecting occupational therapy for orthopedic disorders.¹ First, there should be active exercise of the affect-

¹ Pattee, G. and Parlin, F. W.: "Occupational Therapy in Orthopedic Cases," Hospital Social Service, XIX, p. 438.

ed joints and muscles; second, improvement in the patient's morale; third, the education of the patient. To these writers the combination of medical therapy, soul therapy, and education means partial or complete rehabilitation.

The head occupational therapist at the Convalescent Home and School of the House of St. Giles the Cripple at Garden City, New York, has written about occupational therapy for the convalescent. The thought is expressed that a child's entire outlook on life may be altered by the helpful influence of being made to feel that no matter how crippled he may be, he still has a place to occupy in this busy world just as does the normal child. So many times illness and accidents indirectly cause a child to be spoiled, and he comes to think he cannot do anything. "If directed and inspired to feel that they (crippled children) can do things, they happily adjust themselves to their handicaps and find joy in their achievements...."¹ Not only does the directing of a child's energy in the right direction make him happier, but it also tends to insure the possibility that when he becomes an adult he will be comparatively free from that warped feeling of uselessness and inferiority. Much of the trouble encountered in helping crippled children adjust can be traced to some of the age-old attitudes toward the crippled. In early times the crippled were so persecuted that a proud spirit preferred to kill himself rather than suffer the

¹
Browning, R. C.: "Occupational Therapy During Convalescence," Hospital Social Service, XVII, p. 202.

martyrdom to which he would be subjected. The weaker personalities are inclined to feel that the world owes them a living and it is difficult to instill in them the desire for independency.

Writing from the viewpoint of the mental patients, Laurence Lunt makes four observations about occupational therapy that can be applied to other types of illness as well.¹ For these patients, occupational therapy should be an occupation engaged in by healthy people; it should have the dignity of a recognized way of earning an honest living. Thirdly, it should be so absorbing as to require close attention, and its results should be capable of yielding genuine satisfaction. Enthusiasm should not be forced but should be legitimate because of the worthwhileness of the end results. Lastly, it should be easy, but not too much so. There must be sufficient complexity to stimulate continued interest and sufficient complexity to reward growing skill.

Louis J. Haas in Occupational Therapy for the Mentally and Nervously Ill has made another contribution to our thinking about the mental patient. He thinks the mission of occupational therapy is to create a modified normal atmosphere in which the sick man may spend a percentage of his time. The normal atmosphere of the average man is work activity, the production of something masculine. Occupational therapy can create a real

¹ Lunt, Laurence K.: "Some Observations on Occupational Therapy," Hospital Social Service, XX, pp. 97-101.

work world in which man can live and engage in activities to the extent that he is conscious of the satisfaction of having done an interesting day's work. In this way occupational therapy can help him gain control of himself.

So far this chapter has been an attempt to point out the aims and objectives which serve as drives toward the goal for which the occupational therapists are striving. Necessarily incorporated with this material has been considerable theory which is vital if occupational therapy is to be understood intelligently. Now consideration must be given to the resulting effects of treatment by occupational therapy as they have been seen by people who have had much contact with such treatment.

B. Values of occupational therapy

1. General values.

It seems to be the consensus of opinion that occupational therapy has real value to the person who is ill and contributes toward his recovery. The individual who is ill does not feel up to his own level in spirit. His state of mind is below that of the normal individual. The daily routine is missed. The lack of physical activity reacts upon the individual mentally and makes him discontented. Physical inactivity also interferes with the person's appetite, his digestion, and excretions. Physiological changes lead to discontentment and unhappiness. These feelings, in turn, are associated with

further physiological changes. Perhaps this destructive circle could be broken if the person could be introduced to outside interests, one type of which is occupational therapy, and in that way be made more content and happier. Indirectly then, the outside interests would be aiding recovery.

Here again, we can grasp the idea of J. F. Sands who says that in order that occupational therapy may be curative it must develop resistance.¹ He has set up the spiritual, mental, and physical criteria which should be met if curative work is to be effective. He goes further and points out that carefully graded and selected occupational therapy does this very thing and so is useful. Spiritually, curative work is worthwhile because it prevents a waste of energy in worry and prevents ultimate pauperism. From the mental aspect, occupational therapy can often prevent a psychosis when the case is one of nervous disease or psychopathic personality. Lastly, it may be useful physically in cases where the joints and muscles are involved, and to cardiac and other diseases.

It should be remembered, however, that such criteria cannot always be fulfilled easily. Much insight is necessary so that the occupational therapist will be able to comprehend the spiritual needs of the patient. This comprehension is essential before the therapist can hope to direct the activity in a way which will fill the patient's needs. Much skill and knowledge is necessary so that the occupational therapist can

¹

Sands, op. cit., p. 263.

direct the work in order to have it curative and an aid in physical rehabilitation. Nevertheless, this insight, knowledge, and skill is essential to put occupational therapy on a basis that makes it truly valuable.

There are other general values of occupational therapy that should be mentioned here. Many times the work is done in groups. This is especially the case in the mental hospitals, but it is also the case in some convalescent homes. The opportunity to work together and to share with others can do much to develop social characteristics in the patient who is otherwise apt to lose his sense of social responsibility and his responsiveness to other people because of his hospitalization and the individualized treatment which he has received during his illness. Dr. Lewis B. Hill, writing from his experiences in the Worcester State Hospital, mentions that occupational therapy is valuable in preventing the out-cropping of serious characteristics which appear in any group of un-¹occupied men. Occupational therapy might be thought of as a constructive outlet for excess energy for some of the mental patients. This would not necessarily be true of patients suffering from other diseases. It also offers the patient a relief from his fears, emotions, and tensions, and in this way is an asset aiding recovery.

Such treatment adds interest and zest to what might other-

¹Hill, Lewis B.: "Value of Occupational Therapy in Mental Hospitals," Hospital Social Service, XVIII, pp. 447-53.

wise be a dull routine. Genevieve Hurd writes about the work done by the Victorian Order of Nurses in Montreal, Canada, and says that after the patient is referred by the physician for occupational therapy, the patient's outlook on life unconsciously is changed and he feels a new interest in things in general. Occupational therapy paves the way for the use of creative tendencies. It allows the patient to do something that will instill in him the sense of accomplishment. Accomplishment, in turn, may bring recognition by fellow patients and approval of superiors for the adult, and the approval of the adults for the child. All of these factors are vital to recovery from long and severe illness.

2. Specific values.

Again, we can shift from the consideration of the values which occupational therapy offers generally to people who are ill to the consideration of what it affords to patients suffering from certain specific diseases. Referring again to the writings of Pattee and Parlin, it is understood that they believe the value of occupational therapy for the orthopedic patient lies in the fact that the occupation can bring about the use of the affected parts because it encourages exercise and makes exercise interesting and constructive. Here too, there is the question of morale and effort is made to keep the patient happy. Another value is that it is a means of in-

¹Hurd, Genevieve L.: "Occupational Therapy for Chronic Patients," Hospital Social Service, XIX, p. 344.

directly educating the patient to care for himself.

Speaking from experience as an occupational therapist at the Hardwood Mental Hospital, Lanarkshire, Scotland, Annie Melrose writes about the worthwhileness of occupational therapy for the mental patients. The therapy can serve as a means of gradually bringing the patient back to reality. All existant energy is maintained or increased and non-existant energy is created.¹ Mentally ill persons also need an activity that will help restore self-confidence, a feeling promoted by accomplishment of some task. This author explains that severe illness is a big event in the lives of those who are ordinarily healthy; and it would be a pity if the patient should come through this experience and be no better mentally, to have gained no broader outlook on life, no greater tolerance and understanding toward others, no knowledge of how to rest and play so that leisure hours could be both pleasant and restful. Physical recovery is slow without activity that affords mental rest or distraction. Herein are the values of occupational therapy. In addition to aiding recovery, and putting the patient in a better mental condition educationally and socially, it offers protection against the hospital's sending home a neurotic, irritable patient who is little better for his experience.

Occupational therapy can be used as a means of making the dreamer more realistic, of making the indecisive stick to a

¹

Melrose, Annie H.: "Occupational Therapy at Hardwood," Hospital Social Service, XIX, p. 62.

decision and face reality, and of making the overactive slow down. The trained worker impresses the patient with the seriousness and repute of the therapy and has more value in handling the patients than have the ward attendants.

Dr. Pattison has written an interesting comparison between heart disease and tuberculosis.¹ This discussion includes the similarity of treatment needed. Mention of the two is made here because occupational therapy is a vital part of the treatment for both of these wide-spread illnesses. The best treatment for both is rest of body and mind. Rest from worry is just as essential as is proper diet and fresh air. Medication is more vital in heart disease than in tuberculosis, but hydrotherapy and passive exercise by massage are important in both. Graduated, supervised exercises are of supreme importance in convalescent treatment. Walking controlled by distance is the best form of exercise during convalescence. Occupational therapy, by which is meant any activity, mental or physical, definitely prescribed and guided, has been exceedingly useful in treatment of both the cardiac and tubercular patient. It is interesting to note Dunton's remark that the occupational therapy for tuberculosis has reached an exactness of application greater than in any other illness. Here are two illnesses in which therapy in the forms of occupation, graduated exercise and walking is extremely vital to recovery.

¹

Pattison, H. A.: "Points of Comparison Between Heart Disease and Tuberculosis," Hospital Social Service, XX, pp. 1-6.

The question of the activity to be allowed the cardiac patient during convalescence and to the greatest possible extent following recovery is a significant one. A social worker at Mount Sinai Hospital, Cleveland, Ohio, writes regarding the classification of cardiacs and the work they can do as it is dependent upon their ages.¹ Other writers have agreed with the statement of this author that non-productivity depresses the cardiac patient. If this is the case, it is especially vital that the patient be given treatment that will prevent, to some degree at least, the depression, and instead will offer interesting outlets for energy and mental activity.

An interesting experiment was attempted several years ago by the Bellevue Hospital in New York City. A small convalescent home for laborers with heart disease was opened so that they might get proper rest and could be taught a fitting trade. "The experiment was successful and in two years the important fact that heart cripples could do fairly hard work for the greater part of each day without aggravating their condition was established. In many cases it was found that the work not only benefited the patient, but actually improved the cardiac condition."² This does not mean that all cardiac patients should be put to work, but it does illustrate the fact that guided activity has good effects on the morale and on the

¹

Estrin, Rose Cohen: "The Industrial Placement of Cardiacs," Hospital Social Service, XXI, pp. 496-500.

²

Connor, L. A.: "The Rehabilitation of Cardiac Patients Through Organized Effort," Hospital Social Service, XVII, p. 121.

physical condition.

The second division of this chapter has been an effort to show that the results which can be gained from the use of occupational therapy as a tool of treatment are considered to be valuable by those who have studied the purposes of the profession and who have seen how it has strived to obtain lasting results.

THE OCCUPATIONAL THERAPY DEPARTMENT
AT CHILDREN'S MISSION TO CHILDREN

IV

THE OCCUPATIONAL THERAPY DEPARTMENT
AT CHILDREN'S MISSION TO CHILDREN

A. The Beginnings

At the meeting of the Board of Directors of the Children's Mission to Children on December 14, 1936, the Executive reported that an occupational therapist had been added to the staff as a part time member. The addition was made after the Board of Directors had appropriated the salary at a previous meeting.

For some time the Executive, the case workers, and the Board members had thought of the desirability of the agency's having an occupational therapist. They keenly realized the importance of keeping the cardiac children in bed. Yet children who are accustomed to activity do not happily submit to bed care. They need activity of some kind. The staff had come to believe that normal convalescence occurs more rapidly in people who are happy. Or, as Dr. Pollock expressed the idea at the Illinois Conference of Social Work, "Unhappiness is incompatible with convalescence, and I think this is the primary obstruction to all convalescence."¹

It was thought that occupational therapy had a real place in the program of the convalescent home. Convalescent homes must provide well balanced, nourishing meals; they must provide

¹
Pollock, Lewis J.: "Psychiatric Features in Convalescence", Hospital Social Service, XXIII, p. 465.

the prescribed amount of rest. A trained nurse is there to see that physical needs are met. Even the cardiac patient, however, has a few hours in the day that are not used in sleeping and eating. Worries and wishes frequent unoccupied minds. Children in medical foster homes are inclined to worry about the length of their stay in the home, the number of needles the doctor will put in their arm, the report of the last sedimentation rate, the visits to the dental clinic, the length of time before they can start getting up, the possibility of their not being able to play as other children. In addition to the normal wishes of children, there are two frequent ones, "I wish I were up, " "I wish I were home." Up to a certain point these worries and wishes are natural and are not harmful. However, they can become so intense that they interfere with the physical functions of eating and sleeping, and thus indirectly hinder recovery.

Occupied minds eliminate some of the danger of worry and discontent. For most of the children the daily foster home program must be limited in regard to activity. Time is allowed for the health regime, meals, and rest periods. During the school year time is allowed for lessons. If occupational therapy could be provided, that too, would have a definite place in the foster home schedule. The coming of the therapists would be an event that could be anticipated. The children could select some of their projects and could look forward to working on them. Projects would be a source of common inter-

est among children who had little in common but their illnesses. Finished articles could win approval and recognition. In addition, they might be useful gifts or toys. These are some of the more subtle values which occupational therapy could offer the social case worker at Children's Mission to Children. Happiness, contentment, freedom from worry, the joy of accomplishment, the satisfaction of having anticipation and having it fulfilled, cannot be attained easily with children who are ill. They are, however, essential parts of life. Neither can they be easily witnessed nor measured. Yet the total effects can be seen when an ill child is cheerful, when he accepts physical set-backs and can still be eager for health, when he has interest in both his own home and the foster home.

Occupational therapy had a real mission to fill in the homes of convalescing children. It might aid the development of morale, and indirectly aid recovery; it might help the development of personality.

Another factor had stimulated the agency's thinking along these lines. About two years prior to this action, the Children's Mission to Children and the Massachusetts General Hospital had undertaken a combined Heart Study. Arrangement was made so that the Massachusetts General Hospital could refer any of the patients in this study for placement at foster homes of the Children's Mission to Children. The occupational therapist from the Occupational Therapy Department of the Massachusetts General Hospital frequently visited the children

who were included in the Heart Study. She helped them make interesting projects; she left activity for them to work on during the week; she helped the children make gay window decorations that cheered them. The work done by the Massachusetts General Hospital occupational therapist served as a demonstration for the social case workers of Children's Mission. They wanted their children to have the activity which made the Massachusetts General Hospital patients happy. The children in the foster homes who did not belong to the Heart Study did not receive occupational therapy. Naturally, they felt that the care they were receiving was different from that received by the Heart Study children. They, too, wanted to have activity and to have the fun of making objects. The foster mothers in the various foster homes have always tried to direct the use of some of the children's leisure. Games, stories, and toys help make the time pass more quickly. However, the abilities of the foster mothers to do this type of work varied. Consequently, the children in the different homes did not all have the same opportunities for enjoyment and play.

The first occupational therapist remained with the agency from December 1936 to July 1937. She carried the occupational therapy program alone during her part time working schedule and visited as many foster homes as time permitted. Some of her efforts were made in the direction of encouraging the foster mothers to do more to direct the children's activities and energies toward constructive therapeutic pastimes.

B. The present program

In August 1937 the present occupational therapist came to Children's Mission to Children with a part time schedule of three days a week. It has been under her leadership that the agency has obtained students from the Boston School of Occupational Therapy during the last two school years. Officially the assignment to the agency by the school is for a period of six weeks, two days a week, but the length of time that a student works with the agency varies. Two students are usually assigned for a period. The students are assigned to certain foster homes or to private homes or a combination of both and are given responsibility for the occupational therapy work in these homes. (See Tables VIII - IX). It is true that such a program means frequent changes in the therapists in the homes that are fortunate enough to have the service of a therapist during the whole school year. However, a change of therapists means new ideas for projects; it means a new personality to which the children must adjust. Variety of this nature is good for children who are living a secluded and protected life for a period of several months. It helps keep them in touch with reality situations. On the other hand, the change of workers means that the child is always busy getting acquainted with the therapist and is apt to feel less able to talk freely and to express his personality as quickly. Each change is accompanied by a varying period of weeks when there can be no treatment.

TABLE VIII

TOTAL NUMBER OF VISITS AND DISTRIBUTION
OF TIME SPENT BY STUDENTS AND VOLUNTEERS IN
OCCUPATIONAL THERAPY DEPARTMENT, OCTOBER 1, 1938-JUNE 1, 1939

	Total visits	Total hours in visits	Hours in pre- para- tion	Hours in ob- serva- tion	Hours in travel	Hours in re- cord- ing
Student 1	23	36.75	46.5	6.5	23.	7 *
Student 2	46	51.75	30.	2.25	36.75	0
Student 3	21	32.	37.75	4.5	33.75	7
Student 4	32	44.5	29.5	6.25	55.75	7 *
Student 5	32	52.	14.5	0	60.	0 *
Volunteer	23	46.	14.5	0	57.5	0 *
Total	177	263.	172.75	19.5	266.75	21

*Time was not recorded on student's and volunteer's records but patients' records had been kept by them and so some time must have been used for recording.

TABLE IX
DISTRIBUTION OF TIME IN WEEKS SPENT
BY STUDENTS AND VOLUNTEER IN
OCCUPATIONAL THERAPY DEPARTMENT

Weeks	Number of students	Number of volunteers
7 weeks, 2 days	1	
8 weeks, 2 days	1	
9 weeks	3	
11 weeks, 2 days		1

This period is necessary so that the students may complete their records and prepare for examinations at the school. However, it does destroy the continuity of the treatment.

This year the occupational therapist also had a volunteer who has done occupational therapy. This person was experienced in caring for children and acquainted with handwork. She devoted half a day a week faithfully to occupational therapy in one of the foster homes. However, she was unable to continue her contribution throughout the whole year. Volunteers are used when they seek the opportunity to give this type of service, but they have been very few.

With the coming of the students the occupational therapist has given more of her time to their supervision and less to direct occupational therapy treatment of the patients. During the summer time, the occupational therapist reverts to the program of giving treatment to as many children as is possible or to children who need special occupational therapy treatment.

Thus Children's Mission to Children has added a department to the agency which is to help remedy one of the neglected elements in convalescent care. Elizabeth Gardiner has said, "Occupational therapy and recreation therapy are two active constructive elements which must be included in the regime."¹

¹ Gardiner, Elizabeth G.: "Neglected Elements in Convalescent Care," Hospital Social Service, XXIII, p. 553.

ANALYSIS OF THE STUDY OF THIRTY-ONE CHILDREN
RECEIVING OCCUPATIONAL THERAPY
AT CHILDREN'S MISSION TO CHILDREN

ANALYSIS OF THE STUDY OF THIRTY-ONE CHILDREN
RECEIVING OCCUPATIONAL THERAPY
AT CHILDREN'S MISSION TO CHILDREN

A. Analysis of Occupational Therapy Recommendations Slips

1. Function of the Recommendations Slips.

The social case workers' expectations of the benefits to be derived from the Occupational Therapy Department of the Children's Mission to Children are being fulfilled.

Mary, a bright, nine year old girl was visited at a foster home shortly after placement for rheumatic fever. She greeted the visitor with, "Oh, it is so nice here. It is so easy to stay in bed." Mary was lying quietly on the bed, but she was very busy. She was making a wool doll of yarn. She had selected the color herself. The activity required only a little finger motion and no arm motion. In reality, her mind was busier than her fingers. She told the visitor what other girls had made, what she wanted to make, and how they were going to decorate the rooms for the approaching holiday. Her enthusiasm subdued any regret Mary had about being away from home and not having her little brother with her.

One thirteen old girl had a severe cardiac condition. She had frequent attacks which frightened both the girl and her mother. Ellen worried a great deal about her health even though the doctor had assured her that she would not die during

one of her attacks. Ellen's activity had to be limited and carefully prescribed. Yet some activity was necessary in an attempt to relieve the worry. Girl friends came to see Ellen after school, but they played games and stayed too long. She was always tired after they left. Ellen liked to have the occupational therapist come. The therapist was young and talked to her about a variety of subjects while they worked together on projects. The therapist knew when she was tired and limited the activity accordingly. Ellen could only have the occupational therapist during one of the student's assignments to the Children's Mission to Children. She missed the therapy when it stopped and asked several times if it could not be arranged again.

Bob was a sixteen year old boy who was slowly recovering from rheumatic fever. It was hard for him to have to stay out of school and to miss the things done by the other boys his age. The visiting teacher came regularly and he studied very hard. Some day he hoped to be a doctor. The occupational therapist directed the use of some of his leisure. Model airplanes, blockprint Christmas cards, and leather work were interesting activities. The therapist could guide him so designs and projects requiring too much motion would be avoided. Bob has had two occupational therapists since the beginning of the study but it was difficult for him to understand why he had to wait six weeks after the first one stopped until the second one began visiting.

To the social case worker it does seem that occupational therapy is beneficial to the children who receive it. However, the benefits appear to be limited by the limitations of the Occupational Therapy Department. Perhaps analysis of the cases studied will aid in discovering the nature of the limitations.

The logical starting point for the analysis of the thirty-one cases studied of children receiving occupational therapy at Children's Mission to Children is at the point at which the occupational therapist has the first contact with the case. This is at the time when she receives the Occupational Therapy Recommendations, a slip filled out by the doctor who has examined the child just prior to placement. It has been pointed out in Chapter III that the purpose of occupational therapy is to aid in recovery. The doctor is responsible for directing the plans for regaining health. The occupational therapist, like the nurse, is dependent on the doctor's recommendations. In this specific agency, for instance, she hesitates to give treatment to the patient because she does not know whether or not the heart condition is such that the patient might be severely harmed by occupation. Thus, it can be realized that the doctor's recommendations are vital to the therapist and guide her in her planning of activity. It will be recalled that William Rush Dunton, Jr., stated "that a more general use of this form of treatment would not be attained until the physicians are taught more concerning it and until they know how properly to prescribe its use."¹ Obviously, for the good of the patient, it is

¹Dunton: op. cit., p.v.

important for the doctors to cooperate with the occupational therapist.

2. Use of the Recommendations Slip.

The number of cases studied was thirty-one, in which the total number of slips was thirty-three. Five cases had two Occupational Therapy Recommendations Slips apiece. Three cases had no slips. In addition to the name of the child, the slip calls for eight types of information--the date, name of the doctor, the hospital, diagnosis, precautions, suggestions, position when working, and length of working time. (See Form A). All of these slips were signed by a physician; they would have had no value otherwise. However, none of the thirty-three slips were filled out completely. Eight had only the doctor's signature; four had the date plus the doctor's signature. Such a slip gives the occupational therapist permission to give treatment but is very little aid in helping her plan suitable activity.

It will be noted that there are five items of information which deal directly with the patient's illness and occupational therapy treatment. These are diagnosis, precautions, suggestions, position when working, and length of working time. It is interesting to note the extent to which this information was given by the physicians. There were fifteen slips, not quite half, in which none of these five phases of information were supplied. (See Table X).

The next table shows the extent to which each of the eight phases of information were filled. (See Table XI).

TABLE X

EXTENT TO WHICH 5 PHASES OF INFORMATION
REGARDING TREATMENT FOR ILLNESS ON
OCCUPATIONAL THERAPY RECOMMENDATIONS SLIPS
WERE SUPPLIED BY DOCTORS

Of the 5 phases of information were given	Number
0	15
1	0
2	6
3	8
4	3
5	1
Total	33*

*Five of the 31 cases had two O. T. slips
apiece and three had no slips. Thus the
total number of O. T. slips studied was 33.

TABLE XI

EXTENT TO WHICH ALL PHASES OF INFORMATION
WERE SUPPLIED BY DOCTORS ON
OCCUPATIONAL THERAPY RECOMMENDATIONS SLIPS

Type of information requested	Information given	No information given	Partial information given
Name of doctor	33	0	0
Hospital	8	25	0
Diagnosis	15	18	0
Precautions	8	25	0
Suggestions	8	25	0
Position	10	23	0
Length of working time	12	21	0
Date	22	9	2

It will be noted on Table XI that only eight of the thirty-three slips gave the name of the hospital. However, through investigation and through acquaintance with the names of the doctors, it was learned to what referring agency the doctor belonged. The Children's Mission to Children has found through experience that it is advisable to have one or two doctors who serve on its staff part time. These doctors examine most of the children who are not coming to a foster home directly from a hospital; they visit those children in the medical foster homes if no other doctor is following them. For the purpose of this analysis these doctors will be called the "Children's Mission doctor". Several of the doctors belonged to the Boston Dispensary District Service, but they, too, will be grouped together for the purpose of this analysis. It was found that there were three medical agencies which submitted occupational therapy slips-- Boston Dispensary, Massachusetts General Hospital, and the Children's Mission doctor. The proportion submitted by each is shown in Table XII.

Further analysis of the slips of each group of doctors brought out interesting findings. Inasmuch as each slip was signed by the doctor, this one item of information was given. There were seven remaining items. The average was taken of the number of these seven items which were filled out on the slips belonging to each agency. The results are in Table XIII.

This section would not be complete without mention of the types of diagnosis included in this group of cases. The

TABLE XII
DISTRIBUTION OF AGENCIES WHOSE DOCTORS MADE
OCCUPATIONAL THERAPY RECOMMENDATIONS

Agency	Number
Boston Dispensary	18
Massachusetts General Hospital	7
Children's Mission	8
Total	33

TABLE XIII

AVERAGE NUMBER OF PHASES OF INFORMATION
SUPPLIED BY EACH MEDICAL AGENCY GIVING
OCCUPATIONAL THERAPY RECOMMENDATIONS

Agency	Average
Boston Dispensary	3.4
Massachusetts General Hospital	3.
Children's Mission	.125

diagnosis was included on fifteen of the slips. Of these the types were: chorea, 1; rheumatic fever, 2; rheumatic heart disease, 9; rheumatic arthritis, 1; bronchial asthma, 1; bi-lateral club feet, 1. Further investigation has shown that thirty of the thirty-three cases represented by the thirty-three slips were rheumatic fever, rheumatic heart disease, or chorea. The remaining three were bronchial asthma, rheumatic arthritis, and bi-lateral club feet. (See Tables XIV-A, XIV-B).

The picture painted by these findings is, on the surface, a dark one. Interpretation, however, may brighten it. It has been pointed out that thirty of the thirty-three cases were of rheumatic fever, rheumatic heart disease, or chorea. These are the types of patients in which the Children's Mission to Children has recently been specializing. The medical foster homes and their programs are so equipped and planned that this type of patient is given the best care possible. Consequently, the illnesses which the occupational therapist contacts most often are these three diseases. She is thoroughly acquainted with the needs of the average child who has rheumatic fever or chorea. The doctors who are using and visiting the foster homes frequently are acquainted with the set-up and may feel that the judgment of the occupational therapist along with the observation of the trained nurses in charge of the homes is to be trusted and respected. They might, if this was the case, see little need in wasting their valuable time filling out blanks. If this reasoning is followed further, it is understandable why the Children's

TABLE XIV - A

DISTRIBUTION OF DIAGNOSIS IN 15 CASES
 GIVING THIS INFORMATION ON
 OCCUPATIONAL THERAPY RECOMMENDATIONS SLIPS

Diagnosis	Number
Chorea	1
Rheumatic fever	2
Rheumatic heart disease	9
Bronchial asthma	1
Rheumatic arthritis	1
Bi-lateral club feet	1
Total	15

TABLE XIV - B

DISTRIBUTION OF DIAGNOSIS IN ALL CASES
 ACCORDING TO SOCIAL CASE RECORDS

Diagnosis	Number
Chorea	7
Rheumatic fever	12
Rheumatic heart disease	11
Bronchial asthma	1
Rheumatic arthritis	1
Bi-lateral club feet	1
Total	33

Mission doctor, the one best acquainted with the work of the foster homes and the agency, should feel that he can entrust the occupational therapy treatment to the occupational therapist.

In this connection, it should be noted that the three slips filled out for the patients having other than rheumatic fever or chorea were more complete. Of the seven items in addition to the name of the physician, these slips had four, five, and six of the items of information given. This is far above the average for any of the agencies where the highest average number of phases of information supplied was three and four-tenths.

However, if occupational therapy is to be recognized as a means of treatment which can be used by the medical profession for the furthering of their ends, questions arise regarding their recognition of this new profession to the extent that they will cooperate in an effort to make the work of the occupational therapist more effective. It is not the purpose of this paper to prove that the doctor should offer better cooperation. It should be pointed out, though, that the purpose of occupational therapy is to gain recovery. It also seems that any information and suggestions which would aid in attaining this end should be given to the occupational therapist.

B. Analysis of records in Occupational Therapy Department

1. Description of the records.

The records for the Occupational Therapy Department are kept on cards and are filed in an index box. The front of

the card provides space for identifying information, the diagnosis, the occupational therapy objective for the patient, the planned occupational therapy, and a brief social history. The back of the card has space for the dates of the visits, name of the workers, the amount of time spent in visiting, and the service rendered. (See Form B).

In addition the occupational therapist keeps an attendance book in which all patients are enrolled and in which the workers check their visits. All of the thirty-one cases studied were enrolled in the attendance book; it was from this source that the cases were selected. All but five of these cases had card records on file. Four of these five had attendance checked in the attendance book and had received some treatment. According to the attendance book, the one remaining child had been discharged in October and probably had received little or no treatment.

2. Study of attendance.

These records make possible studies of the attendance, or the number of visits made to the patients. However, discrepancies were found between the attendance checked in the enrollment book and the visits recorded on the card records. Usually the difference was only of one or two visits. These were traced and found to be instances such as occasions when the therapist called at the home but could not work with the patient because the child was ill or attending clinic. The record would note such incidents and a check in the attendance book would indicate a visit to the child. When such differences arose, the

writer used the number indicating the number of visits that the therapist actually worked with the child. There were other instances when the discrepancies were large. Eight visits would be recorded on the card and eleven to twenty-two visits checked in the attendance book. By comparing the dates of the recording with the dates checked in the book, it was noted that a shift of workers was the cause of the discrepancy. There would be no card record for the period when a certain worker had apparently been carrying the case. In such instances, the writer used for the number of visits, the number checked in the attendance book.

The total number of cases studied in respect to the question of attendance was thirty, because there was no record either on the cards or in the attendance book for one of the cases. It was learned that the median for the number of visits paid to the patients in the cases being studied for the period from October 1938 to June 1939 was nine. The average number of visits, using thirty as the total was 11.36. (See Table XV).

Likewise a study was made of the number of hours spent with the patients during the visits made by the occupational therapists. There was no record of the hours for the five cases for which there were no card records. The total for this phase of the study was therefore twenty-six. The median for the number of hours spent with each of these patients studied was 12.75. The average was 15.83 hours. The visits for the most part ranged between one and two hours and the usual time recorded was one and a half hours. (See Table XVI).

TABLE XV

DISTRIBUTION OF NUMBER OF VISITS
MADE TO THIRTY CHILDREN BY
OCCUPATIONAL THERAPISTS

Number of visits	Number of children
3	4
4	3
5	0
6	1
7	2
8*	4
9	2
10	0
11	3
12	1
13	0
14	0
15	0
16	3
17	1
18	0
19	0
20	0
21	2
22	1
23	1
24	1
25	0
26	1
Total	30

*Median

TABLE XVI
 DISTRIBUTION OF NUMBER OF HOURS
 SPENT WITH TWENTY SIX CHILDREN
 BY OCCUPATIONAL THERAPISTS

Number of hours	Number of children
3.	1
4.5	1
6.	1
8.	3
8.25	1
8.5	2
10.5	1
11.	1
12.	1
12.75*	2
14.5	1
17.	2
18.5	1
19.5	1
22.5	1
23.	1
25.75	1
29.	1
30.75	1
32.5	1
40.	1
Total	26

*Median

Analysis of the homes in which these children were living at the time they received occupational therapy shows that all but four were in medical foster homes. These four were being supervised at home and belonged to the Heart Study, a group of cases being carried for the purpose of a study being made jointly with a hospital. With such a small number of patients in this study getting occupational therapy, the writer hesitates to make comparisons. It should be noted, however, that the proportion of children getting occupational therapy in their own homes is small when compared to the number receiving occupational therapy in the foster homes. The average of the number of visits made to the four children who were getting occupational therapy at their homes is 9.75 as compared to 11.36 for the whole group. The average number of hours spent with these patients is ten as compared with 15.83 for the total. (See Table XVII).

It is not difficult to find the reasons for these differences. As the private homes are scattered and more time must be spent in transportation, less can be spent with the patient. Often the homes are in out-of-the-way places and automobiles are needed to reach them. Students do not usually have automobiles of their own and the agency has none available for this purpose. Transportation difficulties account to a large extent both for the small number of visits and the small number of hours spent with the patients. If a student can be assigned to a foster home where she can work with several children during one visit, she is using her time and talent to better advantage than if the

TABLE XVII

COMPARISON OF NUMBER OF VISITS AND LENGTH OF TIME GIVEN TO TREATMENT OF CHILDREN IN PRIVATE HOMES TO THAT OF WHOLE GROUP

	For whole group	For children in private homes
Average number of visits	11.36	9.75
Average total time in O. T.	15.83	10.

same time is spent with one child. This is a factor to be considered when time and workers are limited. Yet, it does not mean that the child in his own home is in less need of an occupational therapist who can show him how to keep interestingly and constructively occupied and thus make it easier for him to stay in bed.

Due to the fact that much of the occupational therapy was done by students who were assigned to the agency by the Boston School of Occupational Therapy for a period of six weeks, the patients who received treatment for an extensive period had more than one occupational therapist. (See Table XVIII). This does not mean that all nineteen patients received treatment for one period and were dropped the next. It was impossible to give all the children occupational therapy during all of the sessions and so some who received it the first session had to go without it the next two so that another patient could be given the treatment. In some of the medical foster homes, however, the children received occupational therapy during all the sessions.

A study has been made of the thirty-one cases analyzed to determine how many weeks of treatment were given in comparison to the number of weeks that the children could have been given occupational therapy. The number of weeks the children could have had treatment depends upon the length of time of placement and supervision at home. No time before October 1, 1938 was included. The total number of weeks between October 1, 1938 and June 1, 1939,--the largest number of treatments the children

TABLE XVIII

DISTRIBUTION OF CHILDREN RECEIVING
TREATMENT FROM ONE OR MORE THERAPIST

Number of therapists	Number of children
1	19
2	2
3	9
Total	30*

*This total does not include the one case for which no therapist was listed.

could have had--was thirty-five. This, however, makes no allowance for vacations. The number of treatments actually received were subtracted from thirty-five to determine the extent to which treatment might have been given but was not. The periods during which children were being supervised at home were counted because occupational therapy can be, and should be given to children convalescing at home as well as to those in medical foster homes. Realizing, of course, that thirty-five treatments is the maximum and that treatment of all children at home as well as in the foster homes is an ideal situation, the writer has found the following results. (See Table XIX). Of the thirty-one cases, there were sixteen in which the treatments given equaled at least half of the number of treatments that could have been given.

3. Types of projects used.

Another type of information given on the card records of the Occupational Therapy Department is notes regarding the projects which were undertaken with the patients. The planned activities are given on the front of the card and those actually used are noted in the comments under "services rendered". The writer made notation on the schedules of the activities actually undertaken with each child for whom there was a card record--twenty-six in number. These figures are not absolutely accurate because occasionally some coloring or cutting, or some other ordinary pastime was omitted from the list. Each patient had taken part in several activities depending upon the time he had

TABLE XIX

DISTRIBUTION OF DIFFERENCES BETWEEN NUMBER OF WEEKS
 OCCUPATIONAL THERAPY TREATMENT WAS GIVEN AND
 NUMBER OF WEEKS IT COULD HAVE BEEN GIVEN

Number of weeks difference	Number of cases
0	3
1	0
2	0
3	1
4	2
5	1
6	1
7	1
8	1
9	2
10	1
11	0
12	2
13	1
14	4
15	1
16	0
17	0
18	2
19	0
20	1
21	0
22	0
23	1
24	0
25	0
26	0
27	3
28	2
29	0
30	0
31	1
Total	31

been receiving treatment and his own skill and rapidity of work. All children had frequent occupation with holiday projects. At Halloween the activities included the making of paper pumpkins, a variety of masks, and decorations for the foster home.

Turkeys--paper and pine cone turkeys--were a Thanksgiving activity. At Christmas time there were decorations to be made for the homes and for the Christmas trees, as well as manger scenes, Christmas presents, and Christmas cards. The remainder of the work divided itself into a wide variety. Animals were often made and made in a variety of ways; they were jointed, stuffed, or made of cork or sponge. Yarn and sewing projects were popular. (See Table XX).

As far as observation and investigation could reveal, there was no indication that there was a planned program for the cardiac children and that projects of increasing difficulty were given as the child's health improved. The occupation seemed to vary with the age of the child, his skill and patience, and any special need of exercise. However, the therapists were always careful in planning activity to see that it was within the limits allowed by the cardiac condition. Notes on the records showed instances where the therapist changed the activity when a child became too excited or shortened the time of the treatment when it seemed necessary for the child's physical well-being.

As a child was allowed to be up longer periods of time, it was possible for the patient to move around the room during

TABLE XX

DISTRIBUTION AND TYPES OF PROJECTS USED

Type of project	Number of cases used
Blockprint cards	4
Rope sandals	1
Cardboard picture frame	4
Cork animals	4
Autograph book	4
Bead doll	3
Valentines	6
Jointed animals	8
Stuffed animals	4
Wool doll	5
Pillow cover	4
Airplanes	3
Leather work	3
Coloring	5
Sponge animals	2
Jig-saw paper knife	2
Cutting	2
Posters	1
Clay work	1
Water coloring	1
Felt applique	1
Doll's dress	3
Weave-it projects	5
Yarn flowers	5
Yarn Santa Claus	2
Wall hanging	1
Clinic project	1
Linoleum pin	1
Crepe paper mat	1
Crepe paper bottle	1
Desk set	1
Jointed cowboy	1
Doll's slippers	2
Ink stand	1
String holder	1
Painted placque	1
Sail boat	2
Crocheting	1

therapy and this child could go to the therapist for instructions and could often help in taking material to children still in bed. Among the cases studied there were few patients who needed special projects for therapeutic values. One boy was given work with clay to strengthen his fingers. The girl with rheumatic arthritis was given projects to strengthen her wrists and she was allowed to do a great deal of crocheting in her leisure time.

4. Study of the objectives.

On the front of the card record provision is made for noting the objectives which the occupational therapist hopes to accomplish with the patient. These objectives are also listed on the Occupational Therapy Progress Report in the social case record. The comments were similar on both records. In addition the Progress Reports sometimes included statements regarding the accomplishment of the objective. Table XXI shows the type of objectives for which the occupational therapists were striving. There were five patients for whom there were no records. More than one objective was frequently listed for each patient. It should be noted that the objective to "teach useful things" was listed by the volunteer worker and not by the students who were being trained in occupational therapy. The objective "to exercise hands and wrists" was for the patient with rheumatic arthritis. Here is an example of occupational therapy which is definitely prescribed to meet a medical need.

It is interesting to note that the recording of "services rendered" included remarks regarding the personality of the

TABLE XXI

TYPES OF OBJECTIVES FOR WHICH
 OCCUPATIONAL THERAPISTS STRIVED
 WITH TWENTY-SIX CHILDREN

Objective	Number of children
None listed on card	6
Planned activity with limited action	8
Feeling of accomplishment	4
Quiet, restful occupation	11
Overcome shyness	1
Practical use of leisure	2
Help coordination	3
Develop strength	1
Develop self-confidence	1
Exercise hands and wrists	1
Stimulate interest	1
Teach useful things	2

child. Comments included such things as the rapidity, the carelessness or carefulness with which the patient worked. Remarks about improving physical conditions, improving habits of concentration, attention, were included. Some children appeared to be the leaders in the groups. Unusual behavior of the child was noted as were the effects of punishment. Information of this type might very well be of value to the social case worker whose contacts are usually for a shorter period and of a more formal nature.

C. Occupational Therapy Progress Reports

Of the thirty-one cases studied, nineteen had one or two Progress Reports included in the social case records. These reports are summaries of the work done by the therapist during her contacts with the child. The information included was very similar to that recorded in the card records of the Occupational Therapy Department. It is for this reason that little space is given here to the discussion of these reports. The statements were largely general in nature. They lacked the specificity of the Occupational Therapy Department records. They would, however, have values for the social case worker who could not take the time to look up the records of all her clients in the Occupational Therapy Department file. (See Form C).

D. Mention of occupational therapy in Social Case Records

Note was made of the number of times occupational therapy

was mentioned in the social case records. Of the thirty-one cases studied, comments about occupational therapy occurred in six of the social case records. Two remarks stated that permission had been obtained from the doctor or the Occupational Therapy Recommendations Slip had been signed. Two of the comments were concerning the objects being made and the work being done. In each of the remaining two cases, statements regarding occupational therapy appeared three times. Both of these were Heart Study cases. In one case remarks were confined to the occupational therapy as it was given the child by the Massachusetts General Hospital therapist. They were about his reactions to the activity and his love for it. The remaining case told of the mother's complaints that the boy did not have enough to keep him busy even though he was receiving occupational therapy treatment. He was unwilling to let the therapist show him how to perform the activity. Instead, he wanted to direct her work. The social case worker discussed the case with the occupational therapist and summarized in her case record the Occupational Therapy Progress Report. This last instance, seems to the writer to more closely approach the type of cooperation that should exist between the social case worker and the occupational therapist when they are striving toward a common goal in physical and personality achievement for the child. (See Table XXII).

However, it should be remembered that the Heart Study cases are being carried as a separate case load and are fewer in number than the usual case load of a social case worker. As

TABLE XXII
DISTRIBUTION OF SOCIAL CASE RECORDS
IN WHICH MENTION WAS MADE OF
OCCUPATIONAL THERAPY

Times O. T. mentioned in case records	Number of cases
0	25
1	4
2	0
3	2
Total	31

their records are to be carefully studied, a great deal of time and thought is being put into the writing of them. Perhaps in the last case mentioned, there was more need of cooperation between the case worker and the occupational therapist inasmuch as the therapy was being used for the purpose of personality development as well as for physical outlet. In the largest percent of the cases receiving occupational therapy, those in the medical foster homes, the principal concern is to provide activity that will make the children happy and more content to remain in bed. In such cases the social workers may be justified in being less concerned over their occupational therapy activities.

CONCLUSION

VI

CONCLUSION

Occupational therapy is not a cure-all, but it has won its place as a valuable tool which can assist the social case workers of a children's medical agency in gaining their objectives. The accomplishments of the Occupational Therapy Department of the Children's Mission to Children have warranted a study of its functions. The Occupational Therapy Department has been a recent addition to the agency and has gradually been working out a system which will meet the immediate needs and lay a foundation for an enlarged program when it may be adopted.

Tony, a little Italian boy under the care of the Children's Mission to Children, has had rheumatic fever four times. The doctors are limiting his activity and guarding against serious heart damage. He would rather die than not be able to play as the other boys. The coming of the occupational therapist eased the situation. Tony would come home from school immediately after it was dismissed so he might work on his projects. After he once got home, his mother could supervise his activity and rest periods. However, Tony could only have the therapist during one of the student's period of assignment to the agency. After that his thoughts turned to coasting--an activity too strenuous for this child.

There are many other children like Tony and like the other children mentioned in Chapter V who need the services of an

occupational therapist. There are children in medical foster homes who will miss their own homes less and be more content if a full program can occupy their minds. Jane needs special exercises to strengthen her wrists. Crocheting and intricate work on dolls for an exhibit has increased the amount of exercise without increasing the monotony. Clay work was used to help strengthen Jimmie's fingers.

One vital factor in programs that are to carry over long periods of time is the keeping of records. For the most part the Occupational Therapy Department records were fairly well kept. There were some cases for which there were no card records, and discrepancies between the card records and the attendance book showed that not all contacts by all therapists had been recorded. Here is an opportunity where improvement can be made. Often if the child had been discharged shortly after the beginning of the treatment, no record was kept. However, it is just as important to know what was done by this child in a short period as it is to know what happened in cases known over a long period of time. It must be remembered that the writing of records takes time, and time used in that way cannot be used in giving occupational therapy treatment to the children. With only a part time occupational therapist and student help, it may be necessary to make a choice about the way in which their time will be spent. The Occupational Therapy Progress Reports seemed to be less regularly kept and their value was limited by the general nature of the statements.

It is unfair to say that the mention of occupational therapy in the social case records is an indication of the social case workers' interest in occupational therapy treatment. However, there were few cases in which it was mentioned. Here, too, time and space of recording are factors to be considered. Yet, if occupational therapy is to be recognized as a part of the care given by the agency, as a case work tool just as foster home care and clinic facilities, then it does seem that it should be given some recognition in the social case record.

Better cooperation with the medical profession is another need. In Chapter V an explanation is given of the reasons for this apparent neglect and of the fact that it does not greatly interfere with the occupational therapy treatment because the therapists have a large per cent of cardiac patients and are acquainted with their needs. "evertheless, the occupational therapy profession has its standards just as does the medical profession and they should be respected. During a recent interview with the occupational therapist, it was learned that the Occupational Therapy Recommendations Slips have shown considerable improvement during the last part of the year. The doctors are slowly becoming educated to their usefulness. The social workers have cooperated well and have done everything possible to make it easier for the doctors to fill out the slips. No doubt, if the social case workers will continue to assume responsibility for the filling out of the Occupational Therapy Recommendations Slips, the doctors will have less chance to

forget them.

The occupational therapy program is still a little too much a thing in itself. The other professions--the doctors and the social workers--are slowly coming to see it as a tool aiding their work. As this concept becomes more firmly entrenched, the occupational therapy program will then seem more a part of the whole of the agency and not so much a separate phase.

The principal difficulty, however, probably lies in the fact that the occupational therapist has only three days a week in which she works for the Children's Mission to Children Occupational Therapy Department. It is impossible for treatment to be given to all children when there is so little time to devote to them. The students during the school year ease the situation somewhat. Usually there are two students who give two days a week. However, they have vacations and have to fit the therapy into their school program. The head occupational therapist must devote some of her time to the supervision of the students. Even then, there is not the help nor the time necessary to give treatment to all children needing it. Volunteers are used when they are available. This may be a source of getting more workers. However, volunteers, because they are giving their time are apt to be irregular and let their personal activities interfere. They would still represent the agency and the children would accept them as such and make no excuses for their being volunteer workers. It would be difficult to keep the faith of the children, if the therapists came too irregularly; they would

lack activity; they could not plan on the coming of the therapist and the fun they would have. Relationships between the agency and the children are vital to the social case worker and should be guarded religiously.

The needs of Tony, Ellen, Bob, Mary, and Jane should be met. Interesting projects in the foster home relieves worry and anxiety; interesting projects at home lessen the temptations of coasting and running up and down hills. Young children need activity that will allow them to rest quietly in bed; adolescent children need activity that will encourage them with the feeling of having accomplished something. There is a need to extend the amount of time given to the occupational therapy treatment of the children. However, this can be done only as the staff of the Occupational Therapy Department is increased, either in the time for which the occupational therapist is employed, or in personnel, or both.

On the whole, considering the difficulties confronting an occupational therapist trying to do a full time task in a part time job, and considering the improvement witnessed since the beginning of this study, it would seem that the Occupational Therapy Department of the Children's Mission to Children is contributing much as a tool which can be used effectively to gain the ends of social case work.

SCHEDULE

STUDY OF CHILDREN RECEIVING OCCUPATIONAL THERAPY
AT CHILDREN'S MISSION TO CHILDREN

1. Name of child:
2. Case name:
3. Age of child:
4. Source of referral:
5. Foster home in which child is placed:
 - a. Number of other children in home:
 - b. Capacity of the home:
6. Date of placement:
7. Date of discharge:
8. Person to whom discharged:
9. Date O. T. began:
10. Date O. T. ended:
11. Doctor following child:
12. Hospital:
13. Recommendations of doctor for O.T.:
 - a. Diagnosis:
 - b. Precautions:
 - c. Suggestions:
 - d. Position when working:
 - e. Length of time working:
14. Occupational Therapist working with child:
15. O.T. objective for child:
16. Type of O.T. used:
17. Number of visits:
18. Approximate number of hours:
19. Time in own home since discharge from foster home:
20. Time of supervision in own home by C.M.:
21. Reapplications for foster home care:
 - a. Dates:
 - b. Action taken:
22. Replacements:
 - a. Dates:
 - b. Home:

SCHEDULE

-2-

-
23. Make-up of family:
- a. Mother:
 - b. Father:
 - c. Number of siblings:
 - d. Ordinal position of child:
 - e. Others in family:
24. Marital status:
25. Religion:
26. Financial status:
- a. Weekly income:
 - b. Source of income:
 - (1) Private employment:
 - (2) Public employment:
 - (3) Social agencies:
 - (4) Others:
 - c. Degree of skill:
 - d. Regularity of income:
 - e. Members of family working:
27. Environment:
- a. Type of dwelling:
 - b. Number of families in house:
 - c. Number of rooms:
 - d. Floor on which child lives:
 - e. Light:
 - f. Ventilation:
 - g. Heat:
28. Social problems noted in record:
29. Methods of treatment used:
30. Response to treatment of C.M.:
31. Record of O.T. in visitor's record:
- a. Number of times O.T. is mentioned:
 - b. Nature of comments:
32. Remarks:

FORM A

CHILDREN'S MISSION TO CHILDREN
Occupational Therapy Recommendations

Name of child

Date

Diagnosis

Precautions

Suggestions

Position when working

Length of working time

Signed.....
M.D.

Hospital



FORM B

CHILDREN'S MISSION

OCCUPATIONAL THERAPY

Name:

Address:

Age: Dr.:

Hospital:

Diagnosis:

Purpose of Occupational Therapy:

Occupation Planned:

Restrictions:

SOCIAL HISTORY

FORM C

CHILDREN'S MISSIONOCCUPATIONAL THERAPY DEPARTMENT
Progress Report

To include:

Your Objective for Patient:

Type of Therapy used:

Attitude: Cooperative Seclusive Resistive Friendly
Impulsive Irritable Indifferent Self-
assertive Moody

Manner: Normal under existing conditions:

Work: Attitude toward Interest in kind Ability to
learn Concentration Versatility Team workPlay: Sportsmanship Skill Emotional reaction
Response to type

Remarks:

Indicating development or retardation

Do you feel that you have gained any part of your
objective? Why?

Signed.....

Write detailed report following suggested outline.

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