CHAPTER 11

Responding to Symptoms and Behaviors

The staff members were very patient with me. I resented their intrusions and their restrictions, but, at the same time, I dimly recognized their actions as evidence of caring and support. Someone sat with me when I could concentrate on a project, such as an embroidery sampler, which I enjoyed although I was not allowed to keep the needle or scissors. I began to feel less like a prisoner because I was given some freedom and because the staff seemed to respect me and care about my getting well.

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CHAPTER OBJECTIVES

After studying this chapter, the reader will be able to:

1. Define *symptom,* and explain why symptoms are useful guides to understanding patient behavior and feelings.
2. Identify the three tools used by occupational therapy practitioners to help consumers experiencing psychiatric symptoms function as best they can and engage in occupation.
3. Describe the following symptoms: anxiety, depression, mania, hallucinations, delusions, paranoia, hostility and aggression, seductive behavior and sexual acting out, cognitive deficits, and attention deficits.
4. For each symptom, identify the diagnoses associated with it.
5. For each symptom, discuss how the occupational therapy assistant (OTA) can use self, environment, and activity to facilitate better functioning for the patient.
6. Identify characteristics of appropriate activities for a person experiencing each symptom, and contrast unsuitable activities and explain what makes them unsuitable.
7. Discuss the role of the OTA in promoting wellness and consumer self-management of symptoms.

Imagine that you are entering a locked psychiatric ward to start your first occupational therapy fieldwork in psychosocial dysfunction.[1] An agitated young person approaches you and asks you one question after another: "Who are you? What's your name? Are you the new patient? Are you a volunteer? Did you see the football game last night? Do you like football? I've got season tickets. Wanna go with me tonight?" At the same time you can see two or three other people standing and sitting around the halls, heads hanging, eyes downcast. Another is pacing the hall, touching and trying every doorknob. Meanwhile, your supervisor is right behind you; and while you are grateful for the support, you are also worried that you will say or do the wrong thing to the patients.

Do you think you could handle yourself in this situation? If you are like most people when they begin working with persons with mental illness, you would probably feel anxious and uncomfortable. At times, it seems not only that you don't know what to do but also that you haven't the vaguest idea how to prepare yourself for this experience. You don't even know what questions to ask your supervisor. The purpose of this chapter is to give you a way of thinking about how people with mental health problems act and about how best to respond to them. We first examine why patients (clients, members, consumers) act the way they do, because this helps us understand how to approach them. Then we will discuss some responses you can make to them.

A FRAMEWORK OF CONCEPTS ABOUT SYMPTOMS

When people who have mental disorders say and do bizarre things, our first reaction may be to label them as "crazy." In doing so, all we have accomplished is to protect ourselves by saying that those people are somehow different from us, that the way they act is not the way normal people act, that their actions make no sense, and that there is no way to understand them. However, if we step back from this reaction and examine the reasons behind it, we may see that we already know a great deal about why patients act as they do.

In most important ways, people with mental health problems are exactly like other people. All people have emotional needs, such as the need to belong and to be accepted by other people, the need to be loved and approved of by those around them, and the need to explore and master their environments. With most people we encounter, it is usually pretty easy to understand what they want from us and how to make them comfortable with us and with themselves. People with serious psychiatric problems may not be so easy to understand. They still have basic needs to be loved and accepted, but the way they express these needs may cause other people to reject them. Other people cannot understand what they want, and they themselves do not always know. Consider the following dialogue between a occupational therapy assistant (OTA) and a client in a community day program:

> OTA [observing that client is applying the modeling clay to the front rather than the back of the copper tooling]: Wait. It goes on the other side, like this. [Demonstrates on sample.]
>
> Client [shouting]: You don't know what you're doing. Bogus, bogus, BOGUS! You aren't a therapist! You're so out of it yourself that it's pathetic. Where's a supervisor? I'll get you fired. Out of my way! [Storms off to a corner of the room and lights a cigarette.]

What went wrong here? Why is the client reacting this way? What is he feeling? What should the OTA do about it? One possible interpretation of this client's behavior is that he felt ashamed at not recognizing that he was doing the project incorrectly. After all, it looked simple to him. He interpreted the OTA's comment as a criticism not just

[1] Much of the material in this chapter derives from Early (13).

of his error but of his entire being. He wanted to feel competent; that is why he chose such a simple project. He felt as if he were falling apart, that there were nothing he could do right, not even a very simple thing like copper tooling. Indeed, it seemed to him that he was completely worthless, that he would never be able to leave the hospital and return to his family and his job. So he displaced all of his frustration with himself onto the OTA. He blamed her for his failure because it was too painful for him to face. And all of this happened unconsciously; the client's unconscious protected him from learning the intolerable truth: that he had made the mistake himself.

Do you see that in some ways his reaction seems perfectly natural? Yes, it might be immature or hostile, but it is a reaction we can understand, a reaction that we have perhaps had ourselves in similar situations. We all use defense mechanisms to keep from facing facts that we find threatening. Perhaps you interpreted this client's behavior differently. Many interpretations are possible. The point is that if we take the time and make the effort to grapple with what clients are really feeling and why, we can often see that their reactions make sense, that their behavior does not just come from nowhere, and that in many ways they are no different from us. This may be a scary idea. It raises questions about how sane we are and how safe we are from going "crazy."

Whereas some clients become verbally abusive, as this man did, others withdraw and still others become suspicious. Some may burst into tears and apologize for ruining the project. Such reactions, while understandable, are nonetheless extreme or peculiar. Behaviors like these are termed *symptoms* because they show that some disease or abnormal state is causing the person to act this way. Symptoms may be visible behaviors, such as these, that show underlying problems, or they may be subjective feelings reported by the person, such as a feeling of extreme sadness or a feeling of seeing things as if they were very small and far away.

Expressing Unmet Needs or Conflicts

To understand the role of symptoms in psychiatric disorders, it may be helpful to recall the concepts of object relations theory (Chapter 2). According to object relations theory, the ego mediates the conflicts among the id (needs and primitive drives), the superego (moral principles), and external reality (real life demands and obstacles). When the ego is not able to solve these conflicts, anxiety results. Anxiety is the most common symptom in psychiatric disorders, and it occurs in a wide range of diagnoses. Anxiety is a state of tension and uneasiness caused by conflicts that the ego is unable to resolve.

Other common symptoms, such as depression, withdrawal, and hostility, are sometimes just the way the person deals with anxiety. It may be helpful to think of these symptoms as maladaptive ego defenses (see Table 2-1). In other words, the person (consciously perhaps, but most often unconsciously) uses the symptom to reduce his or her anxiety. For example, a man who is angry at his boss and frustrated with his job may develop low back pain; this lets him get out of unpleasant situations without having to express his anger directly.

Although symptoms are sometimes effective for avoiding anxiety, they create other problems and may actually increase anxiety. A teenage girl who feels depressed and insecure about her social skills and appearance may withdraw from her peers, eliminating a potential source of anxiety. As she continues to withdraw, however, her peers may consider her less and less socially acceptable, making it harder for her to approach them, hence increasing her anxiety.

Whatever symptom the individual displays, it can help us identify what the person needs and what he or she is compensating for by acting this way. For example, a woman consumer who identifies with a staff member, copying her clothing and hair style or mannerisms, may be compensating for a feeling that she herself is inadequate or

inferior. Clients who make excuses for (rationalize) their own behavior may be having trouble accepting themselves and their own responsibilities. And clients who deny feelings or facts that are unpleasant may be protecting themselves from these painful thoughts.

Symptoms are Not the Disease

Remember, the symptoms are not the disease. They are only the behavioral evidence of the disease. Most of the symptoms discussed in this chapter occur in many psychiatric disorders. The psychiatric disorder, or diagnosis, is associated with a group of symptoms that commonly occur together. This is similar to the way a physical diagnosis is made. For example, the patient who has a fever, a cough, and red spots on his or her chest is diagnosed as having measles because of the symptoms occurring together. Any one of these symptoms by itself or in a different combination of symptoms may lead to a different diagnosis.

A psychiatrist, when evaluating a person and assigning a diagnosis, considers the person's history and presenting symptoms. Although this is similar to the way a doctor might diagnose measles, there is an important difference. Our understanding of psychiatric disorders is not as advanced as that of physical disorders. A psychiatrist can describe how a patient is behaving and can recognize important clues in his history but does not always reach a diagnosis that another psychiatrist would agree with. Indeed, on the next admission the psychiatrist may reevaluate his or her own diagnosis and assign a different one. It is not uncommon for someone to have had different diagnoses on different admissions, especially to different hospitals. You may be wondering whether psychiatric diagnoses are of any use at all. Psychiatrists use diagnoses to select what drugs or other treatment they will use to help the patient.

For your purposes, as an occupational therapy assistant, you may find that a person's diagnosis is not particularly helpful. Instead, you might find that the individual's behavior and/or reported symptoms give you more of a handle on the situation because they give you clues to what the person needs. Also, because symptoms impair functioning in predictable ways, they give you clues to where the person is having difficulty. After all, the purpose of occupational therapy is to help individuals meet their needs, carry on their life activities, and engage in meaningful occupation. By identifying the symptom and deciphering the underlying need, we take the first step toward helping the person satisfy it.

Responses to Events

It can be useful to look at the behavior as a response to what is going on, or as an expression of needs. Behavior management approaches of this type have been developed for children with autism and emotional disabilities (36, 42), persons with Alzheimer's disease or other dementia, and those with traumatic brain injury. Comprehensive behavior support (CBS) analyses a child's tantrums to determine what needs are being expressed and to meet those needs *before* the behavior manifests again. For example, a child may scream and bite when she is tired and needs to take a break. When the therapist recognizes the early signs of distress and provides an alternate relaxing activity, the screaming and biting can be averted (36). Because it sometimes happens that the child uses the behavior to avoid a necessary learning activity, it may be more effective to switch to another productive activity that is less demanding but that still fits the therapy goals (42). A similar approach for persons with dementia examines behaviors to determine their *antecedent cause* (event that provokes the behavior). By eliminating the cause, the behavior can be avoided (22). The therapy staff must especially identify items in the environment that stimulate challenging behaviors so that these items can be removed (40).

Personality and Personal Experiences

Often the particular symptoms displayed are more characteristic of the individual's personality than of his or her psychiatric diagnosis. To illustrate, someone with a diagnosis of schizophrenia may show obsessive-compulsive behavior, such as bizarre rituals (touching doorknobs) and obsessive tidiness. Another person, also diagnosed with schizophrenia, may show a different symptom—for example, repeated assaults on others. Although everyone observing the person can identify the symptom or behavior that is maladaptive, psychiatrists often have difficulty agreeing on why someone has that particular symptom and what the underlying process is. For example, research on obsessive-compulsive behaviors points to evidence of brain abnormalities as a causative factor (39).

Individual Strengths

It is important to remember also that any individual is much more than the bundle of presenting symptoms. Although much behavior may appear to be unreasonable or bizarre, the person usually has some behaviors or qualities that are fairly healthy, which we can call strengths or assets. The person may be able to do crossword puzzles or play basketball well or may spontaneously help others when they have difficulty. An individual's strengths are just as important as his or her symptoms. In fact, they are probably more important because they can help the person control and master the symptoms. For example, when a depressed, withdrawn woman helps another person do a needlework stitch, she feels that she has done something useful. She may be able to stop thinking about her problems for a little while. If she is able to continue doing something at which she feels competent, she will feel more in control, more able to cope with her problems.

As you continue in your reading of this chapter, it is important to remember the concepts we have covered so far:

- Identifying the symptoms and deciphering the underlying need, antecedent event, or environmental stimulus can help in planning interventions.
- Symptoms may be seen as an expression of unmet needs (e.g., for love and belongingness) or of unresolved conflicts.
- Symptoms are not diagnoses. The same symptom may occur in a variety of diagnoses.
- Symptoms are the behavioral or self-reported evidence of underlying psychological or physiological problems.
- Symptoms may be a response to an event or something in the environment.
- Symptoms are sometimes more related to a person's upbringing and underlying personality than to a particular diagnosis.
- Activities selected in response to symptoms should reflect the individual's assets, interests, occupational role, and present level of functioning.

RESPONSE VARIABLES

The OTA, faced with someone who is behaving oddly and who seems very uncomfortable, has three tools available. We will call these tools *response variables* because we can change them to meet the individual's needs. The three response variables are self, environment, and activity.

Self

Self is the assistant's own personality, the way he or she talks to and acts toward the persons in his or her care. It is synonymous with *therapeutic use of self.* The way OTAs adapt their personalities to meet the client's needs significantly affects clients' self-perception and the occupational therapy process. As specific symptoms are discussed, guidelines will be given for how to approach (modify your personality for) clients with those symptoms. These guidelines are merely suggestions;

they should not be thought of as rules or demands for you to change your personality. In general, your relationships with all clients will depend on a warm, interested, and open-minded approach to them and to their needs. You must be comfortable with yourself and with your own behavior if you wish to reach out effectively to others. Any modifications that you make in your own behavior must feel right to you. To feel comfortable in a therapeutic role it is important not to make unrealistic demands on yourself. No one is perfect or perfectly in control of his or her responses at all times. You will put yourself in the best frame of mind for helping your clients by trying to do the best you can and accepting the fact that you, like everyone else, will make mistakes.

Environment

Environment is the context in which your interaction with the client takes place. It includes the presence or absence of other people, the general noise level, the amount of visual stimulation, the quality of the lighting, the arrangement of the furniture, the ventilation and temperature, and the presence of objects,. Whereas some features of the environment are beyond your control (e.g., central air-conditioning, absence of windows), others may be changed to meet the needs of the client. Sometimes the person needs more stimulation, sometimes less. Sometimes the level of stimulation is good but the type of stimulation should be changed.

Activity

Activity is the thing that you and the client are doing together. It can range from copper tooling to writing a résumé to organizing materials to prepare a meal to looking at newspaper advertisements for apartments. The list is endless. In selecting activities it is important that they be based in occupations valuable to the person. Consider the person's goals, interests, occupational roles, previous skills, and present level of functioning. At times familiar activities offer security by giving someone an opportunity to demonstrate that he or she can do something well. At other times, such as when a client is confused and disorganized, familiar activities can make him or her feel worse because the client either cannot do them at all or cannot do them as well as in the past. The most effective activities are those that the person has chosen, that mean something to him or her, and that support his or her occupational roles. The assistant should encourage clients to choose their own activities, even if the choice is only among two or three options.

RESPONSE STRATEGIES

The rest of this chapter presents information to help you respond effectively to clients showing particular symptoms. For each symptom you will find discussion of the following:

- *Definition* of the symptom and a discussion of what it may mean for different individuals (i.e., what unmet needs it may be disguising)
- *Diagnosis* or diagnoses in which the symptom commonly occurs
- *Therapeutic use of self* to help the person feel more comfortable and function better
- *Environmental modifications* to meet the person's needs
- *Characteristics of suitable activities* and recommended modifications in activities
- *Examples of specific activities*

These ideas are culled from many oral and written sources in occupational therapy; they do not work with everyone, and they should not be used mechanically. Do not think of these strategies as a cookbook. We cannot approach every person with depression in the same way, no matter what the guidelines say. Every person is unique. Just as when preparing a meal, it is wise to look in the refrigerator before looking in the cookbook, when working with clients it is important to see what they bring to the situation.

Remember also that the most powerful intervention is to educate the consumer about symptom management, so that he or she can monitor symptoms and reduce or eliminate discomforting feelings (11). This will be discussed further at the end of the chapter.

Anxiety

Anxiety is a state of tension and uneasiness caused by conflicts that the ego is unable to resolve. It is one of the most common symptoms seen in psychiatric illness. It is normal for every person to feel some anxiety, particularly when faced with frightening, challenging, or unpredictable situations. The healthy person controls anxiety through the unconscious operation of the various defense mechanisms (see Table 2-1), the purpose of which is to avoid any unpleasant conflicts and the anxiety associated with them. To a certain degree we can think of anxiety as a positive force. It motivates us to attempt new things—for example, your anxiety on first encountering a new client may prod you to approach and try to talk to him or her.

Although everyone feels some anxiety, it becomes pathological (causing illness) only when it is so extreme and so long lasting that it interferes with effective functioning in daily life. Anxiety may occur alone, as the primary symptom, or with other symptoms. Sometimes it causes other symptoms, just as a fever causes malaise, chills, and aches. For example, remember the client dialogue presented earlier in this chapter: We may conclude that the client became angry and hostile because he was anxious about his perceived failure in copper tooling.

We can recognize when someone is anxious by observing body language and listening to what the person says. Some people worry aloud; they talk incessantly about things that may never happen. Others fidget; they tap their feet, jiggle their legs, bite their nails, pull their hair, tug at their faces, drum the tabletop, and pace the halls. Others express fears about certain places or objects. They may be afraid to go outside or to use the toilet. Regardless of the behaviors through which a person expresses anxiety, the therapeutic objective is generally the same: to control or reduce the experience of anxiety so that the person can function.

Diagnoses in Which Anxiety Is a Common Symptom

As a symptom, anxiety may be found in almost every diagnostic category. The only recognized exception is in cases of social deviancy (antisocial personality). It was once believed that criminals, psychopaths, and other deviant individuals experience no anxiety at all. Current understanding, based on reports from such clients that they feel tense, is that they do feel uncomfortable because they know they are different from other people (5).

Strategy for Therapeutic Use of Self

Encourage clients to talk about what is bothering them and to express how they feel. Answer their questions if you can but avoid being drawn into extended discussions of physical symptoms and their possible causes. It helps to focus first on what clients are concerned about, listen to their fears, and then gradually redirect their attention to a neutral topic or something more constructive. Different responses are needed for individuals who express their anxiety through rituals, phobias, or constantly demanding attention (Table 11-1).

Strategy for Modifying the Environment

In general, the environment should be calm, comfortable, and familiar. People who are disposed to be anxious often become more so when overstimulated by too much noise or too many people. A context that is different from what the person is used to may be frightening. Giving such clients a brief tour of the occupational therapy area and a schedule for activities helps them feel more secure and in control.

TABLE 11-1 FLEXIBLE RESPONSES TO ANXIOUS BEHAVIORS

BEHAVIOR	RECOMMENDED RESPONSE
Ritualistic, compulsive The patient carries out unnecessary and apparently meaningless actions, such as checking for dust on door sills before crossing them	Never criticize the patient's behavior. Instead, recognize that no matter how ridiculous the ritual may appear, it is one the patient uses to cope with anxiety. You can make such patients more comfortable if you can convince them that you accept them no matter what they do.
Phobic, fearful The patient is afraid of things that other people do not find frightening (e.g., going shopping, riding in cars)	Encourage such patients to talk about their fears; help them focus on exactly what makes them afraid. This is especially important when the fear prevents them from accomplishing tasks needed in their occupational role (e.g., a homemaker has to shop for food).
Intrusive, demanding The patient constantly demands attention or interrupts when you are working with others	Reassure such patients that you will be available to help them. Give them a definite time and stick to it. Ignore subsequent interruptions but do not become angry with such patients.

Strategy for Selecting Activities

Guide clients to choose their own activity; ask clients what things they find relaxing or that take their mind off their worries. Help the client select activities that produce a successful result without excessive attention to detail. A project that the person can work on for a while, get up and move about, and come back to later is ideal. Some anxious persons respond well to activities involving a single motor sequence that is repeated (e.g., quick point); they seem to use the regular pace of the activity to control and calm their own pace. Gross motor activities, such as aerobic exercise or stretching and relaxation, can reduce the uncomfortable physical symptoms that go with anxiety (e.g., tense muscles, neck and back aches, racing pulse). Yoga, tai chi, qi gong and other Eastern practices are beneficial. Meditation, relaxation tapes, or biofeedback can also be used. Stress management techniques such as progressive relaxation, time management, and leisure skills may help the person identify stressors and prevent or reduce anxiety. Social support such as a conversation with a friend or a social gathering can also help. Cognitive behavioral approaches to reduce cognitive distortions (see Chapter 2) helps put worries in perspective. Journal writing, nature walks, and multisensory rooms and other sensory approaches are additional possibilities (9) (Box 11-1).

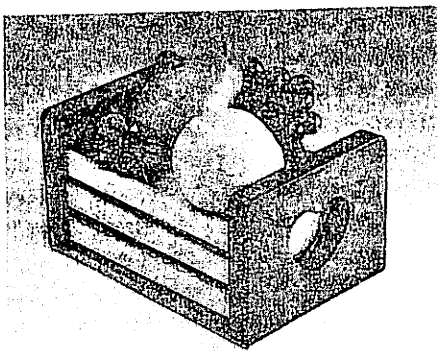
Depression

Depression is a feeling of intense sadness, despair, and hopelessness. Like anxiety, depression occasionally affects most people. Sadness is an appropriate response to painful losses, such as the death of a loved one, being fired from a job, or being rebuffed by a friend. Most people recover from these sad

BOX 11-1

ANXIETY: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Small woodworking kits.* Those with a small number of pieces (three) are best until you are certain the person can handle more. An exception is the heart basket[a] (shown here), in which many pieces are identical and assembly is obvious if a finished model is provided.



Heart basket. The assembly is simple and straightforward; the kit may be sanded and finished over several sessions. The kit requires the help of another person to position and glue the second side of the basket. (Photo courtesy of S&S Arts and Crafts, Colchester, CT.)

- *Simple cooking tasks.* For example making chocolate-chip cookies. There are lots of opportunities for the client to move around while cleaning up or waiting for a batch to be done.
- *Stress management, cognitive behavioral training, and coping skills training.* These can give the person resources to better manage situations that provoke anxiety.
- *Yoga.* This will need physician approval and should be taught by someone who knows the correct body dynamics and techniques. Alternatively, the person can be helped to relax by doing tai chi or qi gong, taking a walk, raking leaves, or doing housework.

[a]Available from S&S Arts and Crafts, Colchester, CT, and other vendors.

feelings and are able to carry on with their lives. Depression becomes pathological when it lasts longer than most people would consider reasonable and when it interferes with ordinary activities.

The depressed person typically shows a cluster of symptoms related to the depression. The most striking is the depressed mood, often accompanied by crying or irritability. Depressed people also tend to have bleak views of themselves and of the world in general and to see the future as hopeless. They feel helpless, hopeless, and possibly worthless and guilty. They usually lose interest in people and activities that previously brought pleasure. Such clients' statements in occupational therapy often betray their low opinion of themselves: "I'm stupid," "Don't bother with me; the

other guys need you more," "I can't even do this right." They are easily frustrated and tend to blame themselves for whatever goes wrong.

Other associated symptoms, termed *vegetative signs*, include changes in activity level and biological functioning. Sleeping too much or not being able to sleep, losing one's appetite or overeating, neglect of personal hygiene and grooming, and diminished energy are common. Depressed people's movements and speech may be slowed down (psychomotor retardation) or speeded up (psychomotor agitation). Their mental functions may be dull; they may have trouble concentrating or making decisions and may be slow to respond to questions. They may be easily distracted and unable to pay attention long enough to complete simple hygiene and grooming tasks.

Many theories address the causes of depression. Evidence suggests that a biochemical element may be responsible—for example, low levels of serotonin, a neurotransmitter (brain chemical), have been found in suicidal individuals. It is also possible that the loss of a parent or similar serious loss in early childhood may predispose certain individuals to depression in adulthood. Another theory is that the depressed person has a less stable and secure sense of self than other people and so reacts strongly to even mild criticism and setbacks.

The cognitive therapists Ellis (14) and Beck (6) argue that people become depressed because they think illogical thoughts. For example, a woman who forgets to pick up her husband's shirts from the laundry may think this is just another example of her inadequacy as a wife and may believe that her husband will divorce her or at least criticize her. Cognitive-behavior therapy (see Chapter 2) attempts to help clients identify irrational negative beliefs and to substitute more logical and positive ideas.

Yet another theory argues that depression operates like the defense mechanisms to protect depressed people from feelings that they fear are even more painful. For example, the "anger turned inward" argument is that instead of becoming angry at the cause of the loss (the person who left, died, or rejected the patient), depressed individuals turn the anger against themselves. Because they unconsciously feel it is bad to be angry, they punish themselves by being depressed. Nonetheless, they may still feel guilty about being angry, and this contributes to self-hatred and a sense of worthlessness.

In still another theory, Seligman (43) suggests that depressed individuals may have learned to feel helpless as a result of repeated failures in which nothing they did seemed to change what happened. Depressed people have "learned" that they cannot control their own lives and have decided to give up trying. They attempt to withdraw from other people, seeking physical isolation by sitting alone, wandering off, or staying in bed all day. In this way, they can retreat from a reality that they perceive as threatening, hostile, and unmanageable. The passive and negative behavior of the unemployed, the homeless, and the economically disadvantaged becomes quite understandable when viewed from this perspective.

Seligman concludes that activities that produce an experience of success and self-control will relieve depression. Neville (38) notes that the volition subsystem is impaired in the depressed client, as evidenced by a belief that one's life is not in one's control and that the future is hopeless. Neville, like Seligman, recommends that individuals with depression be exposed to experiences that reinforce their sense of responsibility and self-control.

Diagnoses in Which Depression Is a Common Symptom

Depression occurs in a wide range of disorders. It is the primary symptom in the affective (mood) disorders. Depression is common in organic mental disorders. It is frequently seen in schizophrenia, in almost all of the personality disorders, and in substance abusers. As previously discussed, it is a normal response to personal loss and so is a common symptom of the various adjustment reactions.

Strategy for Therapeutic Use of Self

Allow depressed clients to talk about what is bothering them; discussion should focus on exactly how they feel and why. The more they understand the causes of their depression, the more likely they are to be able to do something about it. Engel (16) suggests that the therapist avoid being overprotective and helpful; a matter-of-fact, even-tempered acceptance seems best. The assistant should listen and reflect back what he or she hears such clients saying but should never agree that the situation seems hopeless. Instead, the assistant should provide direction and help with selection of realistic short-term goals and activities that the client can accomplish. The assistant should reinforce good hygiene and grooming and encourage clients to keep up their personal appearance.

Clients who are silent and withdrawn present a special challenge. Often they try to discourage staff contact by becoming more withdrawn or hostile and then fleeing. Assistants should not be tricked by these maneuvers into neglecting withdrawn clients. By approaching them many times, each time for only a brief period, OTAs show that they accept these clients' feelings. As clients become more comfortable, they eventually respond. For example, the OTA may visit the client in the client's customary spot and sit quietly, perhaps commenting occasionally about current events or things that have happened in the neighborhood or the clinic. After several visits, the client may be willing to attempt a simple activity on a one-on-one basis. Later, group activities can be attempted while the one-on-one activity is continued.

In general, therapists should match their tempo to that of the client, whether the client is slow moving or agitated. Therapists should be quite clear when giving any directions to clients and avoid giving them more choices than they can handle. It is better to present only two activity choices at first. Therapists should avoid praising what clients accomplish, rather acknowledging their efforts with a simple comment: "It looks like you've finished that. Is there anything more you'd like to do with it?" Depressed clients are usually well aware of the difference between their present level of functioning and their past abilities, and excessive praise may make them think they must be in very bad shape. Assistants should accept whatever their clients can do at the moment and not pressure them into doing more. It is not unusual for depressed people not to want to keep projects they have made. The project is likely to be poorly executed, showing the person's low energy level and limited attention to detail. The OTA should accept the client's decision to reject the project and should refrain from commenting on it further.

When the depressed individual talks about bad feelings, the assistant should under no circumstances change the subject or try to cheer up the client. These approaches deny the importance of the person's feelings and indicate that the assistant does not accept the client or want to deal with his or her real concerns.

Depressed clients who are receiving medication may be expected to show a decrease in depressive symptoms (symptom remission) within the first 3 weeks of treatment. At this time, clients may have more energy but still feel depressed, and there is a real risk of suicide; the risk is greater for those who have previously attempted suicide. On the other hand, two thirds of suicide attempts are successful the first time (41). Some of the signs that a person may be thinking of suicide include obvious ones like talking about it or wondering aloud what it would be like to be dead. Others that are less obvious are the appearance of feeling much better for no clear reason and giving away personal possessions. For example, the client may present the assistant with an item of personal property. Without rebuffing the client, the OTA should encourage the client to talk about why he or she is doing this.

The OTA who suspects that a client is contemplating suicide *must notify medical staff* (nurse, doctor, or primary therapist). Otherwise, the OTA may hear in the Monday-morning staff meeting

that the client jumped off a roof during the weekend. If the client is being seen on an outpatient basis, the assistant should contact his or her own supervisor and the client's primary therapist so that a more skilled person can evaluate whether the client needs to be hospitalized.

Strategy for Modifying the Environment

The environment should be safe and subdued. In general, the more severe the depression, the less stimulation should be present. It may be necessary to reduce the lighting and the noise level and work one on one to get the client to focus on an activity. Too much stimulation may cause the client to retreat further. This is particularly true for withdrawn clients, who may not be able to tolerate the others in a group. As the client becomes more comfortable, the amount of stimulation should be increased gradually; having more materials, supplies, and sample projects visible will increase opportunities for decision making.

The structure on an inpatient ward limits opportunities for patients to make choices about even simple things. For example, meals consist of whatever is served when the staff says it is mealtime. Patients who are suicidal may not be permitted to wear their own clothing so that staff will know not to let them out of the ward. Showering and shaving may be scheduled at the staff's convenience. This atmosphere can further weaken a depressed person's fragile sense of self-control. Therefore, choices should be presented whenever possible. Merely deciding to rearrange the furniture or hang up a picture can increase the patient's sense of responsibility and competence.

Strategy for Selecting Activities

Start with simple, structured, short-term, familiar activities. Unstructured activities should be avoided because depression leaves people with little energy to make the necessary decisions. The activities must be short-term ones because the depressed individual typically lacks the attention span for a longer activity and can work only slowly and intermittently. For the same reason, activities that require rapid responses at particular moments (e.g., slip casting) should be avoided unless a staff member or volunteer is available to assist the person. Repetitive activities allow the individual to succeed with minimal new learning because the motions are learned only once and then repeated. Although familiar activities are generally more comfortable, there is a risk that the client will compare present performance with past performance, further damaging his or her self-esteem. Therefore, simple, unfamiliar activities are sometimes preferred, at least initially.

The first activities used should be ones at which the person is guaranteed to succeed. Even a simple task like making a phone call or brushing one's hair can be a first step. Activities are then graded to include more complexity and require more effort as the person becomes more confident and energetic.

In the beginning, the activities should be ones that can be done alone, without the need to interact or share tools or materials with others. Thereafter, opportunities for minimal socialization should be presented as soon as the person seems comfortable. Those who are agitated benefit from activities in which they use their hands; this substitutes productive actions for nonproductive ones like hand wringing and fidgeting.

People who are depressed may avoid crafts, games, and exercise because they seem too pleasurable or too exhausting. Clients with depression may be more able to accept an activity that is useful to other people than to themselves. Staff should try to accept offers of help from depressed clients to reinforce the client's active choice. Some clients respond well to activities that are tedious, menial, and repetitive (peeling potatoes, mopping the floor); the client may be using these activities to work off feelings of guilt. Although clients should be permitted to do these activities

when they choose, other activities should be introduced gradually.

Gross motor activities can help to release tension, promote the intake of oxygen, and increase blood flow to the brain. There is ample evidence that activity can relieve depression (49), but the real problem is motivating the depressed individual to attempt it. The person's low energy level is a serious obstacle, but it can sometimes be overcome by simply telling the client that it's time for the activity (e.g., "We are going to the gym now.").

Precautions against suicide and self-abuse should be observed at all times. Although depressed clients may feel more in control if they can use sharp tools without harming themselves, the assistant must stay alert to this possibility. Even seemingly innocuous objects can be used in a suicide attempt—for example, a depressed patient might use a leather belt or macramé project in an attempt at hanging. Particularly in inpatient settings, tools and supplies should be accounted for at the beginning and end of every session and before any patient leaves the room, even to go to the bathroom. Similarly, when working with clients outdoors or in open or unfamiliar settings, the assistant must stay aware of all clients; depressed individuals may leave the group and harm themselves.

Activities that teach chronically depressed persons to manage stress and advocate for themselves are important. This includes leisure skills, assertiveness training, and role-oriented treatment focusing on the roles important to them. These experiences help clients to unlearn helplessness.

Selection of activities depends on treatment goals (Box 11-2). For persons with depression, these may include improving role balance, increasing coping skills, and improving social skills. Engel (16) suggests specific additional activities. Gutman (25) recommends teaching the consumer to monitor herself and her moods and to regulate moods through activity that is arousing or calming (depending on need). Clients can feel discouraged when depression recurs, and psychoeducation about the up and down patterns of mood disorders gives them needed information. Keeping to routines to comply with medication is also important.

Mania

Mania is a disturbance of mood characterized by excessive happiness (euphoria), generosity (expansiveness), irritability, distractibility, and increased activity level. The manic individual appears to be operating at highway speed in a 25-mile-per-hour zone. Everything is speeded up. Manic clients may be hyperactive or agitated. They may speak very rapidly (pressured speech) and skip from topic to topic (flight of ideas). They find it hard to concentrate on any one thing, instead flitting from one to another; they are often involved in many different activities simultaneously. They may express an unrealistic view of their own abilities, believing they can accomplish almost anything (grandiosity). They may get involved in very risky enterprises and endanger themselves or their families by spending money frivolously, taking expensive trips, extorting money from others, and so on. They seem unaware of or indifferent to the consequences of such actions.

People in manic states typically have very poor judgment, which reveals itself in almost everything they attempt. Their style of dress may be eccentric or downright bizarre. They may wear several hats or belts simultaneously or cover their clothing with emblems, buttons, or other decorations. Females (and some males) may wear excessive and poorly blended makeup.

One of the most disturbing qualities of persons in manic states is their attitude toward and effect on other people. They have a lot of energy and commonly flatter others and give them gifts. Because of this an unsuspecting staff member can be drawn into a relationship in which the staff member enjoys the client's mania because it fuels the staff member's own self-esteem.

People with mania are very sensitive to others' vulnerabilities—for example, they may say that

BOX 11-2

DEPRESSION: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Some simple, structured, short-term, familiar activities* include housework, organizing papers or books, folding laundry, simple cooking, sanding, clerical tasks, and sewing. The person's previous interests and occupational roles will guide the OTA in selecting the particular activity.
- *Craft activities* that may be less familiar but are still highly structured include mosaics, copper tooling, leather work, and woodworking. These must be graded down to a fairly simple, short-term level at first. Kits are useful, but the OTA should try the kit first, as many have one or two steps that are not obvious or that require dexterity or timing.
- *Gross motor activities* include aerobic exercise, dance therapy, yoga (shown here), running, swimming, ball games, and walking (especially outdoors).

Exercise and fitness. Physical health and fitness facilitate wellness and help with regulation of moods. Downward-facing dog *(adho mukha svanasana)* and other yoga poses *(asanas)* help pacify emotions and increase self-awareness and self-control. (Photo courtesy of the Iyengar Yoga Association of Greater New York.)

- *Values clarification, stress management, coping skills training,* and *assertiveness training* may provide resources for addressing specific problems.

they cannot be helped by a certain new therapist because that person just got out of school and does not have enough experience. If the therapist really feels insecure about this, the person may be able to drive the therapist away and manipulate the self-esteem of other staff who feel superior because they have more experience. Using this maneuver (known as splitting) can create staff conflict, which takes the pressure off the client.

Another tactic used by individuals in the manic state is upping the ante. The client starts by making what seems like a reasonable request (e.g., to go out to the hall to smoke a cigarette). Once the request is granted, the person asks for something else, and then something else, until he or she finally makes a request that is completely unreasonable (e.g., to have everyone stop working and take a break). When the therapist refuses to

grant the final request, the person becomes angry and abusive, arguing that the therapist is uptight and rigid.

What purpose do these tactics serve? Why is the manic person so ready to manipulate others? Some (28) argue that such individuals are very ambivalent about their need to be taken care of. They need other people but are frightened of depending on them. So they arrange to control and manipulate their caregivers. When such a client finally exhausts the patience of the caregivers and the caregivers take control over the client's behavior, the client has the satisfaction of being taken care of without having to ask for it.

Diagnoses in Which Mania Is a Common Symptom

Mania is the primary symptom of a manic episode in an affective disorder, but it can occur in other disorders as well. These include organic conditions caused by substance abuse, paranoid schizophrenia, and some personality disorders. Jamison (27), a psychiatrist, has written an interesting and highly readable first-person account of mania.

Strategy for Therapeutic Use of Self

The manic person's ambivalence about relying on other people raises specific issues for the therapeutic relationship. It is easy to be manipulated by someone who makes you feel special, and the OTA should beware of flattery. Similarly, criticisms of other staff by the client are often the opening gambit in a game of "You're the only one who can help me."

These clients may demand almost constant attention, praise, and approval from staff members. At the same time, their behavior, for which they are seeking approval, is often so bizarre and self-centered that others avoid them. The OTA should be cautious in giving any praise or approval to the person who is manic and should instead firmly and gently focus on how to make the behavior more appropriate. However, it is also essential to avoid criticizing manic clients because they are very vulnerable and easily feel rejected. Some psychologists argue that mania is the flip side of depression. In other words, the low self-esteem and feelings of despair and hopelessness that characterize depression are often just under the surface of the manic person's behavior.

It is important to be calm, matter-of-fact, firm, and consistent with the manic individual. Setting and enforcing limits on what the person can do shows the client that *someone* is in control, even if he or she is not. Such clients may also interpret limit setting as a message that the staff cares enough about them to stop them from hurting themselves.

As these clients' medication begins to take effect and their symptoms diminish, they may become frightened when they remember the bizarre and impulsive things they did when they were ill. Reassuring such clients that these behaviors were caused by the illness can make them feel more comfortable. It is important to recognize, though, that people coming out of a manic episode may face legal or financial problems as a result of their actions during the manic phase.

Getting manic individuals to focus on just one activity is a challenge. They typically make grandiose or unrealistic statements (e.g., "I'm very creative. I know weaving and beading and fashion design. I'm going to weave my own fabric and make a beaded evening gown."). The OTA should not go along with these schemes and should suggest other more realistic activities. The assistant must set firm limits on the use of supplies and materials and not permit the manic person to overrun the clinic. This requires constant alertness and patience; the OTA will have to remind and redirect the client many times over. As the person's mood becomes more stable, expectations for attention span and decision making should be increased (15).

The person is likely to resist rules and expectations for performance, saying in effect, "My way is

much more creative. Don't be a drag." It is important not to get emotionally involved in discussing why a project should be done a certain way; instead, firmly and briefly explain what has to be done and show the patient a sample. If the person insists on doing it differently, there is no point in arguing about it as long as no one is endangered. A sense of humor and perspective is very helpful in getting along with manic individuals. Because they are so distractible and have such poor judgment, manic clients should be carefully watched around electrical equipment and other objects that might accidentally cause injury.

Strategy for Modifying the Environment

Controlling the environment to help the manic patient function is based on a single principle: Manic patients respond to every bit of stimulation present. Therefore, the OTA should eliminate or reduce distractions in the environment to the greatest possible extent. For example, an occupational therapy shop decorated with many finished projects and interesting materials is likely to provoke intense interest in doing everything at once. To avoid this, the assistant should strip the environment of everything but what is essential to the activity. Tools and supplies needed for later steps in a project should be kept out of sight until such time as they are needed.

Remember that *anything* can distract the manic individual. Music, other people, the telephone, the view from the window can all invite the most intense curiosity and involvement. Distractions should be minimized. If possible, have the person work alone, facing a blank wall.

Strategy for Selecting Activities

Because of the high energy level, activities that permit the manic person to get up and move around are ideal. Short-term activities provide immediate gratification to the person with poor frustration tolerance and inability to wait for results. Allen (2) recommends that craft activities be portable because the client is likely to carry projects around.

Activities should be structured and have three or fewer steps. Activities that are unfocused or creative or that require decisions (e.g., oil painting) should be avoided. Similarly, activities should not require fine coordination or attention to detail. Materials should be controllable, not floppy or unpredictable (e.g., leather or wood rather than clay).

Because the manic person needs to develop a longer attention span, provide activities that involve carryover of skills from one day to the next. For example, whipstitch can be done first on leather and later as an embroidery stitch (fabric is floppier and therefore less controllable than leather).

Clients in a manic state may benefit from gross motor exercise because it allows them to move around and use up excess energy. However, it is difficult for the OTA (or anyone) to deal with more than three or four members in an exercise group if one is acutely manic; more staff are needed for larger groups. In later stages, as medication becomes effective, the person coming out of a manic episode can benefit from exploring ways to create and maintain a balanced daily schedule, including ample time for rest and sleep (15) (Box 11-3).

Hallucinations

A hallucination is a sensory experience that does not correspond to external reality. A hallucinating person sees, hears, feels, smells, or tastes things that are not there. Some common hallucinations are hearing voices, seeing animals or people or lights, and feeling burning or crawling sensations on the skin.

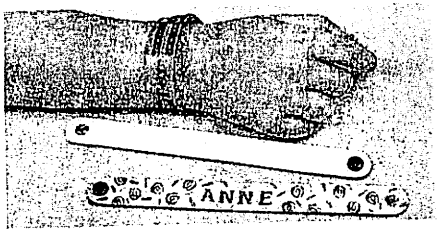
Hallucinations arise from a temporary or permanent defect in the way the brain functions. It is as though a connection were loose or a circuit were overloaded. There is a malfunction in the

BOX 11-3

MANIA: EXAMPLES OF APPROPRIATE ACTIVITIES

As with any other client, it is best to let the manic patient choose the activity. The assistant should present only two or, at most, three choices. Ideas about what activities might be appropriate can be obtained from the person's history or the evaluation.

- *Crafts* that might be used are copper tooling, stringing beads, and sanding and finishing prefabricated wooden projects. Some clients respond well to small leather projects (e.g., wristbands, coin purses with hardware already attached), such as the one shown. The assistant may need to perform one or more of the steps, especially if they involve fine coordination (e.g., ending the lacing, applying a snap). Projects in which the person's name can be part of the decoration appeal to some manic persons.



Small leather wristband. This is a suitable project for someone in a manic episode or with a short attention span. (Photo courtesy of S&S Arts and Crafts, Colchester, CT.)

- *Semistructured activities* can be used with caution. For example, magazine picture collage will invite chaos unless it is structured; by providing only a few magazines and a pair of scissors at first, then supplying the backing paper after the pictures have been selected and cut out, and the glue only after the pictures have been arranged, the assistant will help the client stay in control of what he or she is doing and obtain a better result.
- *Gross motor activities* such as dance, exercise, and volleyball can help the clients work off energy and use their hyperactivity productively. Sometimes it is easier to work one on one in an exercise activity with the manic person than in a group.
- *Time management, stress management,* and *money management* activities may be of use to persons who have recently experienced a manic episode or who have a history of such episodes.

part of the brain that interprets external sensation and that differentiates between what is happening and what is imagined. Changes in several brain structures and imbalances in several brain chemicals have been suggested as the causes of hallucinations (33).

Auditory (sound) hallucinations occur most often. Hallucinating people may hear voices telling them to do things (command hallucinations) or criticizing them or may hear music or strange sounds or someone calling their name. They may perceive a sound as much louder or softer than it

really is. Visual hallucinations are also common and may involve seeing walls move, having one's face look strange in the mirror, or thinking that people look transparent or flat. Gustatory (taste) and olfactory (smell) hallucinations, which are less common, affect patients with temporal lobe epilepsy; usually the hallucinated taste or smell is very unpleasant. Tactile (touch) hallucinations may be of itching or burning or a feeling that insects are crawling on or biting one's skin.

Clients usually find hallucinations troubling, frightening, and uncomfortable. It is not hard to understand this reaction to voices saying awful, threatening things or spiders crawling over one's clothes. However, the client may enjoy hallucinations of voices that praise the client or say he or she has special powers. Similarly, hallucinations that enhance reality are usually perceived as very pleasant. For example, the person may become transfixed by the glittering crystal patterns in an ordinary city sidewalk or by the varied textures and colors on a brick wall. It has been suggested that some individuals rely on their "voices" as a substitute for human relationships; this seems most likely when the voices say reassuring or flattering things.

Diagnoses in Which Hallucinations Are a Common Symptom

Hallucinations can occur in a wide range of psychiatric disorders and may also accompany a high fever. Some of the psychiatric disorders include schizophrenia (see discussion of perceptual distortions in Chapter 3), manic and depressive psychoses, organic mental disorders, and substance-abuse disorders.

In each of these conditions the type of hallucination may differ. For example, auditory hallucinations are common in schizophrenia; voices may comment on the client's behavior, usually in an insulting way. In schizophrenia, the hallucinations seem unrelated to the person's mood. In manic and depressive disorders auditory hallucinations may also be present, but they are *mood congruent*. This means that the voices say things that are consistent with the person's mood (e.g., telling the depressed person that he or she is bad or to commit suicide).

Strategy for Therapeutic Use of Self

Therapy staff should try to reassure hallucinating clients and help them understand what is happening to them, saying for example, "I believe that you see rats in the corners, but they are not really there. It's your disease that makes you see them."

Talking in a calm, firm, natural, rhythmic, soothing manner may comfort the person. Assistants should point out any real sensory stimulus that the person seems to misinterpret ("That sound was the central air-conditioning coming on."). They should avoid sarcastic comments, no matter how tempting. For example, when a client says he or she has visitors from another planet, the assistant should not say, "Oh, really? Which one?" Frese (18, 19), a psychologist and a consumer himself, suggests that a helpful reply might be, "How very interesting. Tell me more about it."

At the same time, however, OTAs should refrain from arguing about whether or not the hallucinations are real. Instead, they might redirect a client's attention to some neutral topic or activity and try to draw the person back to reality. They can acknowledge how the hallucination makes the client feel without agreeing that it is real. Because it is impossible to know a person's emotional reaction to a hallucination, the OTA should not assume that the person feels any particular way about it. However, clients who are hallucinating often react aversively to being touched by other people; therefore, the person should be given lots of room.

One report indicates that having the hallucinating client repeat a word or phrase that is comforting and positive may help reduce the length, frequency, and intrusiveness of hallucinations (33). For example, the person might say, "I am

safe here," or "I have done the best I can and it is good enough." Other strategies include either increasing or decreasing external stimulation, depending on what works; clients are very interested in exploring these strategies once they trust the practitioner and believe that the strategies may work. The key is for the client to identify simple and successful strategies, practice them, and remember to implement them (19, 32).

Reports (7, 32) suggest that cognitive therapy and other educational approaches may help some hallucinating individuals understand how the hallucinations arise. Persons with paranoid schizophrenia, for example, may be taught to identify "voices" as signals from their own brains; furthermore, they can learn to diminish or block them by wearing a radio headset, for example (7). The OTA who is interested in applying these strategies should read the literature and seek additional supervision and direction.

Strategy for Modifying the Environment

Many of those who hallucinate do so when they are under stress, especially in environments that are too stimulating for them. Sometimes just moving the person to a quieter, less overwhelming area will make the hallucinations diminish or go away altogether. Therefore, in general, the environment should be calm, quiet, and nondistracting.

On the other hand, clients should not be permitted to isolate themselves from other people entirely because hallucinations may increase in the absence of any other stimulation. In fact, associating with other people, especially conversing with them, tends to block auditory hallucinations and increase focus on reality. MacRae (33) reported that a client successfully limited his hallucinations by going on a planned walk as soon as the voices began.

Strategy for Selecting Activities

Simple, highly structured activities that encourage involvement and interaction with a few other trusted people are recommended. The structure prevents such clients from drifting away into a private world, and the presence of other people tends to focus them on reality. If possible, the activity should require some minimal interaction with others, if only to ask for a tool. These people should not be permitted to work alone, apart from the group. Activities should not demand attention to detail or fine coordination because the person may still be distracted occasionally by the hallucinations.

Some therapists advocate activities that strongly stimulate the senses. They argue that flooding the person's auditory channels with music or a sing-along may block auditory hallucinations. Allen (1) has observed that hallucinating individuals prefer to work with bright colors, and she believes these somehow interfere with the hallucinations. However, it is also apparent that hallucinations in some persons seem to get worse when other stimulation is increased, as if the hallucination were trying to compete for the person's attention. The most useful information about how a given activity affects a particular individual is obtained from that person. By watching how someone reacts and listening to what he or she says, the OTA can usually learn enough about the effects of the activity to determine whether it is working or how it needs to be changed (Box 11-4).

Delusions

A delusion is a belief that is contrary to reality as experienced by others in one's cultural group. A true delusion is a belief not based on reality. Delusional people may believe, for example, that television shows and newspaper stories have special messages for them or that automobile license plates contain a secret code that they must decipher to save the world. These beliefs are called *ideas of reference.* Or a woman may believe that the FBI is taking thoughts out of her brain (*thought withdrawal*) or putting strange ones in (*thought insertion*). She may feel as if she were

BOX 11-4

HALLUCINATIONS: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Simple, structured, short-term activities* might include coloring "stained-glass" (nonreligious) pictures, discussing specific current events, preparing lunch, and assembling wood kits. Familiar, necessary life tasks, such as doing laundry or housework, can also be used when relevant to the individual's interests and occupational roles.
- *Activities with strong sensory stimulation* include those involving music or dance, watching films or television, and cooking and eating. Falk-Kessler and Froschauer (17) described a group activity in which clients watched and discussed soap operas with the staff. Because many people with psychiatric disorders tend to watch many hours of television daily anyway, this seemed a way to control hallucinations and create a bridge from their imaginary worlds to reality.

being followed (*delusions of persecution*) or that she had special powers (*megalomania* or *delusions of grandeur*). Other common delusions include *erotomania* (the delusion that someone is in love with you) and *somatic delusions* (belief that something horrible is wrong with one's body).

A delusion is a false belief that is peculiar to the individual. It thus differs from a cultural belief, which although odd may be embraced by an entire nation or ethnic group. For example, people in some Caribbean countries believe that pulling on babies' limbs when they are bathed will make them taller, stronger, and better coordinated when they grow up. As another example, Australian aborigines believe that the "real" world that we experience while awake is less powerful and in a sense less real than the dream world of sleep and drugged states.

Students sometimes find it hard to remember the difference between a delusion and a hallucination. A delusion is an inaccurate thought or idea. (*Hint: de*lusion is a wrong *idea*.) By contrast, a hallucination is a false perception, sensory experience, or feeling. A person does not have to hear or see something that is not there to have a delusional idea; a delusion may be based on real-life events; it is the interpretation of these events that is odd. For example, the person may think that the newscaster on television who seems to look him or her right in the eye while summarizing a story knows all about the person and is sending a special message. What the person actually sees and hears is no different from what any viewer would see; it is the interpretation that is different.

The content and quality of delusions can give clues about the person's needs. For example, delusions in which one is special are thought to be a defense against feelings of inferiority and inadequacy. Being a target of persecution also conveys a sense of being special that may mask poor self-esteem, but because other people are viewed as dangerous, it also allows such people to distance themselves from others, thereby not risking rejection.

Diagnoses in Which Delusions Are a Common Symptom

Delusions may be present in any of the psychotic disorders: schizophrenia, bipolar disorder (both manic and depressive phases), and organic mental disorders. They may occur in certain personality disorders (schizotypal personality, paranoid personality), in eating disorders (anorexia nervosa, bulimia), and in persons who have no other known psychopathology.

BOX 11-5

DELUSIONS: EXAMPLES OF APPROPRIATE ACTIVITIES

Some intellectually challenging verbal activities include board games, current events discussion, crossword puzzles, and word games. Chess and computer games might also be used. Aspects of the person's usual occupation should be incorporated wherever possible—for example, a real estate agent can organize files and develop presentation materials or an office assistant can use a word-processing program. Expressive activities such as dancing or writing poetry are recommended by Frese (19).

Brain disorders, especially injury to the right cerebral cortex, may result in *delusions of misidentification.* In this sort of delusion, the person may feel that someone (spouse, for example) has been replaced by a duplicate or that one's original self has been replaced (12).

Strategy for Therapeutic Use of Self

As a rule, it is best to avoid discussing the person's delusions because discussion tends to reinforce them. Sometimes it cannot be avoided, however. Whenever possible, try to redirect the person's attention to an activity or something else that is reality based. It is pointless to try to convince delusional people that their delusions are not true: doing so will only alienate and anger them. So listen with interest but keep the focus on what you are doing.

Developing and organizing delusions that, although odd, make a certain bizarre sense requires a fair degree of intelligence and cognitive skill. Relate to the delusional individual as an intelligent adult. Avoid the appearance of being patronizing or frustrated.

Strategy for Modifying the Environment

The environment should be relatively stimulating and provide opportunities for the person to get involved in real-life activities.

Strategy for Selecting Activities

All activities should be suited to the person's intellectual level. Because people who develop delusions may have better than average verbal and cognitive skills, activities that use these skills are recommended. Of course, the activities should be appropriate to the person's occupational roles and reflect his or her interests, and the person should be helped to select his or her own activity.

Activities that are in any way related to the person's delusions should be avoided. For example, making wire jewelry might not be the best choice for a woman who believes that part of her brain was replaced by a complicated electrical device during a recent hysterectomy (Box 11-5).

Paranoia

Paranoia is a type of thinking in which persecutory and grandiose ideas predominate. General suspiciousness is usually called *paranoid ideation,* whereas very extreme and unbelievable ideas (such as that the attorney general and the police are out to get one) are termed *paranoid delusions.*

Paranoid individuals feel suspicious of those around them; they are constantly alert and concerned about whether others are harassing them, persecuting them, taking advantage of them, or treating them unfairly. They keep themselves aloof and distant from others, often subjecting family and would-be friends to repeated "tests" of loyalty.

One way to think about paranoia is as a defense against rejection. By believing that others are out to get them, these people protect themselves from rejection. This keeps them from developing relationships in which they fear they may get hurt.

Similarly, they avoid experiencing their low self-esteem by instead thinking that they are special in some way. Paranoid individuals seem to need to believe that they are better, more moral, more self-sufficient than other ordinary people. They are afraid to lose their independence and to have to rely on another person.

Diagnoses in Which Paranoia Is a Common Symptom

Paranoia is the predominant symptom in paranoid schizophrenia. It is also seen sometimes in psychotic depressions and in paranoid personality disorder. The suspiciousness shown by persons with borderline and narcissistic personality disorders can be considered a kind of paranoia.

Strategy for Therapeutic Use of Self

Occupational therapy assistants will understand how to approach paranoid persons once they try to look at the world from their point of view. In their way of looking at things, everything is dangerous; anyone or anything can threaten their uncertain sense of self. The OTA should avoid approaching them suddenly, from behind, or in a manner that might be perceived as threatening. It is important not to whisper in these patients' presence because they will believe you are talking about them.

Similarly, any directions or statements made by the OTA should be clear, consistent, directive, and unambiguous. Paranoid individuals are often very intelligent, perhaps more intelligent than many of the staff and, therefore, should be approached as intellectual equals. Arguing with them is pointless; they always win. They often possess extraordinary memories; therefore, it is wise to be truthful and not make promises unless you are certain you can keep them.

Frequently, a paranoid person in an activity group will separate from others and try to strike up a special relationship with a staff member. Some therapists believe that allowing and encouraging this special relationship helps the person adjust faster to the group. The person can be given a special role (passing out supplies, taking attendance) that makes him or her feel important. The paranoid individual is threatened by competition, so competitive games and situations in which one person is compared with another should be avoided. These people should be given the message that they are important and that they should focus on themselves and not worry about what other people are doing.

The question of who is in control of a situation is a real concern for the paranoid individual. OTAs must be careful to stay in charge of the situation and not let such patients run away with the show. For example, these patients may want the other patients to sit in assigned seats (usually away from them); by refusing this request outright, the OTA may alienate paranoid clients; but by giving in to them, the OTA suggests that these patients have a great deal of power. In such a case, artful practitioners work out a compromise that gratifies the paranoid person's need to be alone while still affirming the therapist's own control of the situation—for example, the practitioner may seat the patient at a separate table but let others sit wherever they wish.

Strategy for Modifying the Environment

The paranoid client is easily threatened by changes in the environment; therefore, the environment should be kept as stable and reliable as possible. When changes are anticipated (e.g., a new paint job, a rearrangement of furniture for a special event), the client should be prepared in advance.

Many paranoid patients deliberately isolate themselves from other people. This is a self-protective

measure that the OTA should tolerate and support until the person feels more comfortable. Social contact should never be forced on paranoid individuals. After an initial period of isolation, they should be encouraged to join others in a group; usually they will first take on the role of a watchful observer or "special assistant" described earlier. Gradually, after repeated exposure to the same people, the paranoid client may begin to relate more spontaneously.

Because the paranoid person is easily threatened and frightened, there is some potential for violence. Staff should follow the safety guidelines recommended for the hostile and aggressive client.

Strategy for Selecting Activities

Activities must be ones the person can control. Structured activities involving controllable materials (e.g., leather work) are recommended. Before presenting any activity, the OTA should make sure that it is appropriate for the person's intellectual level and complex enough to engage and maintain his or her interest. In the beginning, activities should be individual and done independently without need for help or instructions. Most paranoid patients can follow diagrams and written directions. Unless there is reason to suspect that the person is suicidal or assaultive, it is best to hand over the tools at the beginning of the session rather than requiring him or her to come and ask for each one individually (Box 11-6).

Anger, Hostility, and Aggression

Anger is a strong feeling of displeasure. Hostility is an unfriendly and threatening attitude directed toward other people. Aggression is an attack on a person or object; aggression can be verbal, physical, or both. Before discussing some of the reasons clients are angry, hostile, or aggressive, it is important to distinguish aggression from assertiveness, with which it is sometimes confused. Assertiveness is the direct expression of feelings and desires; it has come to be synonymous with "sticking up for oneself." There are situations in which a person must be both assertive and aggressive. For example, in New York City parking spaces are at such a premium that it is quite common for two drivers to want the same space. What should the driver who arrived first do? To secure the space, it may be necessary to get out of the car and argue about it. Most New York City car owners consider this assertiveness appropriate.

Another important consideration is that some cultural groups condone aggressiveness by men, especially when avenging real or fancied insults to women. Although the degree of aggressiveness displayed may seem extreme or silly to someone from a different social class or cultural background, it is accepted and even expected in some cultures.

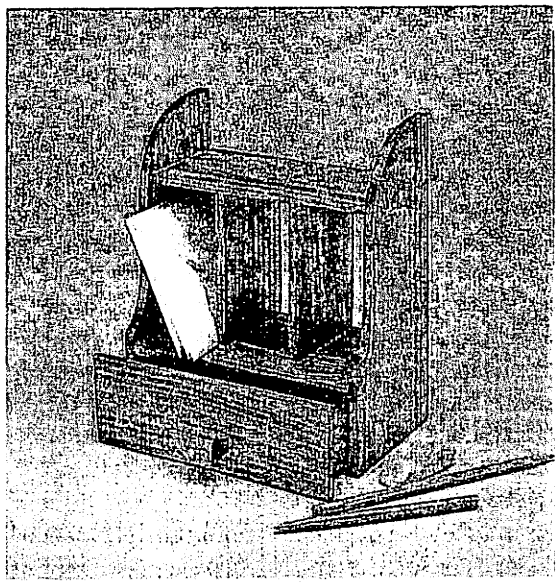
When the OTA is working with individuals who are verbally or physically aggressive, it is important to distinguish between ordinary (culturally endorsed) self-assertiveness and inappropriate aggression. Although almost everyone feels angry at times, sometimes with good reason, most people can control their feelings and avoid acting them out. Those who are unable to express their feelings in words may resort to violence; this is true especially if the person has a history of being abused as a child or being violent as an adult.

Clients who become verbally abusive or physically violent may be expressing any of a variety of unmet needs. They may feel threatened or hemmed in, physically or psychologically. Psychiatric treatment settings are often crowded, and clients may find the physical press of other people and the lack of privacy overwhelming; similarly, they may feel confined and frustrated by the rules and restrictions. Some individuals use physical or verbal violence as a way of venting frustration, of letting off steam; often such people find it difficult to express themselves in words and have not developed any constructive channels for their feelings (e.g., sports, hobbies). Others use hostility and aggression self-protectively; by keeping others at a distance they make rejection impossible.

BOX 11-6

PARANOIA: EXAMPLES OF APPROPRIATE ACTIVITIES

Wood, leather, or metal projects constructed according to written instructions are sufficiently complex to challenge this type of individual. The project shown is a good example. Other possibilities include high-level clerical tasks (organizing files, using computerized data bases), design tasks, jewelry making, and puzzles.



Desk organizer. This relatively complex kit involves the separate assembly of case and drawer (compare this to the simpler heart basket shown in Box 11-1). Many pieces are of similar size and shape. The kit requires organizational skills for orienting the pieces and ordering the assembly. This is a suitable project for someone with a high cognitive level and good attention span. Prior woodworking experience is helpful. (Photo courtesy of S&S Arts and Crafts, Colchester, CT.)

Diagnoses in Which Anger, Hostility, or Aggression Is a Common Symptom

Some persons with psychotic disorders (paranoid schizophrenia, manic–depressive psychosis, psychotic depression, organic mental disorders) become hostile. Usually something has happened to provoke this response, but it is often hard to figure out exactly what. Substance abusers and persons with antisocial personality disorders may also show hostility. Some brain disorders are disinhibiting, meaning that the person no longer feels bound by customary social taboos. Finally, any person may become angry, hostile, and even violent if sufficiently provoked; anger can be a normal response to illness and disability (34, 44).

Strategy for Therapeutic Use of Self

Staff should be sensitive to clients' feelings generally and alert to signs that a client is feeling tense, threatened, or suspicious. People's body language gives clues to their mental state. For example, stiffness or rigidity in the set of the mouth or the shoulders usually signifies anger or anxiety. Threatening gestures and the destruction of objects, no matter how small or insignificant, are other signs. The sooner the possibility of aggressiveness is recognized, the sooner it can be dealt with.

The general approach is to get these people to talk about what is bothering them and to help them use words to express their feelings rather than just acting them out. It is important not to respond in kind, no matter how insulting or provocative the person's behavior might be. If the person is very excited, it can help to say the same calming words several times (broken-record technique) (44).

Try to speak to the person privately, avoiding a public display that may make her feel more threatened or embarrassed. Encourage her to discuss her feelings. Tell her exactly what must be corrected about how she is behaving in the situation, explain that her behavior is affecting you and the other people present, and give her some alternatives for handling it. Avoid punishing or criticizing; these approaches are humiliating and tend to escalate aggressiveness.

It is important to be direct and clear about what is expected. Follow through by enforcing any limits you set. To illustrate, if you have told Mr. Jones that he will have to leave the group if he touches anyone again, you had better make sure you have other staff available who can remove him if this happens. Otherwise, Mr. Jones may continue to test your limits because you obviously cannot be taken at your word.

Be especially cautious with clients who say that you or another staff member or client remind them of someone they do not like. This should be considered a warning that the person may attack when psychotic and out of control. Violent acts are more likely in those who have a self-reported history of violence than in those without such a history (10).

Strategy for Modifying the Environment

Because of the potential for violence, hostile individuals may have to be isolated from others who irritate them. While speaking to hostile or potentially violent persons, the OTA should stand 4 or 5 feet away and to the side, not facing the person directly. This position gives the person room and is not confrontational. It is not a good idea to be alone with someone who may become violent. Similarly, when in any room, be sure that the door is left open, and position yourself so that you are closer to the door than is the client. Do not touch the client. Even what you intend as a comforting touch can be perceived as an attack. Remove all sharp objects and other potential weapons from the area. Even brooms and mops have been used to beat people to death, so *think*.

Strategy for Selecting Activities

Unfortunately, there is no handy formula for choosing activities for the angry, hostile, or aggressive person. Therapists who follow objects relations theory believe activities that encourage sublimation of aggressive feelings are best. These need not be openly aggressive activities. For example, symbolic activities like art and dance may permit the person to express feelings in a socially acceptable way; this seems especially useful for those with poor verbal skills. Activities that require large, forceful motions (e.g., wedging clay) can also express aggressiveness, but reports suggest that these increase anger and aggressiveness (34, 45). Avoid activities that require frustration tolerance and attention to detail. For obvious reasons, eliminate activities that involve sharp tools or small, heavy, throwable objects. Activities that use repetitive motions may help some people organize and control their feelings.

BOX 11-7

ANGER, HOSTILITY, AND AGGRESSION: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Active sports* and other gross motor activities such as dance are useful for releasing tension.
- *Sanding a large wood project* involves repetitive gross motor movements and is mildly destructive; it is an example of an activity that might help reduce tension.
- *Peeling potatoes* is another activity that can serve the same purpose; the tool should be a potato peeler with a rounded point (not a knife). Activities that involve sharp or potentially dangerous tools (e.g., woodworking, metal hammering) should be used only when both therapist and patient feel comfortable that the patient can control himself or herself.
- *Anger management* (23, 24, 26, 45) and *conflict resolution training* (20) may benefit those who have problems managing, controlling, and expressing anger. Such training gives the person the skills of preplanning a response to angry feelings, identifying anger when it occurs, problem solving to handle anger, and empathizing with and forgiving the other party (24).
- *Assertiveness training* provides skills that use reason and verbal expression to meet needs.

Addressing the stress that is fueling the hostile, angry or aggressive state is another option. When angry, a person experiences a high level of physiological arousal (e.g., increased heart rate, respiration, energy) that interferes with rational thinking and problem solving. Aggressive people may not understand that this is happening or may not know that they can learn to monitor and control this arousal by relaxation and stress management techniques (19, 44). Furthermore, they may benefit from specific stress management strategies, such as learning to monitor and reduce demands and to increase resources to deal with situations. Training in assertiveness skills (learning to use words and reason) can replace the habit of expressing rage (Box 11-7).

Seductive Behavior and Sexual Acting Out

Seductive behavior is any behavior that would normally be seen as explicitly (openly) sexual or as provoking a sexual response from others. Examples are highly varied. They may be as subtle as touching someone's shoulder or loosening a tie or collar or as blatant as making sexual remarks or asking a staff member for a date. Sexual acting out is openly sexual behavior in response to unconscious feelings. This includes engaging in sexual acts with other clients. Sometimes the phrase *sexual acting out* is used to describe extreme behaviors of people who have lost contact with reality while in a psychotic state. Such individuals may, for example, masturbate openly, disrobe in public, tuck their shirts into their panties and dance around, or fondle other patients.

Sexual needs do not disappear when a person becomes mentally ill; people with mental illnesses have the same needs as everyone else, but they sometimes have more difficulty gratifying their sexual needs. Inpatients who may have been used to daily sexual activity before hospitalization find that they can see their sexual partners only on weekend passes. To add to their frustration, the lack of privacy may make masturbation difficult or impossible. Individuals with severe and persistent mental disorders may not have developed sufficient social skills to be able to form close relationships in which sexual needs can be gratified. So it

should not be surprising that some clients seem preoccupied with sex.

Sometimes what looks like seductive behavior is really a bid to get attention or to see how a staff member will react. Clients who can make staff members sufficiently uncomfortable can make sure that those staff members will never confront them about their real problems. Similarly, people who feel unattractive or insecure may set up a sexual confrontation so that a staff member will reject them, thus confirming their worst fears.

In addition, clients who are hallucinating may attempt to remove their clothes because they feel insects crawling on them or because they hear voices commanding them to do so. King (30) points out that sexual promiscuity may have its roots in "skin hunger," or a need for warmth and tactile input. So it is important to pinpoint the motivation behind the person's behavior before deciding what to do about it.

Diagnoses in Which Sexual Acting Out or Seductiveness Is a Common Symptom

The most extreme forms of sexual acting out (disrobing, open masturbation) usually occur only in people who are psychotic. Less common, these behaviors are associated with psychosexual disorders (exhibitionism, sexual masochism). The other behaviors mentioned may be seen in any client (or indeed in anyone anywhere).

Strategy for Therapeutic Use of Self

Clients who are behaving inappropriately should be told so in a calm, nonjudgmental manner. Such clients should be stopped from doing things that will later embarrass them. For example, if a woman will not stop her lewd dancing, she should be excused from the dance activity for the day. The rules of the particular setting should be strictly enforced (e.g., most inpatient settings forbid physical contact between patients).

Clients who try to involve staff in sexual relationships may be expressing needs that are not directly sexual. For example, an adolescent boy who fears that he is homosexual may behave seductively to a woman therapist to test his own sexual identity. Some clients may confuse the closeness of the therapeutic relationship with the intimacy of a sexual one (see Chapter 10). When a client behaves seductively toward a staff member, the staff member should carefully explain the nature of the therapeutic relationship and should discourage further overtures gently but firmly. The staff member should avoid *any* physical contact and should not allow the person to talk about the possibility of a sexual relationship between them. As a last resort, if the client is not able to stop, the OTA should arrange for another person to work with the client.

Notify staff and document all sexually preoccupied behavior and remarks to prevent incidents that may happen at night or when fewer staff are around. Encourage clients to tell on others who abuse or harass them sexually.

Strategy for Modifying the Environment

Crowded situations, in which physical contact is almost unavoidable, are not a good idea. The client should have personal space and be protected from the sudden touch, smell, and warmth of others.

Strategy for Selecting Activities

No one would dispute that sex is the best activity for gratifying sexual needs. If the person's religious beliefs permit and the assistant feels comfortable, masturbation can be suggested as an alternative. Also, it is possible to release a great deal of tension, sexual and otherwise, through forceful gross motor activities. Activities that involve other people, especially with physical contact, should be used cautiously, depending on the person's tolerance and self-control. Social skills

BOX 11-8

SEDUCTIVE BEHAVIOR AND SEXUAL ACTING OUT: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Forceful gross motor activities* that can be done alone or without physical contact include, for example, exercise, running, wedging clay, and woodworking.
- *Activities involving others in nonsexual physical contact* are sports like volleyball, basketball, and touch football, and dance.
- *Swimming, cycling, weight training and aerobics,* and *yoga* are example of activities with limited or no physical contact that still permit physical release.

training and other activities that teach or reinforce appropriate social behavior are also recommended (Box 11-8).

Cognitive Deficits: Confusion and Impaired Memory

A cognitive deficit is an impairment or defect in one or more of the mental functions needed for thinking. Some of these processes are orientation, alertness, concentration, attention span, memory, comprehension, judgment, and problem solving.

Orientation is knowledge of where one is, what time it is (hour, day, date, season), and who one is with. This is sometimes called orientation to time, place, and person and abbreviated as orientation 3 (meaning orientation in three spheres of information). Problems in this area are described as *disorientation* or *confusion.* Generally, disorientation to time alone is the least severe form; disorientation to place and time is more severe; and disorientation to person, place, and time is the most severe.

Alertness is awareness of the immediate environment. Problems in alertness may be described generally as *low arousal* (seemingly unaware of stimulation), *clouding of consciousness* (meaning literally that the person seems to be in a fog) or impairment of a specific aspect of alertness. Concentration and attention span are aspects of alertness.

Concentration is the ability to focus one's mental energies on the task at hand. The intensity of focus is the primary concern. *Attention span* is the length of time that concentration can be maintained. Impairment in attention span may be described *distractibility* (meaning a tendency to lose focus because another stimulus catches one's interest) or *inattention* (usually meaning the inability to pay attention even though no competing external stimulus is present). Responses to these symptoms are discussed in the next section.

Memory is the ability to recall past events and knowledge. Health professionals commonly distinguish between short-term memory and long-term memory to indicate the difference between memory of events from months or years ago (*long-term memory*) and memory of more recent events (*short-term memory*). Thus the ability to remember one's date of birth or the names of one's children reflects long-term memory, and the ability to remember whether one had lunch or where one's eyeglasses are reflects short-term memory. Experimental psychologists sometimes use short-term memory to mean memory of events that occurred within the past few seconds (sometimes called "working memory") rather than hours or days (48). Because this can cause confusion among treatment staff, make sure that you understand which kind of short-term memory is being

described. Problems in remembering important information are *memory impairment.*

Comprehension is the ability to understand. Comprehension is composed of many skills, including the ability to recognize words, to identify objects, to place things in order by time or size or some other quality, to extract essential information from a spoken or written passage, and to classify or sort or group objects in a logical fashion.

Comprehension depends upon the development of concepts. We can think of concepts as containers for experiences—for example, our concept of *dog* includes many varieties and sizes of dog; when we see a four-legged animal, we compare it to other items in the concept *dog* to see if it belongs in this container. A person's ability to comprehend depends on the number of concepts available and the way they are organized. To illustrate, an unsophisticated concept of *muscle* might refer just to physical strength ("he's got muscles"). A student of physical medicine or anatomy has a more sophisticated concept—in fact a highly organized group of concepts—including, for example, striated muscle, voluntary muscle, antagonist, and deep hip flexor.

Trouble comprehending may have other than psychological causes. Language skills, prior education, and life experience all affect comprehension. Physiological changes from brain damage or chemicals in the body can also impair comprehension. Problems in comprehension are usually described as *inability to comprehend.*

Judgment is the ability to recognize and comply with established social norms and standard procedures. Like comprehension, judgment may reflect background and social class. Using foul language probably indicates bad judgment in an otherwise conservative businessman but may be the social norm for a dock worker. Problems in judgment are usually called *impaired judgment;* some examples are urinating on the street, making sexual innuendoes to co-workers, and sitting down on a bench marked with a sign that says "Wet Paint."

Problem solving is the ability to recognize, analyze, and ultimately figure out solutions for problems that arise in the course of everyday activity. Some examples of problems that most people have to solve are budgeting money and getting from place to place. Everyone but the very wealthy has to figure out how to pay for things like repair of the water heater or a new car. When the car breaks down or the train is delayed, an alternative way of transporting oneself has to be found. Living on one's own in the community depends on the ability to solve problems such as these. Because cognitive impairments have such a profound effect on a person's ability to function independently, they are discussed several times in this text (see Chapters 6, 22, and 23).

People who realize that their thinking is not as clear as it once was or that they have forgotten and left a pot burning on the stove (for the fourth time) may become very frightened and anxious. They may begin to check things many times over or engage in ritualistic actions. Or they may become anxious, agitated, or even belligerent. Commonly, long-term memory and recall of events from many years ago are excellent. Problems in short-term memory are deeply disturbing, and the person may make up stories to cover them up. This is called *confabulation.*

Many cognitively impaired individuals are also depressed; it is not always clear whether the depression is the cause of the cognitive problems or the result. Most people believe that the depression and the cognitive problems interact with each other in a negative way; the more such people have problems in thinking and remembering, the more depressed they become. Likewise, the more depressed they are, the more likely they are to forget things and have trouble concentrating. Thus the depression and the cognitive problems fuel each other, and these people may become more depressed and more impaired as time goes by. Furthermore, disturbed or insufficient sleep may contribute to cognitive deficits and depression; usually this is temporary, but it may require intervention in adhering to a daily schedule and learning strategies to improve continuity of sleep.

Some individuals with cognitive problems have very *labile* emotions. This means that they rapidly shift from being calm and comfortable to crying or laughing uncontrollably. For example, an elderly nursing home resident who remembers the death of a childhood pet may suddenly burst into tears.

People who are disoriented frequently get lost, especially in strange new environments, such as hospitals and nursing homes. They need help finding their rooms and their way to the bathroom.

Those with poor judgment usually do not recognize that their judgment is off; that they are doing something inappropriate, like washing their hair in the water fountain; or offensive, like fondling the assistant's derriere. They may try to laugh it off or prevent further criticism by arguing. Both of these behaviors can be considered defenses against the anxiety and pain that would result if they understood what they had done.

Problems in carrying out motor actions are often associated with cognitive deficits. These may be more or less severe and can be analyzed according to Allen's cognitive levels (see Chapters 3, 15, and 23). *Dressing apraxia* is a severe form in which the person has trouble carrying out the proper sequence of actions to get dressed and may, for example, put her socks on over her shoes or wear two skirts.

To summarize, cognitive deficits can seriously impair a person's ability to function. The person with cognitive deficits may have a wide range of emotional reactions in response to decreasing function. When working with cognitively impaired persons, it is important to consider their emotional response and to evaluate whatever cognitive skills are still intact.

Diagnoses in Which Cognitive Deficits Are Common

Cognitive deficits occur to varying degrees in many psychiatric disorders. They are always found in organic mental disorders; in these disorders, which include Alzheimer's dementia, the impairment is usually severe and progressive, meaning that it gets worse over time. Cognitive deficits can also result from physical disease. Any disease that impairs circulation affects the brain because less blood and therefore less oxygen reaches it. Brain infections and trauma to the head can result in cognitive problems that may be permanent or transient. In planning interventions it is important to differentiate permanent disabilities from those that are temporary.

Drugs and alcohol affect brain chemistry and therefore can cause cognitive deficits. Phencyclidine (PCP) abuse often results in impaired alertness, concentration, and attention span. Prolonged or extensive alcohol abuse is associated with an organic mental disorder characterized by permanent impairment of intellectual abilities. Some prescription medications, including several used for treatment of psychiatric disorders, can cause temporary cognitive deficits that disappear when the medication is discontinued.

Finally, patients receiving electroconvulsive therapy (ECT) as a treatment for depression usually are disoriented and have short-term memory loss for several days after receiving treatments. With time, these mental functions usually recover, although the person may never be able to remember events that occurred around the time of the treatments.

Strategy for Therapeutic Use of Self

General rules for approaching the person with cognitive deficits are difficult to prescribe. Various clients function at various levels; some forget only an occasional fact or today's date; others are so disoriented that they think Nixon is president or that they are in a factory rather than a nursing home. It is important to approach each person as an individual and to pitch your comments and directions to the person's present level of functioning. By doing this, you help the lower-functioning individual feel more secure and avoid insulting those who are higher functioning. Keeping this important

precaution in mind, the following guidelines should be used.

Because being disoriented can be very frightening, be sure to remind these patients of where they are and who you are. For someone with severe memory impairment (this includes those receiving ECT) it may be necessary to repeat this information each time you see the person. Wearing a name tag with your name and title in large print can help. Keep in mind that disoriented clients may have trouble finding the bathroom; orient them to this and any other important aspects of the environment. Other information that patients may need to know includes the time of day, what is happening now, and what will be happening next.

Although people with cognitive impairment may do very inappropriate things because of poor judgment, the assistant should consistently show a warm and accepting attitude. Clients should not be punished or threatened no matter how inconvenient or unpleasant their behavior has been. Instead, the assistant should gently explain what is expected and then help clients behave appropriately. It is important to intervene immediately when clients do something wrong and to help them correct it then and there. Otherwise they may not know what you are talking about when you mention it later.

Whenever clients are given directions, whether on how to do an activity or how to get to the cafeteria, the directions should reflect the five *C*s: *calm, clear, concise, concrete,* and *consistent.* Speak in a calm tone of voice, articulating the words clearly. You may have to speak more slowly than you do usually, but your tone of voice should be respectful, not patronizing or impatient. Whatever you have to say, make it brief; the person's attention span is short. Use common everyday language, not abstract or difficult words that are hard to understand. Finally, use the same words every time you give the directions. Incorporating the person's own words can be helpful. To illustrate, if a man asks where you put his "specs," use this word rather than *glasses* or *eyeglasses* when you tell him where to find them. If you expect the person to remember the directions and use them later, have him or her repeat them to you. Better yet, write them down or make sure that the client writes them down.

Finally, match your tempo to what the person seems able to handle. The cognitively impaired may take a while to respond; it just takes them longer to process ideas and information.

Strategy for Modifying the Environment

Three main principles are used to modify the environment. First, control the environment to maximize safety. Second, use the environment to cue desired behavior. Third, avoid environmental cues that may trigger undesirable behavior (22).

Cognitively impaired persons, more than any other group of patients, need a consistent and well-designed environment. Good lighting will help keep the person oriented. Even at night, lighting should be kept fairly bright. Colored lines (whether tiled, taped, or painted) on the floor leading to the bathroom and other frequently used areas are also good orientation aids. Reflector tape is recommended.

Locations should be clearly marked with signs. Large print should be used. Pictographs or pictorial symbols may be more easily recognized than words; an example is a picture of a cup and saucer on the door of the cafeteria. Signs or symbols on patients' room doors may help them find their rooms; making the sign can be a good project. Persons with cognitive impairment may need to label, mark, or color code objects in their rooms to help them find them. In general, the environment should be simplified and all needed objects and locations should be clearly marked. Items that are often needed should be visible. Items that are rarely used or that may distract should be hidden (Fig. 11-1).

External memory aids such as a large clock, large calendar, and radio are valuable. These help

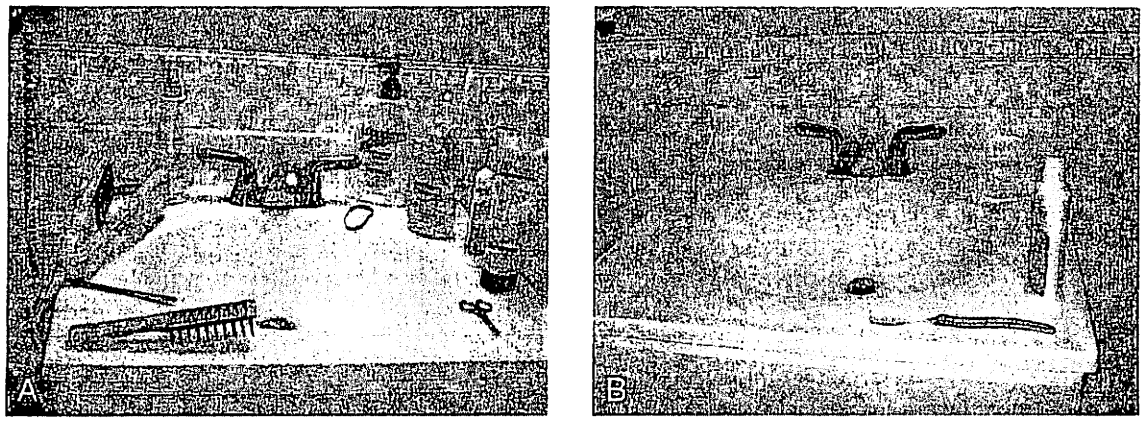


Figure 11-1. A. Cluttered environment. Though the toothpaste and brush are present, they are hard to find. The presence of other objects distracts from the task of tooth brushing. **B. Clarified environment.** This setup clarifies the task and cues the person by providing only the appropriate tools. *Note:* Persons with memory impairment may not recognize the upright dispenser or associate it with toothpaste. Those with weak grip strength will find a traditional tube of toothpaste easier to use than the upright dispenser shown here.

orient the patient to time and to current events. Patients who must remember to do things at a certain time can use *cuing devices* such as programmable alarm watches and timers. Many electronic devices store specific kinds of information; speed dialing on telephones is one example. Sometimes such devices are difficult for the patient to learn to use, in which case their value is questionable. We recommend that to stay current, clinicians make regular visits to electronics stores. Note, however, that devices that require new learning will require training and may be unsuccessful for the person with cognitive impairment.

Because people with cognitive impairments rely so much on structure and routine in the external environment to help them stay organized, they are very sensitive to any changes. Therefore, the environment should be kept the same from day to day; this is true of the occupational therapy clinic as well as the person's living area.

The question of how much stimulation should be available in the environment is fascinating and much debated. Research has shown that environments with low amounts of stimulation can impair cognition because they deprive the senses of necessary information. However, it is also true that too much stimulation can aggravate cognitive impairments because the person cannot process so much information at one time. Clinicians agree, however, that any stimulation presented should be clear and unambiguous. For example, when music is used, it should be played on a good stereo system rather than a cheap tape deck with poor sound quality.

Another factor to be considered in designing an environment for someone with cognitive impairments is its similarity or dissimilarity to the person's home environment. Ideally, the person should remain at home as long as possible, using compensatory devices and the support of other people. When entering the hospital or nursing home, not only are such patients often seriously ill and in psychological distress, but their distress is further exacerbated by the strangeness of the environment. Residents' discomfort can be lessened somewhat if they are allowed to keep mementos of home in the room. They should also be encouraged to set up their belongings in whatever way makes sense for them, as this will encourage carryover of

dressing and hygiene and grooming routines. Finally, when someone is planning to return home or is to transfer to another facility, the future environment must be considered. Teaching of new skills or reinforcement of old skills should take place in an environment similar to this future one.

A large amount of research evidence and specific suggestions exist on environmental management for cognitive impairments related to dementia, traumatic brain injury, schizophrenia, and other brain disorders. The reader working with individual with cognitive impairments is strongly encouraged to consult the references which give additional details on modifying the environment (4, 21, 22, 29, 40).

Strategy for Selecting Activities

The person's prognosis must be considered when selecting activities. Some cognitive impairments are transitory and the person is expected to regain full function (e.g., post-ECT memory impairment). These patients should be given simple, structured, short-term activities that are relevant to their interests to help them maintain their abilities and confidence until they recover. Activities that can be finished in one day are preferable; the person may refuse to work on a project two days in a row if he or she does not remember it. Once cognitive functions begin to return to normal, the person should be quickly reintroduced to familiar activities and skills he or she needs in her occupational roles.

Other conditions (e.g., dementia associated with alcoholism) are permanent but stable; the condition will not get better, nor will it get worse. For these individuals, the specific cognitive deficits must be identified and analyzed in relation to previous occupational roles. Then the person can be taught ways to adapt to the disability within these roles or to find new occupational roles more appropriate to the present condition. The general approach is to simplify known activities rather than introduce new ones.

A third group of conditions, unfortunately, are permanent and progressive; the person will become less and less able to function and eventually will die. These patients need help to maintain for as long as possible whatever skills remain. They should be encouraged to be as independent as they can while they can. Activities should be restricted to those that are familiar, relevant, and necessary. Participation in self-care is important to help them retain a sense of dignity and self-esteem. Most of these individuals can learn new skills only by rote practice and as applied to very specific situations. Gitlin and Corcoran (21) provide specific suggestions to modify objects and tasks to improve performance. In general, the idea is to reduce complexity and make the task clear and doable.

Some general guidelines apply to all three groups. First, unfamiliar and complex activities should be avoided because they will add to confusion. Activities that require independent decision making may overwhelm someone with limited judgment; activities that involve simple choices (e.g., between two colors or two food items) can build confidence, however. The OTA should help these patients carry out activities they value.

Depending on individual need, the person may benefit from reality orientation. This approach, which aims to keep the person aware of what is going in the world, is described in Chapter 22. Touring around the halls and practicing travel within the treatment facility is appropriate for severely disoriented patients.

Some of those who have confusion or impaired memory find it helpful to write things down. They should be encouraged to carry a notebook with them at all times; designing and organizing the notebook can be an ongoing activity. Taking an excursion to town to select an appointment book at the stationery or office supply stores can be a way to assess travel and orientation skills (Box 11-9).

BOX 11-9

COGNITIVE DEFICITS: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Current events discussion, patient government or resident council,* and *reality orientation* are designed to help the person stay oriented and involved.
- *Life tasks* should emphasize self-care and whatever other tasks may be needed for a particular individual (e.g., cooking, housework, laundry, shopping).
- *Familiar crafts and hobbies* can help bolster self-confidence when the ability to do more complex tasks has been lost.
- *Short walks or shopping excursions* provide variety, exercise, and a sense of added purpose.

Attention Deficits and Disorganization

Attention deficits are problems in directing attention to a task or in sustaining attention for a reasonable length of time. Disorganization is a lack of planning and order that interferes with successful completion of activities. Attention deficits and disorganization are often associated with the other cognitive deficits already described. However, because the general management of these symptoms is different, they are discussed separately.

Clients may have trouble concentrating on a task or paying attention to it over time for several reasons. They may be distracted by hallucinations, memories, or other internally generated stimuli or by things around them in the external environment. Individuals with brain disorders may process information more slowly than other people; by the time they figure out what is happening, something else is going on, and they have trouble keeping up.

Clients who have trouble paying attention are likely to have trouble with organization as well. However, another possible cause of disorganization is overstimulation; they have difficulty focusing on one thing at a time because there is so much that catches their attention (this is common in mania). Still another is poor judgment, evidenced by trying to do too many things at one time. Also, someone may appear disorganized simply if he or she lacks the skills or knowledge to perform the activity. To illustrate, someone who has done little cooking will have trouble assembling the necessary ingredients and implements and carrying out the steps efficiently.

Diagnoses in Which Attention Deficits and Disorganization Are Common

Both attention deficits and disorganization occur in organic mental disorders, in PCP and alcohol abuse, and in schizophrenia and affective psychoses. Persons with learning disabilities often have these problems. Normal individuals are likely to have impaired attention and to be disorganized when they are under stress or otherwise preoccupied.

Strategy for Therapeutic Use of Self

It may be difficult to get the attention of someone with severe cognitive impairment. If so, say the person's name *loudly.* If necessary, shout; although this may feel uncomfortable to you at first, it is the only way to get the attention of severely regressed individuals. Those who do not respond to what you say to them *may* respond to being touched firmly but gently on the arm or shoulder.

Lonergan (31) describes therapeutic and benevolent touch as especially effective for persons with dementia.

Be alert to communication in nonverbal behavior. Gestures and grunts may indicate pain or interest. Body positioning, restlessness and facial expression may clues as to the person's mental and physical state.

Clients who are disorganized or having trouble paying attention to a task may simply not be capable of doing that particular task at this time; if so, their attention should be directed to another, simpler activity. The new activity should be introduced matter-of-factly, so as to avoid making the person feel incompetent (e.g., "I think that we should save this for another day; I need to work out some of the details. Try this instead.") The goal is to help the client feel comfortable and competent within the limits of his or her present abilities.

Glantz and Richman (22) point out that many behaviors that look like a problem or deficit can be seen as a strength if rephrased and looked at positively. For example, The person who has limited attention span may be able to attend to a task for 3 minutes. Similarly, the person who works in an unsafe manner may be able to work safely if a safe structured environment is provided. Therefore, speak positively to clients and confirm that they are able to do many things; this enhances independence.

Strategy for Modifying the Environment

Distractions can be reduced by having the person work alone, facing a blank wall. Limit the tools and supplies to those needed for the immediate step or task. If the person is distracted by internally generated stimuli (e.g., hallucinations), vigorous stimulation may be necessary to get his or her attention.

Casby and Holm (8) report that classical and/or favorite music played in the background may reduce stereotypical and disruptive behaviors in persons with dementia. In using music, careful observation of the effects on clients' functional performance is essential, since it is also possible for music to be distracting and confusing.

Strategy for Selecting Activities

Simple, well-delineated activities that have a definite sequence consisting of very few steps are recommended. The assistant may need to do the more difficult steps for the person. Activities that are creative or that have flexible standards or goals should be avoided; they will only increase disorganization.

For persons who have been evaluated with the Allen Cognitive Level Test or Allen Diagnostic Module, activities should be matched to cognitive level. Observation of performance will guide the OTA in determining whether to increase or to decrease the level of difficulty. Allen (3, 4) recommends that tasks be within the person's current ability; the practitioner should intervene rapidly to provide a less-demanding activity if the person shows signs of confusion, frustration, or discomfort.

For persons with dementia, adaptations and environmental modifications (e.g., enlarged telephone buttons, compartmentalized medicine boxes, posted signs) to enable performance of activities of daily living can be very helpful. In addition, the person can learn to rely on other people or on purchased services (takeout food, housekeeper or home attendant) to supplement for lost function (46).

Evaluation and intervention related to safety and emergency management are very important (Box 11-10).

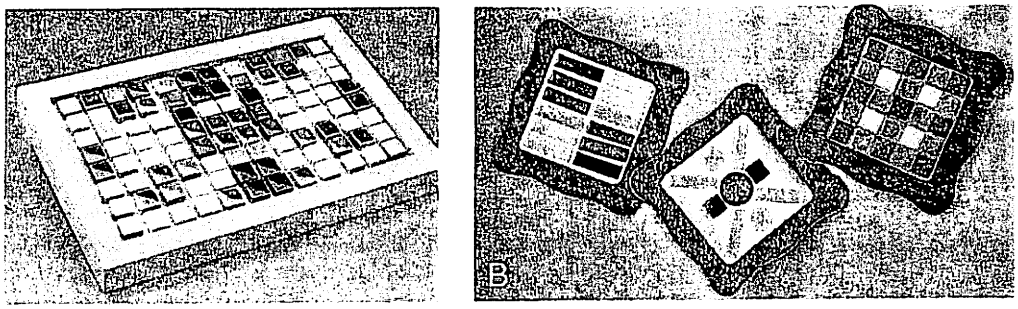
SELF-MONITORING FOR SELF-MASTERY OF SYMPTOMS

Major psychiatric disorders are lifelong chronic conditions. To have a good quality of life, consumers need to manage their illnesses. Proper diet and nutrition, medication maintenance, fitness and exercise, use of social support, and avoidance

BOX 11-10

ATTENTION DEFICITS AND DISORGANIZATION: EXAMPLES OF APPROPRIATE ACTIVITIES

- *Simple craft projects* such as mosaic tile trivets (shown here), leather coin purses, plastic-dip flowers, sewing kits, and copper tooling can all be used, although some steps may have to be modified. For instance, oxidizing the copper might be skipped altogether or done by the assistant or a volunteer.



A. Frame trivet. B. Wood coaster. These projects use mosaic tile and offer options for grading the activity to accommodate different levels of energy and cognitive ability. The trivet requires a longer attention span to complete because it has a larger tiled surface. To finish the coaster, one must glue the backing to frame, which may be done by a volunteer or the OTA. (Photo courtesy of S&S Arts and Crafts, Colchester, CT.)

- *Self-care* and *life tasks needed in the person's occupational roles* are most important. Helping a housewife organize her kitchen or do the laundry more efficiently will probably be more important to her than learning copper tooling.
- *Training in safety and emergency procedures* may make the difference in allowing the person to remain in the community.
- *Coping skills and stress management* can be modified to the level of the person's understanding and control of anxiety and extreme emotional arousal which further interferes with cognition.
- *Computer games* that reinforce specific cognitive skills may also be used. Medalia and Revheim (35) recommend that the target deficits (e.g., linear sequencing, organization) be identified and that the client's interests and level of functioning be considered when selecting software. Nakano (37) reports that computer-based programs are effective only when therapists also encourage and support the client.

of triggers and situations that may cause distress are important skills and habits that enhance recovery. Copeland (11) reported on the Wellness Recovery Action Plan (WRAP), in which consumers create a "wellness toolbox" to recognize, reduce, and if possible eliminate troubling symptoms. The following elements are included:

- A daily maintenance list (of routines and activities that maintain health)
- A list of personal triggers (events or things that tend to provoke symptoms or relapse) and ways to respond to these
- A list of personal early warning signs and the best ways to respond

- Ways to recognize when symptoms are worsening and ways to respond to this
- A crisis plan or advance directive

Although intended originally for consumers with emotional symptoms, these strategies can be used by anyone for any kind of disruptive illness or situation. Detailed information is given in the article (11). Frese (19) also gives useful suggestions specific to schizophrenia.

SUMMARY

Symptoms are the behavioral or reported subjective evidence of underlying psychological and physiological problems. They give us clues about what clients or residents may be experiencing, what they seem to be having trouble with, and what we can do to make them more comfortable. This chapter presents some ideas about how to respond to clients who exhibit specific behaviors or report specific internal experiences, such as hallucinations. The occupational therapy assistant's response is shaped around three variables: therapeutic use of self, modification of the environment, and selection of activities.

The information in this chapter is intended as a general guide and not as a rigid system of rules. It cannot substitute for a proper intervention plan but can be useful for refining the plan once the general goals and methods have been identified. Every person is unique and needs an individualized approach. Occupational therapists and assistants cannot treat the patient's symptoms because symptoms are caused by the underlying disease process. However, the OTA can help the person function better by modifying the environment so that he or she can manage it and by selecting and modifying activities that use his or her remaining capabilities.

REVIEW QUESTIONS AND ACTIVITIES

1. Define *symptom,* and explain why symptoms are useful guides to understanding patient behavior and feelings.
2. Identify the three tools used by occupational therapy practitioners to help consumers experiencing psychiatric symptoms function as best they can and engage in occupation. Explain why we call these tools "response variables."
3. Describe the following symptoms: anxiety; depression; mania; hallucinations; delusions; paranoia; anger, hostility, and aggression; seductive behavior and sexual acting out; cognitive deficits; and attention deficits.
   - For each symptom, identify the diagnoses associated with it.
   - For each symptom, discuss how the OTA can use self, environment, and activity to facilitate better functioning for the patient.
   - Identify the characteristics of appropriate activities for a person experiencing each symptom.
   - For each symptom, describe one or more unsuitable activities and explain what makes them unsuitable.
4. Cognitive deficits may be temporary or permanent. How does this affect the interventions used and the goals for the person?
5. Discuss the role of the OTA in promoting wellness and consumer self-management of symptoms.
6. *Challenge activity:* Give a detailed description of how you would set up the work area for someone in a manic state to make the project shown in Box 11-3.
7. *Challenge activity:* Examine Figure 11-1. What safety problems are present in part A that have been removed in part B?
8. *Challenge activity:* Look at the figure in Box 11-10. Write an analysis of how you would use one or the other of these projects for persons with the different symptoms described in the chapter. How would you set up the work area? What adaptations or modifications would be appropriate? How can you make the activity easier or more difficult?
9. *Challenge activity:* Research the effectiveness of computer activities for persons with cognitive impairments. Discuss whether these are effective interventions, for whom, and under what conditions.
10. *Classroom activity:* Write each symptom described in this chapter on a separate piece of paper and put the papers in a container. Each of 10 students draws a slip of paper and, taking turns, acts as a patient who has the symptom he or she drew. For each "patient," a second student acts as an OTA who is meeting the patient for the first time. The OTA student must use the three response variables to help the patient. The rest of the class helps guess the symptom and then discusses the therapeutic response. (Additional students may act as other patients or staff, as needed.)

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