

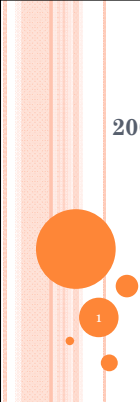
# Concurrent 8- Mental Health

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## 2009 AOTA STUDENT CONCLAVE

### OT in Mental Health

- › Evolution
- › Role of OT
- › Eating Disorders
- › Emerging Practice Areas
- › Sensory Modulation Dysfunction & Sensory Processing Disorder



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## THE EVOLUTION OF OCCUPATIONAL THERAPY

- As early as 1895...
- Initiated by Dr. William Rush Dunton Jr, a psychiatrist at Sheppard Pratt Hospital
- Believed in the healing potential of busy, productive activity
- He is credited with coining the term 'occupational therapy'
- Beginning of a holistic perspective with patients, looking at the whole person versus just physically or just mentally

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## THE CASINO

- The Casino building was built in 1901
- Location of occupational therapy at Sheppard Pratt
- Casino = social spaces where people gathered
- Designed to lure patients out of their rooms, out of the hospital, and into fresh air
- It was located directly across from the main hospital
- Still located there, now in the center of University Village apartments

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## LOOKING AT THE ROLE OF OT IN MENTAL HEALTH

Treatment teams include:

- Dance/movement therapy
- Art therapy
- Horticulture therapy
- Recreational therapy
- Psychology
- Social work
- Family therapy
- Nursing

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## HOW I FOUND MY NICHE

- Roles
- Routine
- Habits
- Occupation of time
- Activities
- Hobbies
- Interests
- Meaningful everyday life

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## BASIC & INSTRUMENTAL ACTIVITIES OF DAILY LIVING

<ul style="list-style-type: none"><li>○ <b>ADLs</b><ul style="list-style-type: none"><li>• Bathing &amp; oral hygiene</li><li>• Toileting</li><li>• Dressing</li><li>• Eating</li><li>• Functional mobility (and transfers)</li></ul></li></ul>	<ul style="list-style-type: none"><li>○ <b>IADLs</b><ul style="list-style-type: none"><li>• Care of others</li><li>• Care of pets</li><li>• Child rearing</li><li>• Use of communication devices</li><li>• Community mobility</li><li>• Financial management and maintenance</li><li>• Health management and maintenance</li><li>• Meal preparation and cleanup</li><li>• Safety procedures and emergency responses</li><li>• Shopping</li><li>• Housework</li></ul></li></ul>
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# Concurrent 8- Mental Health

## INITIAL ASSESSMENT

- Purpose of an OT initial assessment
  - For the OT to understand the patient's background, disabilities & dysfunctions in everyday life due to the eating disorder, develop a tx plan & identify goals for tx
  - For the PATIENTS to increase their awareness of how life was prior to admission, be able to articulate that the eating disorder negatively impacted their world, develop interest in tx & identify goals for tx
- Explanation of OT is very important at this stage

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## INITIAL ASSESSMENT INCLUDES...

- Axis I, II & III diagnoses
- Hx of self harm or SI
- Living situation
- Current employment / school enrollment
- Summary of current symptoms; evolution of e.d. symptoms
- Attention span / concentration
- Problem solving
- Self-esteem
- Self identity
- Self care
- Home maintenance
- Grocery shopping
- Cooking/food preparation
- Clothes shopping
- Money management
- Care of others
- Student / Worker
- Time management
- Socialization
- Leisure/hobbies/recreation
- Stress management
- Community Mobility

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## PAST & PRESENT

- Belief in occupation through doing
  - Including social, leisure & productivity
- Holistic view of person
- What's changed?
  - Expanded the field of occupational therapy in relation to populations, settings, etc.
  - Evidence to back up the core concepts
- We still have a lot of work to do
- Also a question of – have we expanded too much? Become too narrow at times? Do we need to go back to our roots?

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## INITIAL ASSESSMENT

- Eating Disorder Diagnoses
  - Anorexia Nervosa, Bulimia Nervosa, ED NOS
- Common Co-morbidities
  - OCD, MDD, GAD, Bipolar, PTSD, Substance abuse/dependence, learning disabilities, personality disorders
- Medical Complications
  - Hair loss, amenorrhea, syncope, hypotension (or hyper), electrolyte imbalances, muscle atrophy, extreme fatigue, osteopenia or osteoporosis, orthostatic pulse, hematemesis, tooth decay, etc.
  - Eating disorders have the highest mortality rate of any mental illnesses <http://www.state.sc.us/dml/anorexia/statistics.htm>

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## INITIAL ASSESSMENT

- Attention/concentration
  - Preoccupied with eating disorder thoughts 24/7
    - Ruminating thoughts, flight of thoughts
  - Lack of nutrition = loss of brain power
  - Patients can usually recognize their deficit with this
- Problem solving
  - Inability to initiate or complete a task
  - Very rigid, black or white, all or nothing thinking
  - Fear of failure
  - Avoidance
  - Perfectionism

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## INITIAL ASSESSMENT

- Self esteem
  - Strong history of poor self esteem
  - Great difficulty identifying positive traits or personal strengths
  - Negative body image dictates feelings of self worth
  - Severe body image distortion
- Self identity
  - This is where we ask patients about the CURRENT roles in their lives
  - Student, worker, daughter, sister, friend, athlete/hobbies
  - Ask how the eating disorder impacted role engagement & performance

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## INITIAL ASSESSMENT

- Self care
  - Self neglect
    - decrease in desire or ability to perform regular shower/hygiene tasks
  - Sleep disturbances
    - Increase – coincides with avoidant problem solving style, or with extreme fatigue
    - Decrease – mania, too preoccupied, ruminating thoughts, less time for sleep
  - Exercise
    - Compulsive exercise is treated as a sx of an eating disorder
  - Nutrition (lack of)
- Home maintenance
  - What is the role of the pt within the home
  - How were they able to initiate & complete tasks
  - Avoidance of chores versus over engagement

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## INITIAL ASSESSMENT

- Grocery shopping
  - A necessary task that is greatly disturbed by an eating disorder
  - Disturbances include:
    - Total avoidance
    - Going excessively
    - Avoiding certain foods or aisles
    - Excessive label reading
    - Decreased decision making
    - Buying impulsively
    - Fear of being around other people

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## INITIAL ASSESSMENT

- Food preparation
  - Utter avoidance of the kitchen, no participation in meal-prep
  - Overly engaged in cooking, favorite hobby
    - Either with own portion control issue when eating
    - Giving food to others
  - Sensory aversion
- Clothes shopping
  - Avoidance – due to negative body image
  - Shopping for child's clothes even when an adult
  - Wearing overly baggy clothes
  - Impulsive spending

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## INITIAL ASSESSMENT

- Money management
  - Many patients with restrictive food habits, also lead restrictive lives & are very tight with their money
  - Impulsive eating usually correlates with impulsive decision making & impulsive or compulsive spending
  - Poor money management also relates to severe suicidal ideation, "what's the point?", "who cares"
- Care of others
  - Putting others before self
- Student or Worker role
  - Decreased performance, or performance level hasn't changed but it requires increased time
  - Perfectionism, straight As, success driven

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## TIME MANAGEMENT

- Eating disorder symptoms are absolute thieves of time & daily hours
- Time is also imbalanced due to disproportionate value & time devoted to other roles in life
- Those with Anorexia Nervosa typically value school, work, exercise & productivity
- Those with Bulimia Nervosa typically over value social & leisure activities

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## TIME MANAGEMENT EXERCISE

- Depicting routine prior to admission
  - Concrete, visual representation of imbalances
  - Allows pt to continually reflect on impact of the eating disorder
  - Group discussion – what do you need more of? Less of? What time of the day was hardest for you? How do you feel looking at this lifestyle now that you are separate from it?
  - A negative emotional reaction to this activity = change of values
- Create a balanced schedule for post d/c
  - Including social, leisure, self care, sleep, housework, work, school, spirituality, relaxation

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# Concurrent 8- Mental Health

## A NEED FOR OT TX

With all of these varying dysfunctions in necessary daily tasks for healthy living...

Why would persons with eating disorders NOT need occupational therapy?

And yet... very few eating disorder programs include occupational therapy.

Reasons include:

- Higher salary (in comparison to other rehab mental health staff)
- Poor understanding of OT
- Little research supporting use & effectiveness of OT with persons with eating disorders

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## OT & ED

- Main goal of OT in all settings... to facilitate therapy that allows persons to regain the desired roles, activities, habits & routine of life prior to the disability, dysfunction or illness.
- MOHO is the frame of reference I use in day to day practice due to its emphasis on human performance & roles
- Effective assessments include: role checklist, interest checklist, COPM, ACL (or other cognitive & safety assessments)

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## USE OF A TASK..... THEN AND NOW

- Not just a craft group!
- Purpose of Task Group
  - Cognitive skills – building attention & concentration, task initiation & completion
  - Processing skills – direct challenge to perfectionism, all of nothing style thinking, fear of failure, etc.
  - Self esteem building – feeling you can do something, have an effect over something, build pride
  - Practice of socialization – encourages conversation, common interests sparks easy conversation
  - Exploration of leisure skills & interests – patients have little to no hobbies prior to admission, many will start to buy supplies & work on projects for days off from tx
  - Building stress management skills – workign with your hands to as a distraction tool, organize thoughts, release anxiety

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## USE OF A TASK..... THEN AND NOW

- Remember Dr. William Rush Dunton Jr, the psychiatrist at Sheppard Pratt Hospital who initiated the concept of occupational therapy
- And who believed in the healing potential of busy, productive activity
- This is the essence of task group
- I often begin task group by reading, discussing, and processing this famous quotation by Mary Reilly...

"Man, through the use of his hands as they are energized by mind and will, can influence the state if his own health."

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## EMERGING AREAS OF PRACTICE

- Sensory modulation initiative in hospitals
  - Preventing seclusion & restraint
  - Increasing coping skills
- Sensory processing disorder in DSM-V
- Sensory issues & dysfunctions in mental illness
- Life coaching
- Outpatient practice
- Feeding disorders → eating disorders?

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## SENSORY MODULATION INITIATIVE IN HOSPITALS

- The Therapeutic Use of Weighted Blankets
- Sensory rooms/carts to encourage distress tolerance & avoid escalation
- Therapeutic use of brushing
- Education of all disciplines on the varying types of sensory processing, how sensory objects/coping skills can be used, calming & alerting techniques, etc.

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# Concurrent 8- Mental Health

## SPRING 09 RESEARCH PROJECT

- Research question
  - Do persons with anorexia or bulimia nervosa have underlying sensory processing dysfunctions?
- Background Info
  - OTs regularly observe sensory processing dysfunction in persons with eating disorders
  - Research does exist that proves sensory dysfunction in those with **schizophrenia** (1), **Asperger's syndrome** (2); and citations of patterned responses for individuals with **ADHD** and **PTSD** (3); there is no documented research addressing sensory issues and persons with Eating Disorders.
  - All of these studies used the Adolescent/Adult Sensory Profile

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## RESEARCH HYPOTHESIS

- Using the framework of Dunn's Model of Sensory Processing, DSM-IV criteria of anorexia nervosa and bulimia nervosa, and OT clinical observation, the researchers hypothesized:
  - ◆ Participants with **anorexia nervosa** will score strongly in the quadrant of "**sensory avoiding**" behaviors, which suggests they have "a low neurological threshold" and "includes behaviors that limit exposure to stimuli" (4) based upon DSM-IV criteria of reduced total food intake and very restricted diet (5), OT observation of limited engagement with environment and social withdrawal.
  - ◆ Participants with **bulimia nervosa** will score strongly in the quadrant of "**sensory seeking**" behaviors, which is a "response to high neurological threshold and encompasses pleasure derived from rich sensory environments and behaviors that create sensation" (4) based upon DSM-IV criteria of abnormal consumption (5), and OT observation of excessive activity and poor impulse control.

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## METHODOLOGY

- ◆ Assessment Tool: *Adolescent/Adult Sensory Profile*
- ◆ All eligible participants completed the self-questionnaire on days 3,4, or 5 of inpatient treatment
- ◆ Information collected from a thorough chart review and the current OT initial evaluation.
- ◆ Informed consent was obtained for all subjects.
- ◆ Convenience Sampling Method – First 20 patients admitted that met inclusion criteria
- **Inclusion Criteria** = Diagnosis of AN or BN, admission to inpatient unit
- **Exclusion Criteria** = Diagnosis of ED NOS, patient under the age of 12, direct admittance to PHP or IOP, any participant readmitted

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## RESULTS

- Sample Size - 20
- Age Range - 14 to 39
  - Mean Age - 23.1
- 19 Females, 1 Male
- Anorexia Nervosa - 8
- Bulimia Nervosa - 12

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Patient #	Diagnosis	Low Registration	Sensation Seeking	Sensation Sensitive	Sensation Avoiding
1	BN	High	=	High	=
3	BN	Very High	=	High	High
4	BN	Very High	=	High	=
14	BN	High	=	High	High
18	BN	High	=	High	High
19	BN	High	=	Very High	Very High
8	BN	High	High	High	=
20	BN	High	Low	=	High
13	AN-2	=	=	High	High
15	AN-1	=	=	High	High
11	AN-1	=	=	High	=
7	AN-2	=	=	Very High	High
6	BN	Low	=	High	Very High
16	BN	=	High	=	=
2	BN	=	Low	=	=
12	AN-2	=	Low	=	=
21	BN	Low	=	=	Low
5	AN-1	=	=	=	=
9	AN-2	=	=	=	=
17	AN-2	=	=	=	=

## RESULTS

- 7 out of 20 participants scored highly within 3 quadrants
  - 100% of these individuals had diagnoses of bulimia nervosa.
- 5 out of 20 participants had high scores in sensation sensitive, avoidant, or both.
  - 3 out of 5 of these individuals matched the hypothesis for anorexia nervosa
- 1 out of 12 participants with bulimia nervosa matched the hypothesis, scoring high in sensation seeking
- 3 out of 20 participants matched the normative data sample, with no outliers

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### SO WHAT?

- After the study, we continued to administer the Adolescent/Adult Sensory Profile to patients who were interested in it
- Trends stayed the same
  - Very little scored within the norms
  - Continued trend of those with AN scoring as sensation avoidant or sensitive
  - Continued trend of those with BN or trauma hx scoring with sensory modulation dysfunctions
- Positive feedback – patients express relief, “oh, that’s why I do that” or “that’s why I’m like that”

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### USE IN TX

- Has been used in marriage & family counseling to resolve conflict
- Used to find ‘best fit’ for coping skills
- Sensory exploration increases patients awareness of likes/dislikes, what is alerting/calming
  - Starts to take patients out of robotic state
  - Affect regulation
- Discuss home/environment adaptations
- Discuss concept of ‘sensory diet’ (instead use the words ‘sensory routine’)

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### A CALL FOR ACTION

Mental Health practice offers so many opportunities for immediate professional growth

There are assessments that need updated (ex: KELS, interest checklist)

So much research is needed (both qualitative & quantitative) to prove our ideas

So many settings we should be in (ex: outpatient psych settings)

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### WHAT I WISH I KNEW AS A STUDENT...

- Theories really do matter
  - Frames what you do in everyday life (how you explain OT, how you view a patient, how you can defend your tx, differentiate OT from another discipline, etc.)
- OT is OT whether you work in mental health, physical dysfunction or pediatrics
- Evidence-based practice really is important... and necessary
- Conducting research is possible & doable
- Don’t become too focused on the day to day tx, maintain focus on enabling patients to reach functional roles & habits for sustained healthy living

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