M.J.O.T.

Malta Journal of Occupational Therapy.

EDITORIAL

Dear colleagues,
It has been a long time since we published issue number 6. Naturally this is due to the fact that few articles were presented. This has been a repetitive plea from the editorial board but it remains a major problem.

Together with all our readers we appreciate the effort of the organizers in providing a regular timetable for our professional development. The association should also be proud of organizing study mornings twice a year.

Your financial contribution to purchase the journal will help us upgrade the quality of forthcoming issues. We hope that while reading this issue you will note the improvement to previous editions.

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AUTISM: A CASE STUDY FROM AN OCCUPATIONAL THERAPY PERSPECTIVE.

(Special project submitted in part fulfillment of the Diploma in O.T.)

Ruth Galea St. John SROT

Autism is: "*a clinical disorder characterised by qualitative impairment of social interaction, verbal and non verbal communication, imaginative activity, and a markedly restricted repertoire of activities and interests.*" (Adapted from DSM IV 1994).

Children with autism present a unique clinical picture as they manifest a broad spectrum of symptoms. These effect their individual learning styles, their unique problem areas and their individual response to different treatments. Autism thus requires a well-integrated approach of the multi disciplinary team.

The purpose of this case study was to experience the treatment with its results, on a child with autistic traits, referred for occupational therapy. The research design included sessions once weekly for thirteen weeks with a two-week break towards the end of the program, so as to decrease the dependency on routines. Initially duration of sessions was planned to be half an hour and as Luke's attention span would increase the duration was planned to become forty-five minutes.

WORKING WITH THE CHILD

The areas which were assessed were the following: Gross motor skills, fine motor skills, perceptual skills, sensory sensitivity, play skills, self-help skills, social functioning, social skills and pre-writing skills.

The problems noted in the assessment were:

- Poor eye contact
- Mannerisms: e.g. head banging was reported by the mother, but this was not evident during the assessment.
- Poor communication skills e.g. jargon was heard throughout the assessment, no words were said in context. Idiosyncratic speech, such as echolalia was present.
- Signs of attachment to inanimate objects e.g. a calculator.
- Evidence of preoccupation with sameness and resistance to transitions.
- Decreased attention span including distractibility.
- Low frustration tolerance.
- Inconsistent social responses.
- Poor pre-writing skills.
- Poor dressing skills.

GENERAL TREATMENT

No curative treatment has yet been developed and no one treatment modality has been found to eliminate all the symptoms autism presents. Some treatment

methods found to work with individual autistic children but cannot be used with all sufferers are: medications (Perry, et al, 1996), special diets (Aarons and Gittens, 1991), psychoanalytical approaches (Aarons and Gittens, 1991), other therapies like music therapy, underwater therapy, dolphin therapy, trampoline therapy, and wet sheet therapy. (Peeters, 1997), TEACCH (Treatment and Education of Autistic and related communication Handicapped Children), auditory Training (Rimland, 1991) and deep Pressure (Grandin, 1986).

OCCUPATIONAL THERAPY FRAMES OF REFERENCE USED IN CASE STUDY

Bloomer and Rose (1989) refer to seven traditional frames of reference that can be applied with autistic children, where the therapist opts to use techniques described in these approaches. The frames of reference they mentioned were developmental, occupational behavior, sensory integration, biomechanical, acquisitional, rehabilitative and psychoanalytical approaches.

The three frames of reference used during my treatment were:

- behavioral modification aims at improving specific behaviours or skills through structured manipulation of reinforcement. This can work in a token economy system where desired behaviour is rewarded and all other behaviour is punished or ignored. In this way behaviour can be gradually shaped into whatever pattern is desired by the person in control of punishments and rewards.
- developmental approach which is based on developing tasks and roles according to a predictable sequence. Treatment focuses on establishing a baseline level of performance, while providing activities along the development continuum. Among the treatment approaches that fall under this frame of reference are the cognitive education and the sensorimotor approaches.
- occupational behaviour theory, which is based on the fact, that humans are biological, psychosocial and cultural beings who spontaneously explore and master the environment. Intervention was focused on acquiring and performing skills of work, play and self-care. Goals depend on developing life skills and personal interests while in a clinical setting, which can later be transferred in the community. (Bloomer and Rose, 1989)

Table 1 Case study goals, Frame of reference used and results.

GOAL	Develop m-ental Approach	Occupat-ional Behaviour	Behavi-oural Approac h	COMMENTS
Increasing tolerance in sitting and attending behaviour.		✓	✓	By the end of the programme the child was able to attend to more than two activities of my choice, and which he would initially refuse.
Improving eye contact.	✓	✓	✓	Positive results were being achieved halfway through the programme, were it was reported that Luke had a full session with constant eye contact. Later on in the programme the child regressed. Finally, it was recorded that there was poor achievement in this area.
Minimising attachment to inanimate objects.			✓	By the end of the programme the child did not bring the object of attachment to the unit and did not take it school.
Increasing body awareness.	✓			The child did well in this area, were he could point out to his own body parts, when asked without assistance.
Improving age appropriate play.	✓	✓	✓	The child was joining in imitative play at school, and was co-operating more in play during his treatment sessions.
Decreasing jargon and increasing functional communication.	✓	✓	✓	By the end of this study, echolalia was reported to being constantly increasing, at home. Few functional words were being used in context. Sounds were being imitated. The child could not say his name unless prompted.

RESULTS

Refer to table 1

CONCLUSION

As the etiology and pathogenesis of autism is still not clear, no single treatment in all areas of health care and education have been consistently reported to improve the symptoms. This presents a challenge to the occupational therapist working with autistic children who has to use her medical and professional background to plan a treatment programme. The aim of this case study was to experience the treatment of an autistic child and compare the findings to the occupational therapy literature. Considering that the diagnosis of autism is not clear-cut and the fact that in occupational therapy, no one frame of reference has been proved effective, it can be concluded that treatment of autism has to be symptomatic.

Though by no means can the results of this case study be generalized, most of the approaches used during treatment were recorded in the literature and have been found to improve some of the symptoms. Furthermore, when an autistic child is referred to occupational therapy, the therapist should be:

"aware of autism, the problems it presents to a child, the role that occupational therapy plays in helping the child's developmental processes and the role of the parents in the treatment process." (Stancliff, 1996, p20).

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MUSCULAR DYSTROPHY (M.D.)

Demis Cachia SROT

WHAT IS MUSCULAR DYSTOPHY?

The word dystrophy comes from the Latin and Greek roots meaning "faulty nutrition". During the 19th century, tools were very limited in diagnosing Muscular Dystrophy. Muscles in many diseases appeared to be wasting away, and the doctors theorised that they somehow weren't being properly nourished.

Today, we know that many muscle-wasting diseases are caused by defects in genes for muscle proteins. Most of these proteins appear to play a role in supporting the structure of muscle fibres, although some may play a role in the biochemical process that go on in muscle fibres. The term M.D. refers to a group of genetic diseases marked by progressive weakness and degeneration of the skeletal or voluntary muscles, which control movement. The muscle of the heart, in some forms of M.D., is also affected.

M.D. can affect people of all age. Some forms of M.D. can appear in infancy or childhood; others may not appear until middle age or later. With the progress in medical care, particularly of problems affecting the heart and lungs, children with M.D. are living longer.

The major forms MD include:

1. Myotonic
2. Duchenne
3. Becker
4. Limb-Girdle
5. Facioscapulohumeral
6. Congenital
7. Oculopharyngeal
8. Distal and Emery-Dreifuss

Some of these names are based on the locations of affected muscles i.e. "Facioscapulohumeral" refers to muscles of face, scapula and humerus. Others are based on the muscle protein involved, the onset age or the doctors who first describe the disease.

The symptoms of this condition differ in severity, according to the age of onset, primary muscles involved, the rate at which they progress, and the way the disease is inherited.

WHAT CAUSES M.D.?

A flaw in muscle protein genes causes MD. Each cell in our bodies contains tens of thousands of genes. Each gene is a string of chemical DNA and is the "code" for a protein. If the composition of a protein is inadequate, it affects its make up and the amount produced.
All forms of MD are generally inherited but in some cases no family history of the disease may exist. MD is not contagious.

DIAGNOSIS OF M.D.

- Evaluation of patient medical history,
- Physical examination,
- Diagnostic tests used to distinguish between different forms MD including:-
  - Studying muscle tissue – muscle biopsy
  - DNA testing
  - Electromyogram (EMG)
  - Nerve Conduction Velocity (NCV)
  - Blood Enzyme Tests

THE TEAM APPROACH TO HOLISTIC CARE

In order to provide quality treatment and care of the individual with Muscular Dystrophy, a comprehensive and individualised approach is required. The health care team may include physician, neurologist, orthopaedic, nurse, social worker, rehabilitation counsellor, clinic-school liaison, occupational therapist and physiotherapist. Roles may overlap according to the needs of each client and situation. Patient care should be a co-ordinated effort and communication among team members is vital.

The roles of health care team members in treating this condition are described below:-

PHYSICIAN

The physician is responsible for diagnosis and medical management. The physician works with the nurse to direct patient care, the physical and occupational therapists to develop an individualised muscle care and adaptive living skills program, and the psychosocial staff to ensure the individual's and family's emotional well-being at home and in the community.

Responsibilities of a physician within the team are multiple: providing direct patient care, educating medical colleagues, allied health professionals, the lay public and, most importantly, individuals affected by muscular dystrophy and their families. One of the most significant roles of the physician is as co-ordinator; to obtain and utilise information and services from various allied health professionals.

NURSE

The nurse has a central role in co-ordinating daily operation of the health care team. Because the nurse provides a critical element of continuity between outpatient and inpatient services when hospitalisation is required, a close relationship often develops between the nurse, the individual affected by MD and the family. As a result of such close relationships, the nurse can often recognise and inform other team members about psychological, social and financial conditions that could affect overall management.

The nurse can provide support to an individual affected by M.D. and his family during significant events such as diagnosis, alterations in treatment and death. Experience with health care

problems that frequently occur in the disease, together with personal knowledge of each individual treated in clinic; can allow the nurse to facilitate the organisation of care provided.

PSYCHOSOCIAL STAFF

(Social Worker, Rehabilitation Counsellor, Psychologist)

M.D. has significant psychosocial implications, particularly during potential developmental crisis such as diagnosis, alterations in therapy, adolescence and death. The psychosocial members of a health care team can evaluate each family's and individual's ability to cope with issues related to M.D. and determine appropriate therapeutic intervention when needed.

Referral to a professional therapist or to support services available in the community may be helpful. In addition to reinforcing the importance of medical care, psychosocial team members can help the family and individual with M.D., function at an optimum emotional level. Because of the extensive amount of attention required by the disease and its effects upon a growing child and adolescent, relationships among siblings and parents can be affected. By providing education, support and assistance in locating community resources, problems can be reduced for the entire family.

The psychosocial staff members also assist the family and those with M.D. in obtaining financial assistance through appropriate state benefits. By providing guidance in education, community involvement and planning for the future, the psychosocial team members help those with M.D. prepare for the greatest possible degree of independent living.

CLINIC - SCHOOL LIASON

(Facilitators)

The majority of individuals with M.D. are adolescents or younger and should be involved in some type of educational program. A trained professional, familiar with general and special education programs, school law and teaching methods can be an invaluable asset to a family and to the school. By helping to educate school staff and student peers, teachers can encourage understanding and healthy adaptations that keep the student with M.D. involved in school activities.

As a liaison person between the clinic and school, the facilitator can encourage appropriate annual educational evaluations and adequate school placement with consideration of the student's continually changing abilities as the disease progresses.

PHYSICAL THERAPIST

Currently there is no treatment that can stop or reverse the progression of muscle degeneration in muscular dystrophy. However, maintenance of muscle strength through physical therapy can allow

individuals to function at an optimum physical level and avoid premature contractures and joint stiffening. Regular evaluations are necessary to provide information for development of an individualised physical therapy program.

In addition to direct care, physical therapists instruct family members, young adults with M.D., health care providers and school personnel in proper techniques for daily physical therapy exercises.

OCCUPATIONAL THERAPIST

As M.D. progresses, adaptive equipment becomes increasingly valuable in maintaining an individual's independent functioning. Assistance with activities and recreation can be provided by the occupational therapist.

Occupational and physical therapists work closely in evaluating muscle strength, abilities and limitations.

The need for adaptive equipment may help the patient to become more aware of The physical therapist can recommend exercises that will continue to maintain flexibility and strength while taking into consideration adaptive equipment recommended by the occupational therapist. The need for adaptive equipment may help the patient become more aware of his decreasing physical abilities. The emotional support of the occupational therapist, while encouraging the use of equipment, can greatly enhance the overall success of medical management.

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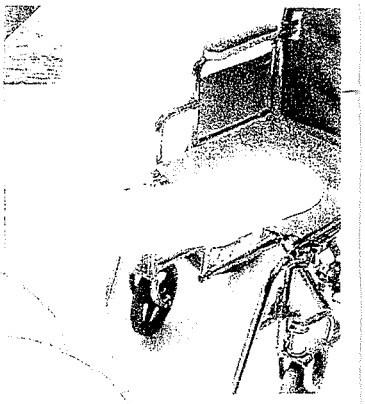

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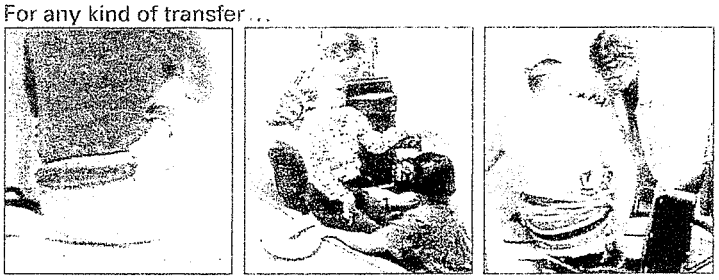

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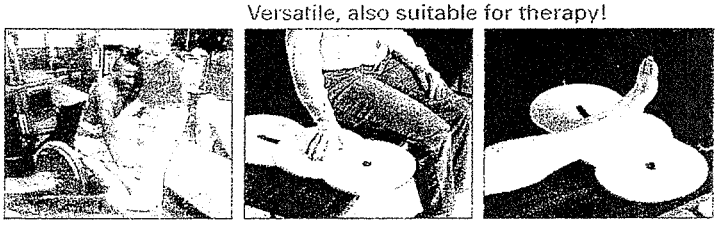

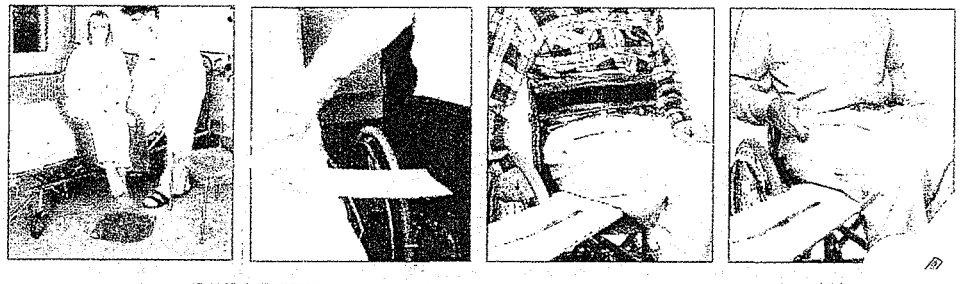

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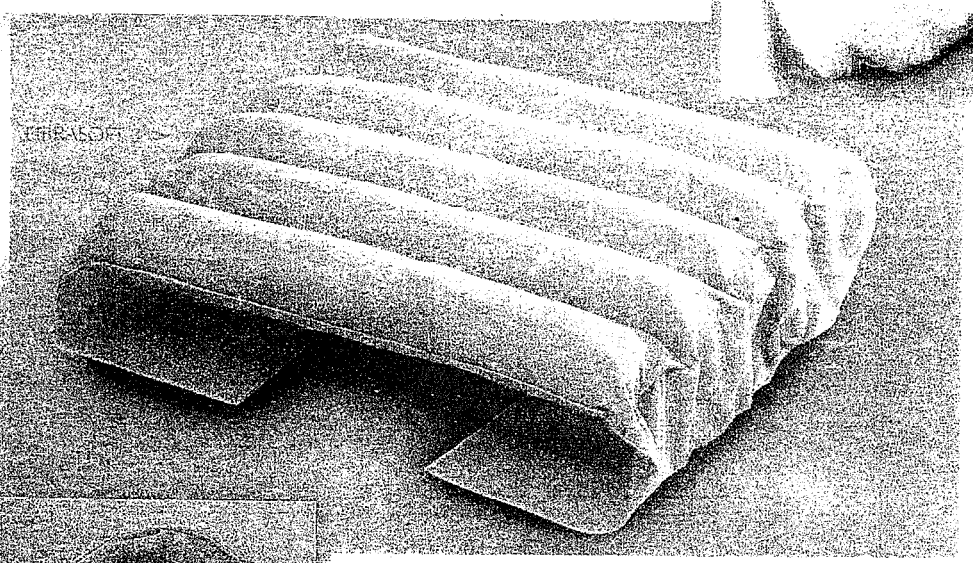

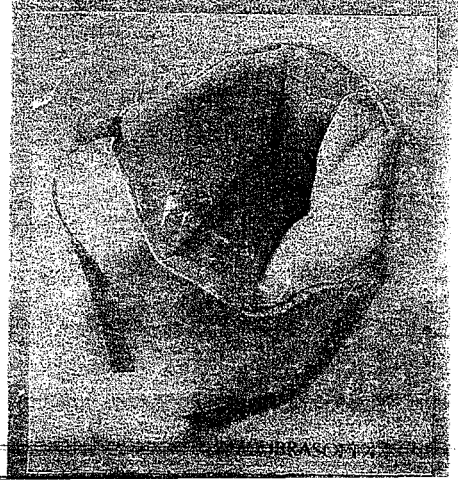

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ANXIETY DISORDERS

Miriam Zammit SROT

Anxiety is an anticipation of some impeding danger and a feeling that one deal with even the smallest of things – an instinctive mechanism for survival. The essential feature in this disorder is the sense of "free-floating." As in other anxiety disorders (such as panic attacks and phobia) the dominant symptoms are highly variable, but complaints of continuous feelings of nervousness, trembling, muscular tension, sweating, lightheadedness, palpitations, dizziness and epigastric discomfort are common.

The National Institute for Mental Disorders believes that anxiety is the number one health problem for women. Its course is variable but tends to be fluctuating due to chronic environmental stress. Research has shown that this condition is chronic and can be controlled by administering tranquilizers and painkillers.

Although anxiety is usually thought of as an unpleasant feeling, people do not always try to avoid it. Some people actively seek anxiety and get great pleasure from mastering of dangerous situations e.g. racecar drivers or spectators who experience second hand tension.

Mild anxiety can be quite useful. It helps people deal with the problem situation more efficiently. It provokes you to action and gears you up to face a threatening situation – it helps you cope. Anxiety is considered abnormal only when it is greater than the usual response to stress in a given culture and a handicap to a person in everyday life. Extreme fear can paralyze us and severe anxiety hinders performance.

Anxiety occurs in many psychiatric problems such as depressive disorders. Most depressed people often imagine other illnesses and may show agitation, trembling and other similar symptoms to the mentioned condition.

In anxiety states, the anxiety may be chronic and sustained but more usually comes and goes. Each episode can last a few minutes to hours. The intensity of nervousness varies from paralyzing terror to mold tension. These episodes can be so uncomfortable that in order to avoid them one may stop carrying out personal and domestic activities of daily living, social interaction or productive work. Basically people suffering from this condition avoid situations they fear would initiate a panic attack occurs.

A person's life becomes increasingly dominated by the precautions they have to take in order to avoid the situation they fear. Sufferers usually know there is no real

danger, they may feel silly about their fear, but they are still unable to control it. People suffering from any anxiety disorder will sometimes not want to ask for help because they think that others might perceive them as "abnormal".

DIAGNOSTIC GUIDELINES

According to the ICD 10, the sufferers must have primary symptoms of anxiety most days for at least several weeks at a time and usually for several months. These symptoms should usually involve elements of:

- Apprehension (worries about future misfortune, feeling "on edge," difficulty in concentrating etc.)
- Motor tension (restless, fidgeting, tension headaches, trembling, inability to relax)
- Autonomic overactivity (lightheadedness, sweating, tachycardia, epigastric discomfort, dizziness, dry mouth, etc)

HELPING PEOPLE WITH ANXIETY

The sufferer will tend to look pale, tense and irritable, and this can cause arguments with those close to them especially if they do not understand what the sufferers feels. Education on this condition is very important for friends and family members so tat they can be more understanding and supportive.

Medication

The most common tranquilizers are the valium-like drugs. They are effective at relieving anxiety but they can be addictive after only four weeks of regular use. These drugs should only be used for a short period of time, perhaps to help during a crisis, but not for long term management.

Self Help Groups

These are a good way of getting in touch with people with similar problems. They will both be able to understand what one is going through, and may be able to suggest helpful ways of coping.

Learning to Relax

It can be a great help to learn a special way of relaxing, to help control anxiety and tension. Both the above mentioned types of therapies are usually included in an individualized occupational therapy programme. Relaxation groups and Self-Help groups are usually conducted by an occupational therapist.

Nutrition Therapy:

Most people don't think of consulting a nutritionist to help them, yet eating the right food can have an enormous impact on the mental well being.

Certain foods and drinks such as processed foods, coffee, sugar, tea and alcohol can make you feel more stressed because they are stimulants and will make you feel more anxious. It is also recommended to maintain a healthy diet rich in whole grains, vegetables, fruits, lean meat and fish. Regular meals are a must, in order to maintain a good level of blood sugar, because low blood sugar levels can make one feel anxious and moody.

POINTS TO KEEP IN MIND DURING/AFTER A PANIC ATTACK - COPING STRATEGIES

C- Comfort you. The knowledge that, although they may be painful and frightening, these feelings are perfectly natural. They do not mean hat anything more dreadful will happen to you. Once the panic has passed, it is likely to return for a considerable amount of time.

O – Observe what is actually happening to your body, instead of making matters worse by worrying about things that are never going to happen.

P- practice relaxation. It will help you control the physical feelings associated with rising anxiety and may prevent the anxiety entirely.

I - Imagine the pleasant scene that you envisaged at the end of your relaxation session.

N – Notice that when negative thoughts subside the panic quickly diminishes.

G – Go forward again in an easy and relaxed manner.

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EPILEPSY AND LIFESTYLE

When epilepsy is diagnosed in the child, the first reactions, especially in the parents are shock and fright. This may lead to some degree of overprotection. But once the seizures are controlled and appropriate explanation and advice has been given both the parents and the child's confidence should grow and the latter should be encouraged to lead a normal life as much as possible. Ideally, children should be treated like other children and should take part in most of the activities that other children do, to ensure normal development.

Factors such as nature of the seizure, seizure frequency and duration and presence or absence of physical/intellectual retardation all impinge on the decision as to how much a child can do.

DRUG TREATMENT

Epilepsy cannot be cured but it can be controlled by medication. It is important that the parents/carers:

- Follow the doctor's instructions when giving the necessary drugs to their children.
- Do not increase the prescribed dose without the doctor's consent, even though the child might have suffered extra fits due to intoxication.
- Do not stop or reduce the prescribed dose without the doctor's consent since this can lead to severe generalized convulsions or even more severe consequences.

PRACTICAL ADVICE FOR CHILDREN WITH EPILEPSY

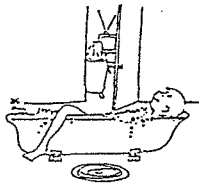
* Swimming:

- never swim alone
- a companion/teacher should always be informed of the child's condition. First Aid in seizure care should always be shown in this case.

* Bathing:

When using a bath

- the child should never be left alone in the house.
- the bathroom door should be kept ajar
- the bath water should be kept reasonably shallow.



When using the shower :

- the shower should be fitted with shatterproof glass
- if the child is alone in the shower unit, it might be difficult to get him out if he has a gran mal seizure during showering.
- A temperature control device should be fitted to the water system in the shower to avoid burns during a fit.

* Bicycle or horse riding:

- the child should wear a helmet.
- he should ride in a protective environment
- if possible the child should not ride alone.

* Climbing

- due to the dangers this activity presents, it should best be avoided.

PROVOKING FACTORS

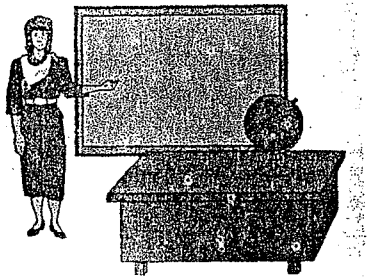
There are a number of provoking factors which may trigger a fit in children with epilepsy. Theses are important, as they should obviously be avoided as much as possible. These include:

- lack of sleep
- stress
- alcohol
- infections
- drugs
- flashing lights.

EPILEPSY AND SCHOOLING

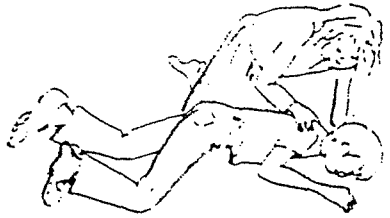
These children need to share the company of other children, go to normal schools and partake in the usual activities. They are normal children with a particular problem which is infact much less disabling for many of them, than children suffering from other conditions. Children suffering from epilepsy should not be treated differently from normal children.

Although there is some evidence that in some children, learning and behavioral problems do rise in connection with their epilepsy, mainly due to the adverse reactions of the anticonvulsant drugs, the majority of them do well and go on to gain university degrees.



WHAT TO DO IF SOMEONE HAS A MAJOR FIT

- If the person falls near something dangerous like a fire, move them away; otherwise do not move the patient.
- Do not try to force anything between the teeth, since these may break.
- As soon as the jerking stops and breathing starts, make sure that the child can breathe freely.
- Loosen the clothing around the neck and put the child in the recovery position.
- Do nothing more - leave the child to recover.
- DO NOT:
  - slap the face
  - try to bring the child around
  - give anything to drink
  - restrain unless it is absolutely essential.
- If the child suffered an injury with which you cannot deal or if you cannot stop any bleeding, seek medical help.
- If a fit goes on for more than five minutes, or if the child does not regain consciousness within fifteen minutes of the end of the fit, medical assistance should be sought.

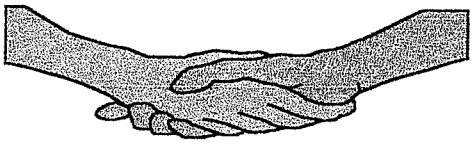


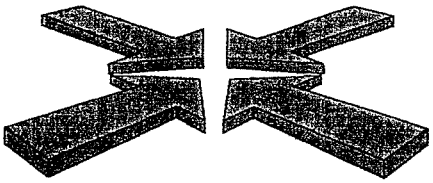
What is Epilepsy?

People with epilepsy lose control of their body, usually with complete or partial loss of consciousness, at various unexpected times. In other words, they may make movements without consciously wishing to do so and often without being aware of what is happening. This loss of conscious control may be referred to as an 'absence', 'blackout', convulsion', 'turn', 'seizure' or 'fit'. Lack of public understanding of epilepsy causes fear, and fear in turn induces prejudice. There can be no doubt that there is a general prejudice towards those with epilepsy, not only in Malta but throughout the world.

The following is some information for the parents/ family to help the child to grow up to enjoy a full and active life when previously it was thought all doom and gloom.

Carmen Deguara SROT (complied as part of the final pediatric credit for the completion of the Diploma)





STOP AND THINK?
Do you want to develop our profession further?
Are you ready to bring about change?
If yes, fill in this form and become a member of the M.A.O.T., today (for tomorrow may be too late!!!!) and mail it to:

Ms. Tracy Falzon

MJOT c/o O.T. Department,

Mount Carmel Hospital, Attard.

Name:_____ Tel. No: _____

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Year of Graduation/Student intake: 19__ Date of Application: _____

Work place (if applicable): _____

MEMBERSHIP FEE: Qualified O.T's and Other Paramedic Staff: Lm 6.00

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