THE ISSUE IS

Diversional Activity: Does It Deserve Its Bad Name?

No word in the English language is as upsetting to an occupational therapist's ears as the word diversion. It strikes at the core of the occupational therapist's being and threatens her or his very existence. The idea that some activities used in occupational therapy might be diversional is heretical to many in the profession; diversion is seen as unscientific and therefore dismissed as inappropriate for use by professionals as a means of treatment. In this paper I reexamine the original concept of diversional activity so that we will be better able to decide whether it should have a place within the current context of treatment. To examine this issue in some breadth, I will make reference to both American and Canadian experience and I will assume that the profession has developed in a similar fashion in both countries.

Historical Review

The concept of diversion is deeply embedded in the origins of the profession. The direct lineage of the birth of occupational therapy from within the Moral Treatment movement of the 1800s makes this clear (Barris, Kielhofner, & Watts, 1983). In fact, throughout history, diversion has been a strong theme in the treatment of illness in general, and of mental illness in particular. Along with purposeful occupation and employment, diversion was given a prominent place by the Egyptians in 2000 B.C., the Hebrews in 1030 B.C., and during later periods in both Greece and Rome (Haas, 1946).

According to the account given by Haas (1946), it was not until around 1915 that the therapeutic value of diversional occupation was called into question. However within a few years, World War I had begun to take its toll, and therapists no longer had the luxury of pondering this question; instead they began to treat the thousands of sick and injured soldiers who returned home using the wide range of activities then at their disposal. In Burnette's (1923) words, it appeared that occupational therapy had been "transformed overnight by the exigencies of the war into an honoured if somewhat bewildered guest at the doctor's table" (p. 179).

In the early twenties, diversional activity was given an important place in Adolf Meyer's (1977) psychobiological approach to the treatment of mental illness. Meyer, a prominent psychiatrist and one of the founders of the profession of occupational therapy, saw occupation as helping to fulfill one of the necessary conditions for health, that is, in achieving a proper balance between work, play, rest, and sleep—the activities of life. And if a balance was necessary to maintain health in those who were well, then it was also good treatment for those who were ill. In fact, Meyer stated "the proper use of time in some helpful and gratifying activity appeared to me a fundamental issue in the treatment of any neuropsychiatric patient" (p. 639). It should be noted here, that Meyer believed in providing opportunities for activity and not prescriptions. Neither was he concerned about an activity's ability to simulate work; rather he suggested that the leading principle in selecting activities should be any form of helpful enjoyment.

The psychobiological theory that Meyer advocated saw mental illness as primarily stress induced. According to this theory, any one person could be more or less predisposed, biologically, to respond poorly to stress, but it was socioenvironmental forces that caused disequilibrium, and disequilibrium resulted in mental illness. To recover, the individual needed to be protected both physically and mentally from the stressors. Physically this could be accomplished with the help of a supportive family or by admission to a hospital; but mentally this protection could only be achieved—in the days before medication—by activity. Since the Moral Treatment era the view had prevailed that no two absorbing thoughts could occupy the mind at the same time (Bockhoven, 1972). Activity, it was thought, could not only divert one's attention from stressors, it could even preclude stressful thoughts from invading. Ultimately, activity would become habit, and in this way, the balance and
rhythm of healthy life would be reestablished (Kaplan & Sadock, 1985).

The idea that attention should be diverted from stressful situations, and that activity could be used for this purpose, continued to be incorporated into treatment during World War II when it became obvious that socioenvironmental stress was a contributing factor to the conditions seen in soldiers. Canadian occupational therapists, sent abroad to treat their country's soldiers, were asked to give special consideration to the needs of these people who, being away from home, were seen as suffering an additional, specific stress. Howland, the first president of the Canadian Association of Occupational Therapists (CAOT), noted that Canadian soldiers would have fewer visitors than English soldiers, and hence less stimulation. Thus, activities were used in something of a preventive fashion, with the understanding that if morale were poor, recovery would be impeded (Howland, 1944). It is interesting here to recall that one of the meanings of the word moral in the Moral Treatment movement was expressed in terms of morale: It was considered important to instill in patients feelings of enthusiasm, hope, and confidence (Bockhoven, 1972). Thus it was not uncommon to see injured servicemen occupied in activities unrelated to their disorders, activities that had been provided solely for the purpose of maintaining or raising morale. The activities were relevant and therefore meaningful, and they were often product oriented and therefore purposeful, but they were, nonetheless, diversional; they were designed to divert the soldier's attention from the stressful situation.

At that time most conflict over the idea of diversional activities not being therapeutic probably stemmed from the fact that diversional activities could not be considered work or simulations of work. In the early years of the profession in Canada, work played a very central role and activities were often selected for their ability to assess vocational interests and aptitudes, particularly with war veterans (Robinson, 1981). It should be remembered, however, that worklike activities had initially been chosen because of their ability to divert attention, that is, for the explicit purpose of diverting the ill person's preoccupation with himself or herself and with his or her brooding and destructive thoughts. This was the case particularly for those suffering from mental illness, but it was also recognized as necessary for the physically ill. In an article written for the Canadian Geographical Journal in 1944, which was reprinted in the Canadian Journal of Occupational Therapy in 1986, Howland delineated five forms of occupational therapy, as follows:

1. Diverstional treatment for the purpose of keeping the patient interested over a long period of time.
2. Physical treatment for restoring the activity of muscles, joints, and tendons.
3. Recreational treatment, a combination of diversional and physical activity associated with games and sports.
4. Psychological treatment for nervous and mental cases, to restore normal mental action by carefully selected diversion.
5. Preventive treatment, which is purely diversional or recreational, for the prevention of nervous and mental states and for the retention of morale in hospitals, and for troops in camp. (italics mine) (p. 19)

It is clear from Howland's account that occupational therapy was considered an important form of treatment and that within occupational therapy, diversional activity played a significant role.

The next and perhaps the most serious challenge to the concept of diversion as part of the treatment process came in the forties and fifties when the impact of the medical model came to be felt in occupational therapy (Kielhofner & Burke, 1983). The reductionist paradigm of the medical model demanded that everyone on the team be engaged in treating the broken parts of the individual. Occupational therapy rose to the challenge, and activities soon became directed almost exclusively at attacking pathology. Dunton and Licht, writing in 1957, still alluded to the need for mental stimulation for those who were bedridden. They stated, somewhat begrudgingly, that "although it is not strictly therapeutic, it remains highly desirable for patients who wish to be occupied . . . to have that wish granted if it is consistent with their medical management" (p. 27). But the idea that occupation in itself could be health giving was no longer considered respectable.

The reductionist paradigm of the medical model first found its expression in psychiatric occupational therapy within a psychodynamic perspective. As psychiatrists began to see value in occupation, they began to prescribe the form it should take, thus placing occupational therapy even more squarely within the framework of the medical model. Diagnostic categories became very important, and patients who exhibited symptomology were now given activity y, with the firm conviction that this was a treatment that directly addressed the psychopathology (Dunton, 1945). Although there undoubtedly was some merit to this approach, it is important to note that studies which have examined the meaning of activity (Aliard, 1964; Fox & Jirgal, 1967; Henry, Nelson, & Duncombe, 1984; Kremer, Nelson, & Duncombe, 1984; Smith, Barrows, & Whitney, 1959) have found striking discrepancies between the meanings attributed to activities both within and across various populations and under varying conditions. (See McColl, Friedland, & Kerr, 1986, for a review and discussion of this literature.)

Thus, the focus in occupational therapy which had hitherto been on the importance of occupation per se, and which had included diversion, receded into the background both in physical medicine and in psychiatry. This reductionist period was of enormous importance for the profession because it gave therapists a more clear-cut idea of what treatments to provide. The security was short-lived, however, and in the sixties and seventies, occupational therapists found themselves in a territorial struggle. In physical medicine they were often competing with physical therapists, while in psychiatry they competed with social workers, nurses, and psychologists. As treatment in psychiatry moved away from psychoanalytic models, it became apparent that the longed-for respectability and accep-
tance of occupational therapy within psychiatry would not be found within a reductionist approach. Meanwhile, activities no longer considered purposeful by occupational therapists, and therefore ignored, went by default to other groups—to music and drama specialists, to recreationists, to art therapists, to craft workers, and to volunteers.

It was difficult to fit diversional activity into a reductionist view because its purpose was very different; instead of focusing on the patient's identified problems diversional activity set out to take the patient's attention away from the identified problems. Although it had never claimed more than a small part within our treatment repertoire, the whole concept of diversion was now dismissed, along with much of the concept of occupation itself. To those who have analyzed the developmental history of the profession, the shift away from the focus on occupation as health giving and toward a direct attack on pathology signaled that a paradigm shift, that is, a change in our way of thinking about old concepts, had taken place (Gilfoyle, 1984).

In the last decade or so, there has again been discontent within the profession. Concern has grown that we have lost much as we have strayed from our original focus on occupation. This discontent, we now recognize, is not only normal but healthy in terms of the stages of scientific evolution through which we can expect to pass (Kleinhofener & Burke, 1983). More recently, emphasis in occupational therapy has been on function and the model of occupational performance. At this moment in our history, it seems quite clear that occupational therapists are in the business of helping clients develop skills, restore function, and maintain abilities—all within the areas of self-care, productivity, and leisure.

**Diversional Activity and Current Treatment Rationales**

Central to the concept of diversion is the old idea from the Moral Treatment movement that the mind cannot think two thoughts at once. It was assumed then that there was a limited amount of space for thinking, and that if healthy thoughts—necessitated by the carrying out of an activity—were in place, then there would be no room for unhealthy thoughts, if only for that period of time during which the activity was taking place (Bockhoven, 1972). This phenomenon remains under study more than a century later within the field of cognitive science where time-sharing and multiple processors, serial and parallel processing, and conscious and unconscious processing are among the dual-task paradigms being explored (see Gardner, 1985, for a detailed discussion). Within the field of neuropsychology, the concept of intrahemispheric functional distance put forth by Kinsbourne and Hicks (1978) and the limited-capacity theory of interhemispheric processing advanced by Friedman and Polson (1981) are being put to empirical tests. The answer to the question, Can two different thoughts be processed in the brain at the same time? is still not clear, but it appears to depend on several factors. These include the position of the competing thoughts along the processing continuum, the modalities of both input and output, the complexity of the competing tasks, and the locations in terms of the actual brain space in which the thoughts are processed (Eysenck, 1982; Gardner, 1985; Parasuraman & Davies, 1984). Therefore, although we can no longer say unequivocally that two thoughts cannot be processed at the same time, we can say unequivocally that processing is affected when attention is distracted from one task or thought by another task or thought.

There are treatment approaches outside of the discipline of occupational therapy that capitalize on this ability of diversional activity to interfere with cognitive processing. Three treatment approaches that use diversional activity in a very purposeful manner are stress models, cognitive therapy, and logotherapy.

**Stress Models**

Selye's (1976) discovery that a variety of stressors could result in the same stress reaction brought with it the notion that generic stress-reducing activities could be used as treatment. Selye's general adaptation syndrome, which results in biochemical changes irrespective of the origin of the stressors, is composed of three stages: the alarm reaction, the stage of resistance, and, because our bodies have a finite amount of adaptation energy, the stage of exhaustion. When the body is trying to achieve general adaptation, it is trying to restore itself to its former state of homeostasis (Selye).

Although much research has been carried out in this field in recent years (e.g., on stressful life events, person-environment fit, and the notion of perceived stress), Selye's (1976) original concept of stress still appears to maintain a central position (Cooper, 1983), and his ideas on how to deal with stress are readily perceived in most stress management courses. Selye made it clear that stress was not only inevitable in human life but to some extent desirable. To have ways of dealing with stress, then, is necessary for maintaining health. Management techniques that focus on the alarm reaction stage of the general adaptation syndrome facilitate a return to homeostasis. Selye suggested four general ways of dealing with stress: removing unnecessary stressors from life, not allowing certain neural events to become stressors, developing a proficiency in dealing with conditions that are not wanted but cannot be avoided, and seeking relaxation, or diversion, from stressful demands.

Central to Selye's treatment approach is the idea that people must learn to observe their own responses to stress and recognize when it is time to stop or change their activity, that is, when it is time to find a diversion. In reference to mental stress, he suggests that by highlighting some other problem through diversion, or by activating the whole body by exercise or relaxation, the source of worry automatically becomes less important in proportion. He said, "you must find something to put in the place of the worrying thoughts to chase them away" (p. 417). This simple idea is no different from that expressed during the Moral Treatment movement when it was said that "no two absorb-
ing thoughts or emotions can occupy the mind or heart at the same instant" (as cited by Barris et al., 1983, p. 177).

**Cognitive Therapy**

Interest in cognitive therapy has steadily increased since Beck (1976) first introduced this approach to the treatment of emotional disorders in the 1970s. Beck placed great importance on what an individual thinks about an event because it is this thinking which affects the response. The goal in cognitive therapy is to identify intervening thoughts, which tend to be automatic and generally negative in character, and then to contradict or refute them (Beck). Although the technique is verbal in nature, it depends in large measure on the activities in which the patient engages. In many instances, particularly with depressive disorders, therapy consists of scheduling activities designed to be pleasurable and successful, which can then be used as evidence for contradicting the patient's negative thoughts. In addition, these "structured exercises" as they are called, provide the patient with an opportunity to practice focusing or concentrating. However, all of this can be achieved only if the activity is capable of diverting the patient from perseverative negative thinking. Because the choice of activities is crucial, the therapist must know about the patient's strengths, understand his or her background, and appreciate his or her values. Not only does the activity have to be of sufficient interest to motivate the patient at the outset, it also must be carefully graded to ensure continued success and thus be capable of undermining the patient's belief that he or she cannot do it (Beck, Rush, Shaw, & Emery, 1979). These concepts are all very familiar to occupational therapists.

The techniques of diversion are obviously not solutions to the patient's problems; they are, however, tools for producing short-term attitudinal changes. The patient is then ready to work at finding more long-term, basic solutions. In addition, diversion per se is often taught to patients as a coping skill. It is suggested that simple activities such as taking a walk, talking on the telephone, or observing the environment may be used as a means of distraction. Humor may also be used for these purposes. Beck and his colleagues (Beck et al., 1979) think that when a patient has learned to use diversion as a coping skill, he or she has gained an important sense of control.

**The Humanist School: Logotherapy**

In the humanist school of thought, one of the essential goals of treatment is to help the patient find meaning in life (Goleman & Speeth, 1982). In the existential philosophy that pervades this body of work, life is viewed as an entity in itself; it is imbued with meaning only as the individual experiences it, that is, in a phenomenological context. Life must be viewed with detachment, yet it also must be experienced. Frankl (1967), a major contributor to this theoretical perspective, notes the specifically human capacity for self-detachment. He refers to this state of detachment as the noetic dimension, in contrast to the somatic and psychic dimensions. Man, he suggests, can leave the "plane" of the biological and psychological, to enter the "space" of the noological. This capacity for self-detachment can be used in different ways. For example, it may be used for the purpose of paradoxical intention, that is, to be able to do something that appears to be the opposite of what is needed; or it may be used to counteract a compulsive inclination for self-observation through what Frankl (1967) called "derefection" (p. 156). Thus, patients can ignore their neuroses and focus their attention on something away from themselves. They are directed to a life full of potential meanings and values that have specific personal appeal. This is known as "right activity." Frankl also speaks of "right passivity," which is a ridiculing of symptoms rather than running away from them or fighting them. In both cases, the individual must gain distance to achieve perspective. To do so, Frankl suggests that the patient be "dereflected" from his or her anticipatory anxiety to something else. Therapists working within a humanist frame of reference are familiar with these approaches to helping a patient find meaning in life.

**Diversional Activity and the Current Paradigm of Occupational Therapy**

Are there patients/clients who would benefit from diversional activity? Are there people who need to be distracted or diverted, either to maintain health, as in the tradition established by Meyer (1977), Howland (1944), and Selye (1976) or as a preparation for treatment, as outlined in the approach by Beck (1976) and Frankl (1967)? Should occupational therapists be the ones to provide such treatment?

Society is filled with people who suffer greatly from psychological and physical stress. In some cases, the stress is overwhelming, the individual decompensates, and hospitalization is required before any other form of treatment can begin. In other cases, people suffer in a more chronic fashion because they have not learned how to manage their stress. In either case, occupational therapists and other professionals try to teach these people to manage their stress. These programs all employ the techniques of relaxation and diversion. There is little doubt that more should be done in this area of stress management by occupational therapists both in terms of treatment and in the area of health promotion (King, 1978).

The stressful effects of hospitalization are basically no different today than they were in Meyer's day, or after the world wars when therapists saw the positive effects of diversional activity on their patients' morale. Both Gray (1972) and Parent (1978) pointed out that intervention is needed in this important area, which still tends to be ignored. It is rare, for example, to find occupational therapists on trauma and orthopedic floors unless there are upper extremity or head injuries to be treated. Who, then, is intervening to facilitate the patient's ability to cope with the stress of his or her illness or disability? Who is seeing to it that patients can occupy their time with activity that simulates and thus maintains health? Who is working to prevent secondary psychological complications and speed recovery by raising morale and facilitating the patient's sense of control?
Fortunately there are many people who, no matter how ill, are able to take control of their lives and maintain their mental health while progressing through the stages of recovery. They do not need diversional therapy. They find activities for themselves, they have good social support, they do not need to be made ready for rehabilitation, they achieve a healthy balance for their day. The others, the “difficult” patients, the ones with limited or severely strained emotional and physical resources, need all the help they can get. They do not form relationships with the staff so readily, they do not have social support, they may not be highly motivated, and they do not seek out available services. Unfortunately and paradoxically, because they are so needy, they may not be highly appreciated as important by the founders of the profession of occupational therapy. The concept deserves to be researched more thoroughly and put to empirical tests. We may find that it deserves to reclaim a small but important place among our treatment tools.

**Conclusion**

We are told that a paradigm shift is occurring in occupational therapy, that there is again a shift in our way of thinking about old concepts (Gilfoyle, 1984). In recent years there has been a recognition that much of what we originally had was of value and should have not been tossed aside. Kielhofner (1982) suggested that three broad premises of early theory need to be restored: (a) human beings have an occupational nature; (b) when occupation is disrupted health can be threatened; (c) occupation can help restore health. Within that philosophy, diversional activity should maintain a small but important place. For some individuals, it will be a necessary first step, preparing them for treatment; for others, it may be a last step, preparing them to cope better on their own.

As has been recommended by West (1984), it is time to reaffirm the concept of occupation in occupational therapy and to implement it once again, in all its forms. We must not continue to reject it because of its apparent simplicity. For as Mary Reilly said in one of her less familiar but no less profound statements: "The wide and gaping chasm which exists between the complexity of illness and the commonplaceness of our treatment tools is, and always will be, both the pride and the anguish of our profession" (Reilly, 1962, p. 1).

Divergential activity is a common-place tool for treatment. It has existed for centuries and was recognized as important by the founders of the profession of occupational therapy. The concept deserves to be researched more thoroughly and put to empirical tests. We may find that it deserves to reclaim a small but important place among our treatment tools.

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**References**


