The levels of participation in activities (and creative participation) as seen clinically in psychotic patients

The psychotic patient shows the levels of participation but this is different in intensity and duration from other patients in neurology, paediatrics or physical services.

This is a two part article:

1. 1-4: general observations about the level of participation
2. View of the levels seen in psychotic patients

1. Quality of the emotional response as seen in the psychotic patient
    - The intensity of the emotional response is lower and there are blunt emotions.
    - When the patient does experience an intense emotion he/she does not know how to externalise it.
    - If expectations are too high, the patient will withdraw

The OT therefore has to closely observe the patient for small changes and should not expect a dramatic response.

The response can also be delayed.
The response can be different in the same setting on different occasions.

2-3 sessions are necessary for the patient to become familiar enough with a task before he feels free to show an emotional response.

2. Security-seeking imitative behaviour
    - Most therapists have observed that when a patient is given a task to carry out, that it is done in the exact same way that the therapist has demonstrated it to the patient.
    - That does not mean that the patient is on the imitative participation level.
    - The difference lies in the size of the task.
    - The patient copies or imitates in order to give himself security and not because he grasps the whole task or has internalised the execution thereof.
    - It is done automatically with no element of evaluation
    - To distinguish between this security response and a true imitative response, do more evaluation/assessment….
    - Give the patient a task with 4 steps and clear instructions and look at the response

Example of a 4 step task:

1. Cut this piece of wood into a piece of 2” and 4”
2. Glue it back together
3. Sand the block thoroughly

Patients on a level lower than passive participation would find it very difficult to do this.

- The ‘imitation’ response is often seen.

- It is therefore more appropriate to familiarise the patient with the task or situation before the response is assessed

3. The most successful/appropriate way of presenting the materials of a task

- This applies mostly to patients up to active participation
- The psychotic patient finds it difficult to select appropriate stimuli out of the environment as well as struggles with the interpretation of expectations and actions.
- Tasks should be presented with caution

Tone/self-differentiation/self-presentation

- One object at a time
- Present the object(s), material(s) on a work surface and remove completely after use before presenting the next objects(s)/material(s)
- Verbalise that the one task is finished and the next will now start
- For the 'normal' person, enthusiasm is encouraging; for the psychotic patient it is a threat and will lead to negative responses/withdrawal – adapt your enthusiasm to fit with the patient
- OT has to present tasks in a goal-directed manner, with minimal enthusiasm
- If the OT is very enthusiastic, she palces the expectation on the patient that he has to enjoy the task (through her body language and approach). Because this is so difficult for the patient, he will withdraw.

4. Structuring of the assessment and treatment situation

- Psychotic patients find it difficult to choose stimuli selectively
- Increased stimuli may lead to the patient feeling overwhelmed
- Therefore, limit the stimulation in the treatment area to give the patient the opportunity to show his true abilities
- Quiet area with little distractions
- The atmosphere has to be relaxed and comforting so that the patient can feel free to participate
- The OT has to be relaxed and should not let her own rigidity/inhibitions carry over to the client

5. The way different levels of activity participation manifest in the psychotic patient
    - The level of improvement is seen through the manifestation of volition
    - The level of activity participation is deduced from the behaviour of the patient regarding the handling of materials, tools, people and situations
    - One handling situation is not enough
    - The type of handling situation should be consistent before it can be deduced that the patient is on that level

a) Pre-destructive action
    - The patient will take an object that is presented; may look at it and place it back without emotion
    - Handling of the object/action is of short duration
    - Seems as though it means nothing to the patient

b) Destructive action

- Lowest level – self-destruction
- Might crush material presented (paper in hand) or break, tear, chew it
- Movement used for the above is usually small, in mid-range and shows little energy
- Very little enthusiasm or real enjoyment
- Sometimes the patient may respond intensely with quick, small movement – get the impression that the patient is fixed on the task – all external stimuli is blocked out
- The patient is usually thereafter much more relaxed, but no verbal expression of the relaxation
- No recognition of construction and no ability to show it

c) Incidental constructive action
   - Can do half step concrete task (no planning by the patient)
   - Construction is incidental – the OT has to plan it
   - Patient is becoming aware of construction, thus the patient can recognise it and respond positively about it – smile, look surprised, prepared to try again, verbal

d) Explorative action
   - Will try things
   - Element of planning and 'seeing' the end product
   - Can be exposed to a bigger variety of materials
   - Able to have a concept of ¾ step task and can then execute it
   - Wider area of emotional responses – can enjoy and show it
   - May sometimes not respond at all and may try 1-2 times and then wait – indication of volition and ability to sustain effort
   - May show interest and inquisitiveness – make it interesting!
   - Does not conform to social norms yet
   - This explorative action should be interpreted more wisely – patient is exploring/getting to know his environment – patient should therefore have every opportunity

e) Imitative action
   - Patient is able to do a whole activity for the first time
   - Concept formation is now at such a level that the patient can form complex concept –
   - Can understand and accept norms
   - Can start to manage and use criticism/feedback
   - Can accurately imitate and according to norms that were given from outside and then internalised
   - More discrete about the type of behaviour that is imitated
   - Would imitate therapist in a group or identify / agree with another group member
   - Enthusiasm is a mirror of that shown by others
   - Can have discussions with the patient about his behaviour, evaluate together and look at ways to improve it
   - The OT has to be aware of the example that she is setting

f) Originative action
   - Individuality is seen
   - Executes tasks according to norms
   - Task is seen as a whole
   - Can evaluate and add own changes to task
   - Own opinion
   - Choice of activity
   - Needs support and encouragement of OT
   - Acceptance and recognition is important

g) Product-centred action
   - Evaluation, judging, decision-making and adaptation at this level
   - Element of comparing themselves/product with others and therefore accurate assessment of abilities is essential in order to avoid negative/destructive comparisons NB!

h) Situation-centred action (contributive action)
   - Judgement, interpretation, conclusion, decision-making, adaptation with regards to situation