Research Paper

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The effectiveness of occupational therapy intervention on catatonic patients

Medical Science

KEYWORDS :

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ABSTRACT

The two descriptive case series of catatonic features which undergone the occupational therapy intervention for four to five months periods on the basis of inpatient service. The purpose of giving occupational therapy intervention is to make the patient independent in Activities of Daily Living and in all aspects of his life through using the purposful therapeutive activities. Their clinical features are observed in depth by the occupational therapist in the ward and interviewed them in the therapy room. Sessions are twise a day for six days except sunday. And ward activities along with occupational performance are practiced under the supervision. In the therapy section various occupational therapy techniques and approaches are implemented and monitor the prognosis. Materials and tools are used appropriately, instructions are given gently. Home exercise programs are also given to them after the discharge while there are some improvements seen during hospitalization. And then reviewed by the occupational therapist once in a month on OPD basis. Activities of daily living of these patients are improved well.

Introduction

Catatonia is a state of neurogenic motor immobility. In its severe form, it involves the absence of movement and speech, and imposed postures. The most common symptoms are stupor, mutism and negativism. Other symptoms include staring, withdrawal, rigidity, echolalia and echopraxia. The individual may be in an excited, agitated and possibly aggressive state. Not all catatonic symptoms means that a person has schizophernia. A catatonic symptom may also be provoked by an organic brain disease, metabolic disturbances, or alcohol and drugs, and may also be seen occasionally in certain mood disorders, like depression.

Occupational Therapy is a health rehabilitation profession designed to help people of all ages with physical, developmental, social, or emotional deficits regain and build skills that are important for functional independence, health and well-being.

The occupational therapy is more likely to focus on the disruption of occupational performance areas of work, leisure and self-care rather than on specific symptoms. Occupational therapists often minimize the importance of symptomatology, believing symptoms to be seperate from their main concern of functional ability. And he also provide general intervention for the patient.

Occupational therapy may start with an assessment to evaluate the individual's level of daily functioning. Occupational therapy intervention depends on how the symptom directly or indirectly affects the patient's ability to engage in daily life tasks. The involvement in purposeful activities does not necessarily diminish the symptoms; but rather allows the individual to function despite them. However, finding activities that are therapeutic and meaningful is a challenge in a population that typically experiences fear of failure, anhedonia, and poor initiation. The technique used with a particular patient must be simple that is easy to remember and implement. The strategies need to be incorporated in to daily living outside the clinic by providing home program. And also the therapist educate about the purpose and structure of the intervention to the patient's family, employer, caregiver in order to support the patient and also provide assistance in modifying the environment. Finally the therapist monitors the results of the chosen techniques and modifies the program as needed. The biggest task for the therapist is to motivate the patient and the caregivers to take active participate in all the stages of the programs, which is not an easy objective in the cases suffering from chronic illnesses.

Case description

Case study 1

A typical features of catatonia patient age of 35 years old male with negative symptoms was admitted to the JIPMER hospital. He was uneducated and belongs to the low socioecconomic status. He was worked as an auto driver in his local area of pondicherry prior to the onset of psychiatric illness. Meanwhile, he had a few friends when he was very young and gone for roaming with alcoholic habits. Sometimes he did a weight lift exercises and not frequently go for work. He was disowned by his family and relatives. Before the hospitalization his relatives took him various setup where the traditional practices such as black magic and home medicine are applied to him.

Current symptoms were the feeling of hoplessness and worthlessness, sucidal ideas, anhedonia, asocialily, apathy. Patient tells that limbs are wasted and amputated, and somtimes telling that the both shoulder joints are moved or dripped down from the riginal position due to did a weight lifting exercises. Ultimatly his body weight was increased due to medication without the occupational performance.

Occupational Therapy intervention

On observation he was stout and not grooming well, sometimes restless behaviour. In ward he lay on his bed anytime. He appears to be uncomfortable to most people but not harming them and refusal to eat necessitates parenteral nutrition. On examination incoherent speech presented, insight absent, and his mood was not normal. His daily structure was poor and he could not balance self-care, work, leisure and rest. The patient showed inappropriate behavior while apparently responding to internal stimuli, such as gesticulating and muttering to self, not related to the outside envionment; inappropriate affect and poor attention to tasks.

The assessment of occupational performance components showed that patient was seen in the form of stooping posture, feel lethargic, and involvement of cognitive functions were poor such as memory, attention span, concentration, initiation and problem solving. On assessment of psychosocial skills: poor motivation, low self-esteem, withdrawal, unable to cope with stressful situations and poor time management were the prominent. Initially, on giving activities he refused to do them saying he was not capable of doing anything. But the therapist encouraged and supported him and gradually he started participating in some of the activities and games but he could not complete even simple tasks that he should have been able to do. He was counselled for the mis- perception about his illness. Then tasks are given to him. Activity scheduling are well designed by the occupational

therapist for the patient and it was keep practiced regularly, these are includes ward helping tasks, envelop making, weaving and simle table games; and breathing technique, aerobic exercises under the supervision. The patient was also instructed to make positive statements about himself on a daily basis and rehearsed this technique with the therapist. At the time of discharge, the caregivers at his residential facility were educated to be supportive and provide him with opportunities to practice these skills. Later on that after several years he was well settled in the life and continued the same occupation of auto driving work with out ultered a state of mental health.

Case study 2

A case of atypical features of catatonic patient age of 20 years old male with the problems of slowness of movement in self-care, mobility and the functional performances. Memory disturbances and the poor socio-occupational functioning; phobia also associated with these. He was an educated and discontinued the current study, and unmarried. He did not have any bad habits and he belongs to his parents. He went to the martial arts course and also he undergone some technical traning course, like fitter(welding, winding) for six months. But he was not going for work. Frequently he complaints that about his physical discomforts. Before admit to the hospital he underwent many kinds of treatment which are all unhelpful to him. Present complaints are inability to do the activities by own and the wandering tendency was presented. Sometimes neglect his personal hygeine and irritability towards the parents. He has given medication in the ward along with one or two ECT was completed by the physician. Sometimes he needs counsel for controlling his anger and take care himself interms of hygeinic activities.

Occupational Therapy intervention

After the medication period of two weeks he refered to occuaptional therapy for further management. In the therapy he observed keenly here he was a thin and groomed well. He always in the bed and not initiated any movement but he was oriented well. pressure of speech was presented. Communicate with the others are very poor. His mood was affected; subjectively he saying that he was normal but objectively he feels sad. He was not initiating the task which was given by the occupational therapist. He could not complete the activity and asked the attender or the therapist to complete it. He was lacked in motivation and the cognitive functions. Here the therapist used cognitive therapy for eliminating the negative feelings and thoughts. And the approaches like Model of Human Occuaption, Occupational Behavioral Approach and Sensory Integration, and some techniques such as deeb breathing exercise, meditation are applied for coping the stressful situations and for the occupation. During discharge period counsel the about the adjustment in the home and the society, and also given some home exercise programs.

He was adviced to keep practising the activity and exercises. And also he was suggested to continue medication along with the program. He was reviewed by an occupational therapist once in a month on OPD bases.

Discussion

At the begining, the patients could not be engaged any activity until the occupational therapist build a ropport with the patient and maintain very well. And he also encouraged the patients and supporting them appropriately. Here the therapist's attitude towards the patients are active friendlyness and firm-kindness. After the occupational therapy intervention the patients are improved well in ADL along with the support of community and the family co-operation. There are certain factors which could be affect the clients occupational performance components. According to occupational therapy practice conceptual framework it may be external stimuli which are person, occupation and the environment. With the occurrence of relapse being so apparent, it is important for occupational therapists to determine and understand which occupational performance factors are associated with relapse in hospital or clinical settings diagnosed with schizophernia.

Limitations

The complete elimination of catatonic symptoms in one end and the other one end of the acute symptoms was not changed, it would be more objective. In addition, the specific techniques or methods are more needed in the intervention. At present there is no standardized tools are used for measuring these results or the outcome measures.

Conclusion

Catatonia is a complex phenomenon with different symptoms and functional deficits. Hence, it is often difficult to determine the effectiveness of any intervention strategy. Yet, the occupational therapist may better determine the type of intervention required which depends upon the type of symptom is presented. The is no set of prescribed activities that intrinsicaly have this capability. It is the therapist's responsibility to explore with the patient which type of tasks might produce the desired results. The findings of the study are consistent with the assumption.

REFERENCE

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing. | | Catatonia associated with another mental disorder(Catatonia Specifier) DSM-5 category: Schizophernia Spectum and other psychotic disorders: The British Journal of Psychiatry, 176(4), 357-362. | | Rajani S. Kelkar. Occupational Therapy intervention in hallucinations: Indian Journal of Occupational Therapy April – nov.2002, vol.34, no.2. | | Rogers J. Order and disorder in medicine and occupational therapy. American Journal of Occupationla Therapy 1982; 36: 29-35. | | The Occupational Therapy Practice Framework: Domain and Process, 2nd edition The American Journal of Occupational Therapy 625. | | Wallace C., Nelson C., Liberman R., Lukoff D., Elder J., & Ferris C. A review and critique of social skill training with schizphernic patients. Schizophernia Bulletin 1980; 6(1): 42-63. | | Willard & Spackman's 8th edition: Text book of Occupational Therapy |