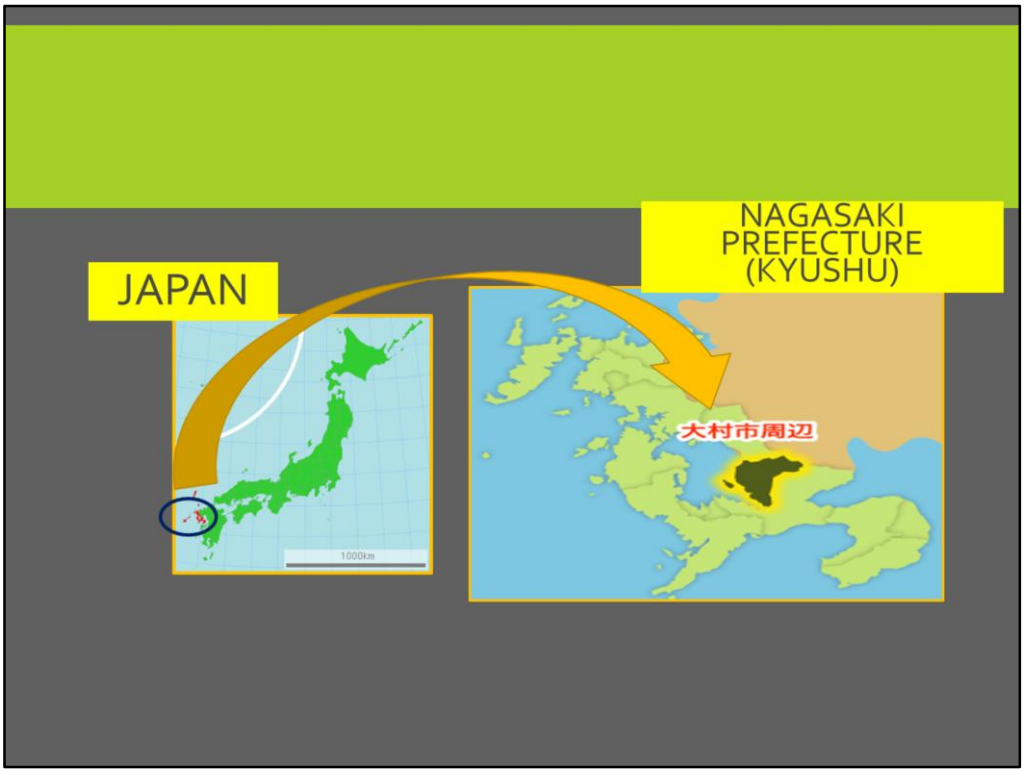
A CASE EXAMPLE OF HOW CLIENTS HAVE RESPONDED POSITIVELY TO OCCUPATIONAL THERAPY IN A VDTMOCA-INFORMED HOSPITAL SETTING (JAPAN)

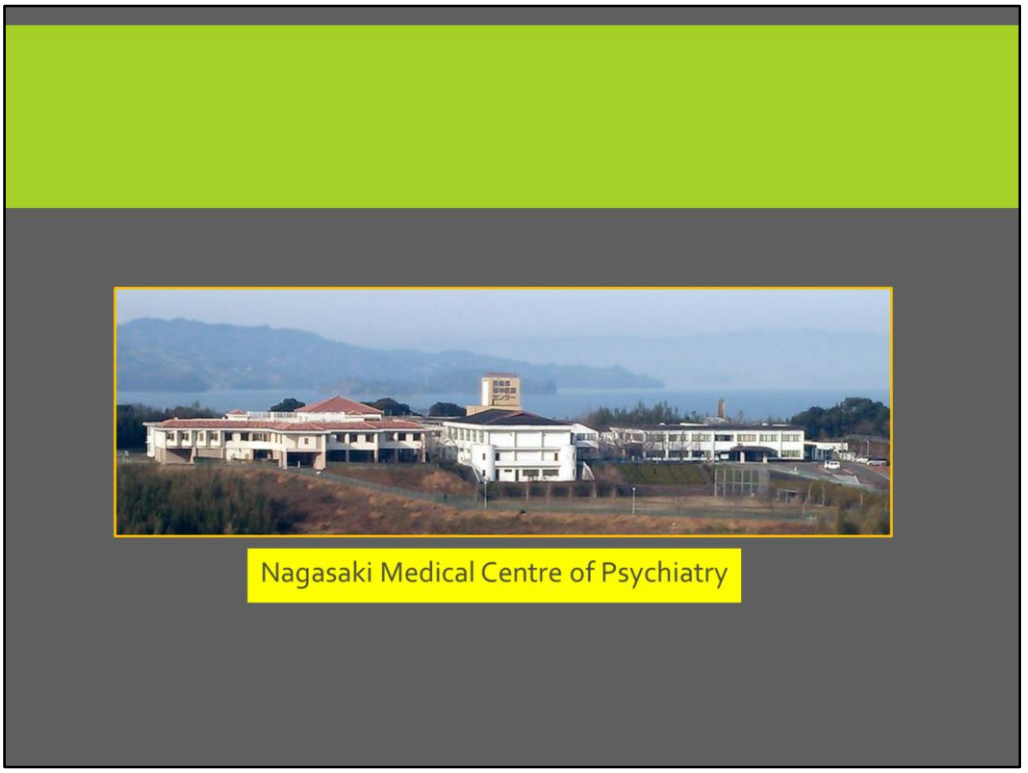
Yukihisa Motomura

Nagasaki Medical Centre of Psychiatry

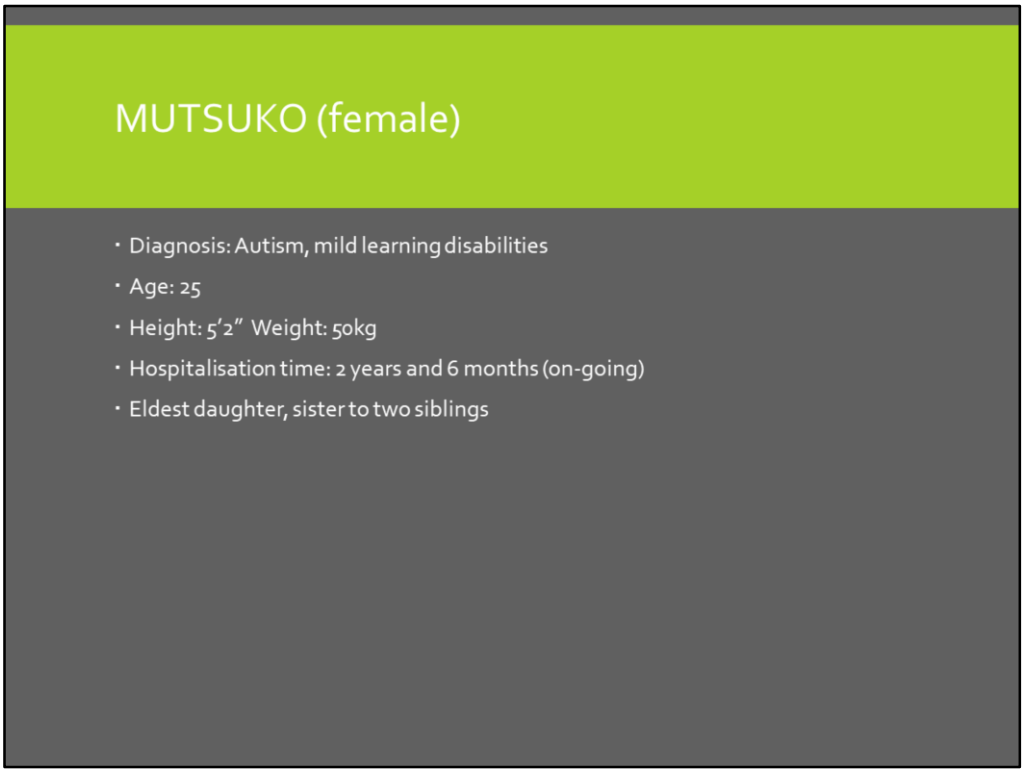
I am one of a small group of OTs who formed a study group several years ago to learn the VdTMoCA, and we have been sharing the model with OTs at workshops and our national OT conference. To show you <u>where we are.</u>



On the left is Japan, and Nagasaki is in the southern tip. If we take that area and zoom in, this area is known as the Nagasaki prefecture, in Japanese it's called Kyushu. As you can see, Nagasaki borders the coast –. The hospital that I work in is in the hills overlooking the sea.



Nagasaki Medical Centre of psychiatry. It provides in-patient services for adults and adolescents, acute and long-stay. I work in the forensic service.



I am going to share with you the case of a lady that I have been working with for x years, and who Wendy provided clinical supervision on when she visited in 2014. She is lady who presented with behaviour that was significantly challenging to the MDT. As an OT team, prior to using the VdTMoCA, we would not have been able to provide effective occupational therapy for her and similar patients. This case illustrates what a difference the VdTMoCA has made to people that we serve as patients, to OTs and to other disciplines.

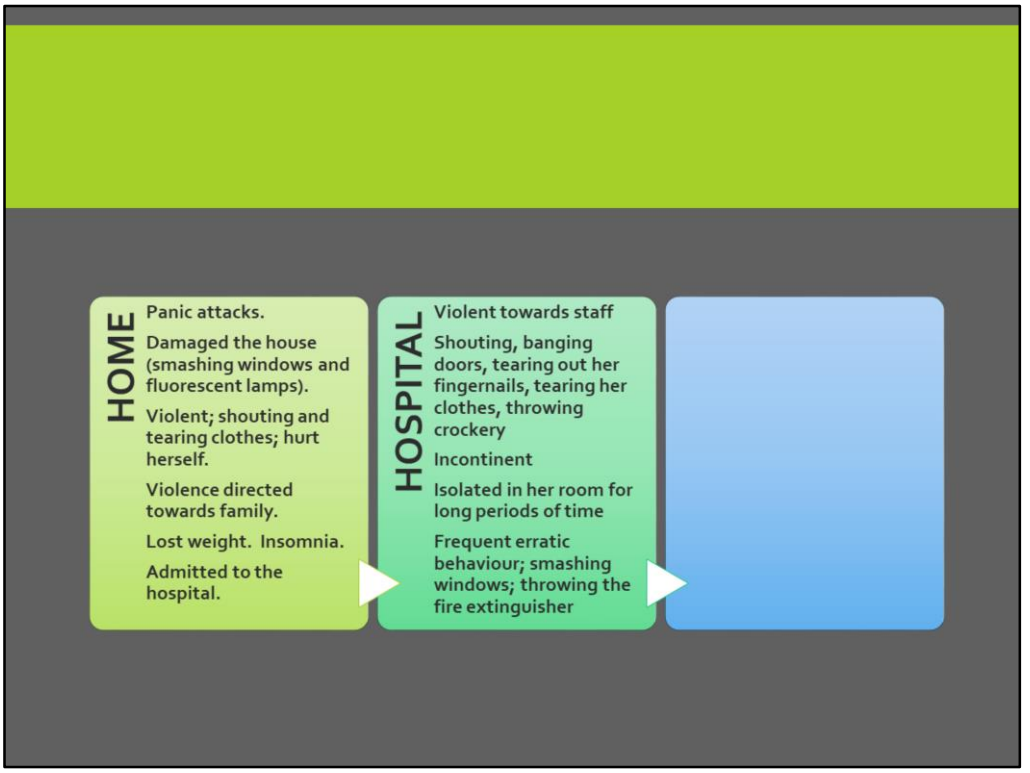
I have given her the pseudonym of Mutsuko.
She has a diagnosis of autism and mild learning disabilities, age 25, 5'2" and 50 Kg in weight. Mutsuko has been in hospital for 2 and a half years, her admission is on-going.

She is the eldest of 3 children. Since being admitted, her parents have divorced due to a conflict of opinion regarding her rearing. After a while, her father remarried and Mutsuko has been told that her mother has passed away, but it remains unclear whether she really understands this. Her father is the Chief Director of a social welfare service corporation, and he has expressed interest in caring for her upon discharge.

She had a medical check-up at the age of 3, due to a delay in speaking, a lack of interest in toys, and being unable to play with friends. She was regularly seen at a hospital that specialized in the development of young children, where she was diagnosed with autism. She has been medicated since she was 4 years old.

From the age of 7 until the age of 11 she took special classes in primary school. At the age of 12, she went to a school for children with special needs where she lived in a student dormitory until the age of 18.

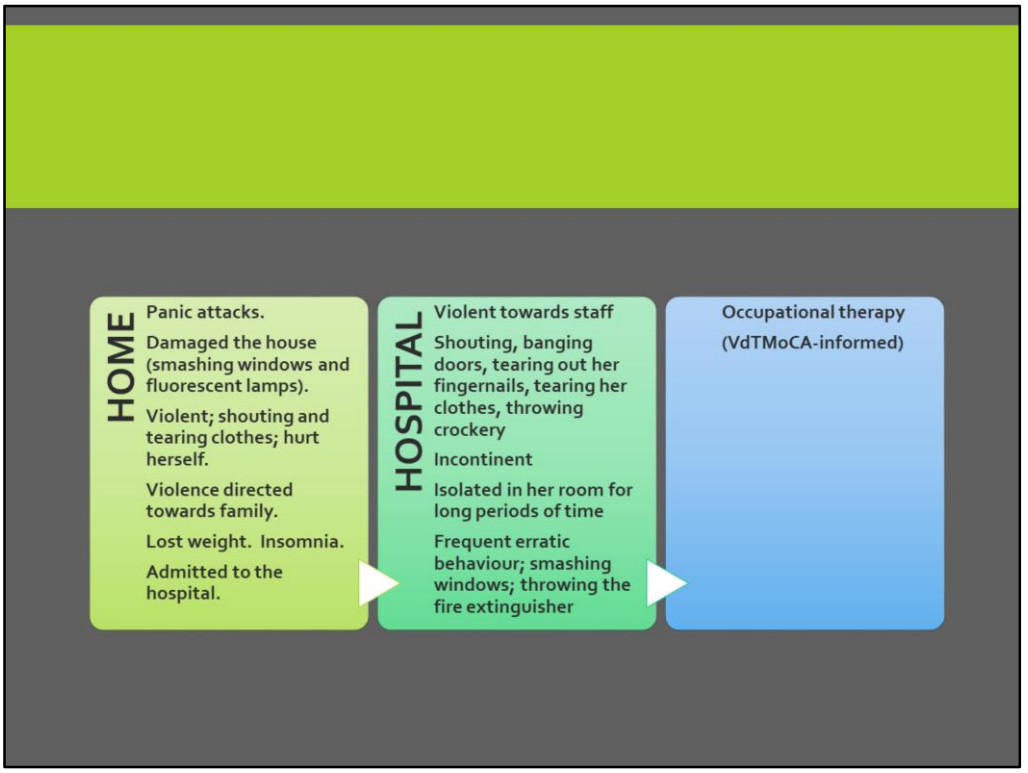
On leaving school, she went home. Her father was managing a small-scale occupational therapy centre at the time and had to do long commutes, therefore he hired a day time carer to help with her care at home. Shortly after this, she begun to have panic attacks and She would damage the house (smashing windows and fluorescent lamps), she was very violent, shouting, and tearing her clothes apart and she would also harshly hurt herself. She was violent towards her family, she lost weight and suffered insomnia. Her behaviour became too challenging and she was too high a risk to herself and others to manage at home, and was therefore hospitalized when she was **23 years old.**



In the hospital, her violent episodes continued, becoming violent against the staff, shouting, banging doors, tearing out her fingernails, tearing her clothes, and throwing food dishes. She was incontinent.
In order to manager her, she had to be isolated in her room for long periods of time. When on the ward, she would respond to the 2 nurses on duty. However, there was frequent erratic behaviour, smashing windows, and throwing the fire extinguisher around.

This is the isolation area of the ward – the PICU area. Consisting of a mattress on the floor and a lavatory and washing area. It is very stark and clearly deprived of occupation and stimulation.

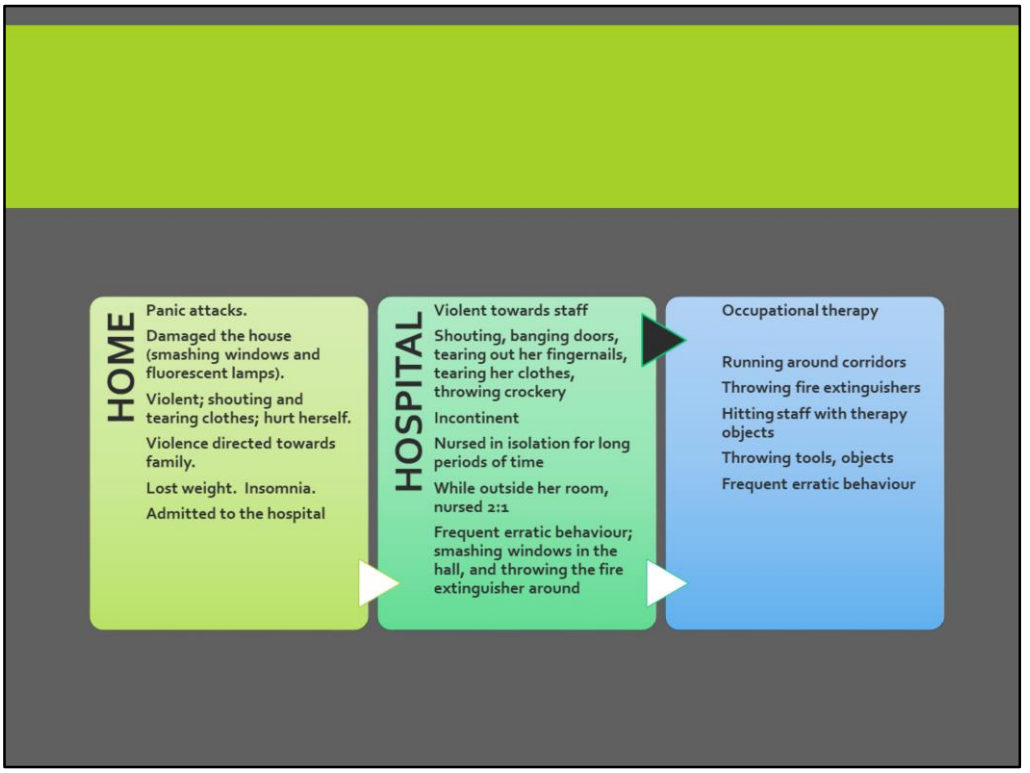
<u>After a year of admission consisting predominantly of nursing care and medication,</u>



her erratic behaviour was less frequent and she became more emotionally stable. The MDT thought the reduction in risk made working with her off the ward possible, and we decided to try providing occupational therapy intervention, informed by the VdTMoCA.

To show you the environment. On the left you can see the floorplan of the ward and the separate OT department and the route to OT through the corridors, photographed on the right. These are the corridors that I refer to later

This is the main OT room where we normally provide OT to large groups of patients, which Maeda will explain in his presentation. Initially,



When we first tried OT with her, she would suddenly start running around the corridors, throw the fire extinguishers around, and in the OT room she hit the OTs with therapy objects and threw objects.
Before I show you how we used the VdTMoCA treatment principles, let's look at her profile across the occupational performance areas to understand her level of creative ability at this time.

Personal Management:

Her impulsivity was high; she would suddenly throw things around. Regarding food, she swallows whatever there is on the daily menu almost without chewing. She needs to be monitored by the staff when eating sweets, since she fills up her mouth full and swallows them whole and is at risk of choking.

She is unable to use chopsticks or spoons well, hence a lot of food is spilt and there are times when she eats directly with her hands. On occasion, she urinates and defecates in the **care-room**. Although she can put on and take off clothes, she does not realise when she is wearing them inside-out. Also, she finds it difficult to dress for the season or for the situation appropriately. When she gets excited, she tears apart all the clothes she is wearing, and there are times when she ends up naked - often found naked and trembling by the nursing staff. When taking a bath, she can wash herself and uses a towel to dry off her torso, but requires assistance with drying her limbs, back and buttocks. She follows instructions when asked to wash her hands, but she does it poorly. We assessed her as on the level of Tone, transitional phase

Social ability:

When someone says "Hello, Mutsuko" up-close, she acknowledges the greeting and replies back "Hello", but there is no conversation. She is unable to voice her requests effectively. She repeats what she has been told in the past, such as "Don't hit people", "Don't break things" and "Don't shout". She seems unable to fully express what is perceived by her senses.

We assessed her level as Self- differentiation, therapist-directed phase.

Constructive use of free time.

She does not seem to be aware of her own interests and needs, - she looks forward to the staff

bringing her food, but she does not have a notion of free time and occupational balance. We assessed her as on the level of Tone, transitional phase.
Work ability – this was difficult to estimate initially, because there had been such occupational deprivation on the ward, but as described, her action was unconstructive, frequently destructive – we estimated her level to be Tone, transitional phase.

Level and phase in each of the four occupational performance areas

Level of creative ability	Phase	Personal management	Social ability	Work ability	Use of free time
Self-presentation	Transitional				
	Patient-directed				
	Therapist-directed				
Self-differentiation	Transitional				
	Patient-directed				
	Therapist-directed		X		
Tone	Transitional	X		X	X
	Patient-directed				
	Therapist-directed				

Tone treatment principles:

Accepting, uncritical manner.

Calm, matter of fact approach.

Attempt to get patient to look at you/product/object.

Use physical contact with care.

Use a quiet area.

Provide sensory stimulation; encourage reaching out and making contact with objects.

Basic Reality Orientation.

Overall, she was the level of Tone, transitional phase. In OT, we started working with her at this level – as you can see, the treatment guidance provided by the model makes absolute sense with her – these are just a few items of the model's guidance and will be familiar to many of you. This is what we did at the beginning.

Working with her on her own, we took time to orientate her to materials, objects, people and the situation of the OT environment, and as she started to respond we used some of the Self-differentiation treatment principles. I'm now going to move on to show you how I have worked with her as she progressed into the Self-differentiation level. I provide 2 OT sessions a week of 30 minutes each. This is an example of activity that we currently do….

TREATMENT PRINCIPLES FOR THE LEVEL OF SELF-DIFFERENTIATION

- Orientate to activity, materials, objects, people, situation ✓
- Constant verbalisation (concept formation) ✓
- Step-by-step instructions (direction) ✓
- Only materials and objects needed now ✓
- Encourage expression of likes and dislikes ✓
- Low expectations to do "well" or "right" – involvement only is satisfactory ✓
- Total, unconditional acceptance of person and behaviour; matter of fact and calm ✓
- Show approval ✓

It is making parfait –a frozen desert.

The materials and objects of making the **parfait** are Ice-cream, cereals, chocolate sauce; a scoop for the ice-cream and a spoon.

the cereal is put into the cup, Then, use the scoop to put some ice-cream in the cup and mix, Pour on chocolate sauce and eat with the spoon. **PHOTO**

As per the treatment principles provided by the model, To prepare her for the session, we clearly say her to her "Mutsuko, we are going to do XYZ in the activity room". We call her by her name and we say our names. During the activity, we name the tools and utensils, and say what we use them for and what we will be doing. We give step by step instructions and only have in front of her what she needs to use now, this is to avoid her being distracted and to enable her to focus her attention.. To increase awareness of self and the environment, we ask her about the materials and objects that she is experiencing, such as the colour, smell, texture, whether it feels cold or warm etc.. There are no expectations to do anything well or right, we accept her as she is, and we always praise her to encourage her maximum effort and performance.

After a year of working with her, Mutsuko now does a range of activities twice a week. We are trying to develop a profile of activities that she finds satisfying, whilst also being activities that have the potential to develop her abilities. Her activities currently include gardening, percussion playing, drawing, origami, handling clay, making quick drinks and deserts.

Work Ability:

Self-differentiation, therapist-directed

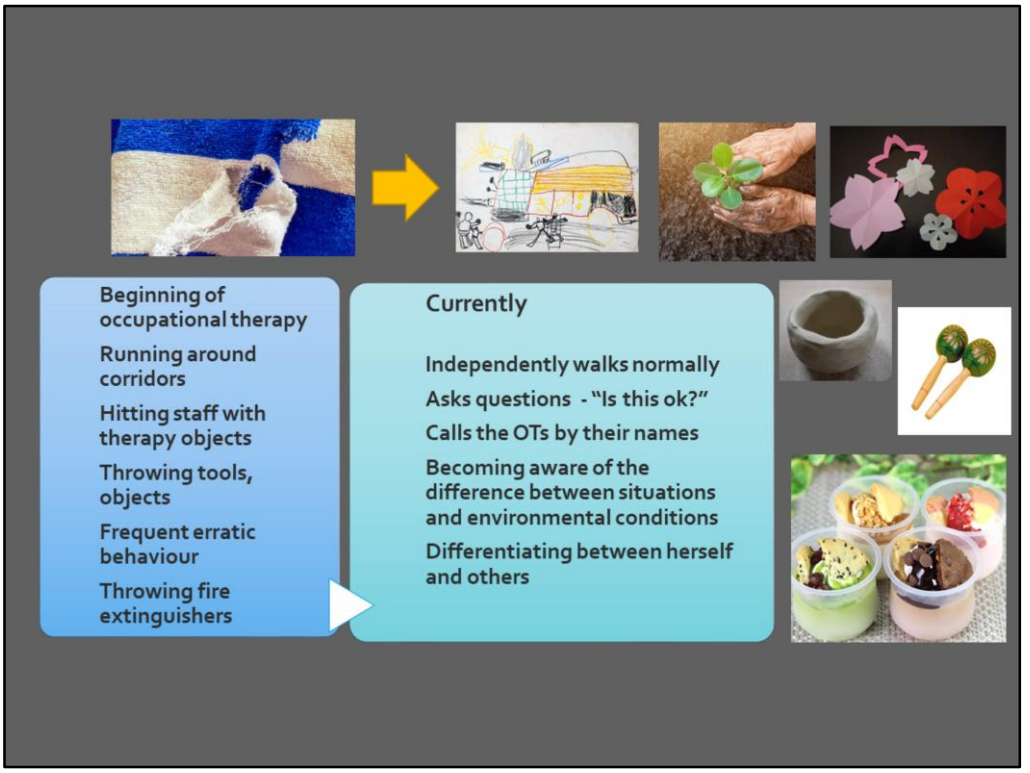
- Fleeting awareness of utensils (e.g. scissors, cups, pencils)
- Poor quality handling
- 2-3 minutes focus of attention with step-by-step instructions to completion of simple activity
- Gauging force is problematic
- Does simple drawings; folds origami
- Upon completion, she does not show any particular signs of satisfaction or enjoyment (task identification/emotional range and expression)

Her work ability we can see now as Self-differentiation, therapist-directed phase

At some point in the activity she becomes aware of the utensils that are around her. Her handling of them is poor quality. She is able to stay focused on the activity for 2 to 3 minutes, with step by step instructions. If the activity is simple, she is able to complete it by following the therapist's instructions. When she paints, she applies a lot of pressure on the brush stroke, but she can do simple drawings and paintings. She can also fold origami, but she struggles to line up the sides and edges, but we do this activity because it is culturally significant and familiar. Upon completion of activities, she does not show any particular signs of fulfilment or satisfaction., therefore there is no evidence of task identification. Her emotional range is very narrow

Although the OT describes and explains the activities, Mutsuko does not appear to understand the activities fully. However, she does follow the instructions, and is able to ask during each step of the activity,"Is this OK?". She clearly struggles to reply to questions regarding her experiences of the materials and tools. For example, when asked to describe how the ice-cream feels, she would reply "hot".

In terms of evaluation of our therapy, we think that we need to use activity that enables her to connect more with the properties of materials, have greater sensory stimulation and stimulation of emotion.



However, since we started using the VdTMoCA for the level of Self-Differentiation, the erratic, chaotic and destructive behaviours have stopped completely. Without the need to escort her by taking her by the hand, Mutsuko now walks normally to OT and stays for the full duration of the 30 minutes session. She asks about what she is doing, asking "Is this ok?". She is now able to call the OTs by their names, and she is becoming aware of the difference between situations and environmental conditions. She is also becoming aware of time and aware of routine.

She is considerably more able than before, and we believe, with a better quality of life.

Although one might say that this is purely down to addressing the lack of stimulation that she had, the key point is that prior to learning the VdTMoCA, we wouldn't have known how to respond to her challenging behaviour, or how to meet her needs for stimulation and activity. In a trial and error way, I'm sure that we would have offered her a range of activities, and in a way that she couldn't respond to positively i.e. in a way that was not enabling her. The VdTMoCA helped us to see and understand her ability and what she was motivated for, and to meet those needs in a clearly reasoned way.

The MDT's understanding of OT has also changed significantly. The consultant psychiatrist has credited occupational therapy with making a significant contribution to the positive change seen in Mutsuko. Regarding the nurses, Mutsuko's key nurse

has fed back that:

KEY NURSE FEEDBACK

- *"We [nurses] have little means to explore Mutsuko's potential, especially since nursing staff have to focus on self-care. It was exhausting to provide her with self-care, since she was particularly prone to negative behaviours. However, thanks to the occupational therapy, I was able to discover a positive dimension in Mutsuko that I did not know before, and she kindly taught me all the things she could do. In addition, I find the positive feedback that OTs provide us regarding how to work with Mutsuko, is very helpful".*

Thank you

Thank you for listening to my presentation, are there any questions that you would like to ask?