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Expanding the Role of Sensory Approaches in Acute Psychiatric Settings

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Introduction

Since the earliest days of our profession, occupational therapists have strived to provide person-centered and strengths-based quality care. Although many mental health care settings endorse person-centered care, interdisciplinary staff members must engage in therapeutic exchanges that embody such an approach (Champagne & Stromberg, 2004). This requires the consumer to be central and active in all aspects of the treatment planning and implementation processes whenever possible. Occupational therapists can learn a great deal from consumers if they choose to listen actively and engage in co-creating treatment plans and therapeutic environments that afford diverse, meaningful, and sensory-rich opportunities in real time (Champagne, 2003b; Hasselkus, 2002). As facilitators of self-organization and change (Lazzarini, 2004), it is important to recognize the many different ways in which occupational therapists may influence an individual's unique dynamic system and the greater treatment milieu. Occupational therapists must explore: Do occupational therapists help co-create therapeutic environments where people feel safe? Do their therapeutic exchanges afford opportunities for consumers to discover ways in which to shape one's own system's tendencies and patterns? How do the services occupational therapists provide help to facilitate and support the processes of self-organization and self-actualization?

The co-creation and use of nurturing treatment environments and sensory-supportive approaches offers a wide range of treatment options as well as a place to engage in meaningful therapeutic exchanges. Hasselkus (2002) referred to place as an "organized world of meaning" (p. 28). Occupational therapists are taking a leadership role in the planning and implementation of sensory approaches in a variety of settings in collaboration with staff and consumers. Although little is provided in the literature regarding the current application of such approaches, particularly among adults within acute care psychiatric settings, this is an emerging practice area. This article explores the importance of the skilled and responsible use of meaningful, sensory-supportive and trauma-informed approaches quintessential to person-centered models of care.

Complex Adaptive Systems

"Imagine a living system composed of components that ignored each other and did not interact. Such a system would possess neither structure nor function" (Kelso, 1999, p. xi). The study of complexity and dynamics is the study of change. Human beings are complex, self-organizing, adaptive systems. People learn, grow and change through the processes of intentionality and self-organization in context and time (Skarda & Freeman, 1990). The study of neurodynamics suggests that the self-organization of our actions in the world is the product of context; previous experience; the states of arousal and attention; the expectancies of responding to stimuli; and the intentionality of individuals, including their goals and meanings (Freeman, 2000a; Lazzarini, 2004).

Occupational patterns, occupational performances, and outcomes do not merely depend on internal and external environmental stimuli (Lazzarini, 2004). "Every intentional act is an expression of the internal state of meaning in the brain and body" (Freeman, 2000a, p. 145). Behavior is, "the subjective aspect of the context in which the limbic mechanisms of intentionality construct the patterns of neural activity that are observed as behaviors" (Freeman, 2001, p. 6). Thus, behaviors may be viewed as occupational patterns, performances and as processes of communication. This includes habits, rituals, tendencies, and preferences.

Occupational therapists can offer opportunities for consumers to explore novel and familiar sensorimotor and environmental thera-

Conference Preview

■ Karla Gray

AOTAs 85th Annual Conference & Expo will include four Workshops, nine Short Courses, seven Posters, and two Papers on 'mental health' topics. These sessions cover a broad scope of practice.

The Mental Health Special Interest Section meeting will highlight the evidenced employment service models and discuss the unique contributions that occupational therapy brings to that process. Attendees will be able to collaborate with leaders in the field of community based mental health. This session will be held on the afternoon of Thursday, May 12th.

Two mental health 'Round Table Consultation' presentations will occur over the lunch hour on the 13th. Please note that these sessions require pre-registration due to space constraints. One session will focus on issues specific to child/adolescent mental health and the other on private practice. Each is 45 minutes. The exact times will be included in the conference brochure. Continuing education credit will be granted.

The progress to date on the Board Certification in Mental Health will be highlighted during a Round Table on Saturday. If you are interested in attaining advanced practice certification in mental health, this session is important to you.

The conference hotels are all within a two block area walk from the convention center. Several restaurants, in all price ranges, the Aquarium, and many other interesting places are within walking distance. Watch for the conference program in your mail box early in 2005. ■

peutic exchanges, aiding the individual in identifying and adding those things that are meaningful and helpful to their repertoire of skills. Ultimately, this may positively influence the consumers' ability to participate more fully in meaningful life roles. Looking at the parts, the whole, and the greater whole, we begin to recognize how our attitudes, beliefs, approaches, and the overall treatment environment ultimately afford or constrain opportunities for consumers to engage in meaningful therapeutic exchanges. This heightened awareness not only contributes to enhancing the therapeutic relationship, but also demonstrates the recognition of the multiplicity of factors involved in dynamic therapeutic processes. This deeper awareness of the importance and significance of the interrelatedness and interconnectedness of the mind–body–world, of what is meaningful to each individual, and of how this may profoundly influence the processes of self-organization and self-actualization will greatly enrich occupational therapy practice.

Sensory Approaches

One of the unique contributions of occupational therapy in mental health practice is the skilled use of sensory approaches for therapeutic purposes. Our brains seek information and direct us to stretch forth into the world to look, listen, smell, taste, and touch (Champagne & Stromberg, 2004; Freeman, 1991; Thelen & Smith, 2000). One of the significant variables in the process of self-organization is how the person modulates sensory stimulation from all of the senses (Champagne & Stromberg, 2004; Freeman, 1991; Thelen & Smith, 2000). As we become more attuned to those things that we all use or do to shift our dynamic brain states to self-organize and engage in life, we become more aware of how helpful such techniques may be, particularly when in crisis states. Crisis states are dynamic processes of change and phase transitions generally characterized by acuteness, uncertainty, surprise, unpredictability, and the chance of reorientation (Tschacher, 1995). Lazzarini (2004) referred to such states as "occupational crises." Occupational crises are not static states. They are dynamic longitudinal processes of experience and may be described as the responses of the system facing certain environmental perturbances (Tschacher, 1995). In acute care settings, occupational therapists work in the midst of occupational crises. Therefore, we must be knowledgeable about and able to offer responsibly a host of individualized therapeutic options that are safe and appropriate for use during occupational crisis states.

Sensory approaches are such options and may include direct or indirect sensory stimulation, sensorimotor activities, environmental modifications, and the creation, practice and implementation of sensory diets. Every mind–body–world experience involves sensory stimulation and although we may choose to focus on one or a few of the specific sensory systems used during a particular sensorimotor activity, it is important to emphasize that our experiences are multimodal (Thelen & Smith, 2000). Activities we engage in that provide sensory and motor stimulation are referred to as sensorimotor activities (Bundy, Lane, & Murray, 2002; Ross, 1997). When sitting in a bean bag chair and looking at a scenic picture during a relaxation exercise, the coordinated use of the eye muscles during vision is a very dynamic and integrated sensorimotor process (Thelen & Smith, 2000). However, this is only one of the many sensorimotor activities the individual is engaging in during this activity. Sitting in the bean bag chair is another. Becoming more aware of how these are multimodal and embodied experiences is necessary for occupational therapists using sensory approaches in practice and in research.

It is important to explore with each individual the types of stimulation, activities, and environmental variables he or she believes have a tendency to help facilitate self-organization. When asked, many people are able to think of things that tend to help them. What is often more difficult for people to identify is what things help when experiencing more extreme levels of distress. Sensorimotor activities such as wrapping in a weighted blanket, holding ice, biting into a lemon, performing deep breathing or isometric exercises, and brushing techniques are examples of sensorimotor activities that consumers may engage in when in distress or for preventative purposes (Champagne, 2003b; Linehan, 1993; Moore & Henry, 2002). The meaning, however, is not within the object or activity itself, but within each individual. Such activities may provide calming and/or alerting sensory experiences, or qualia [one's subjective emotional-perceptual experiences of self], and become meaningful ways to help the person self-organize, remain safe and in control. Such activities are often referred to as distraction, self-soothing, or relaxation techniques.

Wilbarger (1984) coined the term *sensory diet,* referring to the repertoire of sensorimotor activities that appear to influence one's ability to function more optimally. Incorporating the consumer's sensory diet into the development or his of her crisis prevention plan is essential. If the consumer is not an active part of this process whenever possible, the type, frequency, intensity, and duration of the sensory approach chosen by health care professionals may not necessarily be meaningful or helpful to the consumer, and in some cases may have a negative influence. It is fundamental to work with each consumer to explore and develop strategies to use for preventive purposes, during, and after critical times.

If these options are understood by the treatment team as an important part of the individual's sensory diet, as self-organizing activities, they may be made more readily available to the consumer. The ability to offer alternative forms of stimulation and environmental modifications, identified as helpful by the consumer, may help to decrease or more skillfully help the individual manage difficult thoughts, arousal states, emotions, and cravings when they occur and may contribute to the decreased need for the use of restraint and seclusion (Champagne & Stromberg, 2004; National Executive Training Institute [NETI], 2003). Occupational therapists can assist each consumer and the interdisciplinary treatment team in the identification of a host of helpful sensorimotor activities and environmental modifications that appear to be helpful to the consumer.

Person-Centered Crisis Prevention Tools

Many consumers are able to rate their perceived levels of symptom or problem severity using self-rating scales and questionnaires, although some may require assistance. Using a 0 to 10 scale is often helpful when consumers are considering how their specific symptoms or problems tend to intensify. As a person becomes more aware of their tendencies, through the processes of reflection, it is often reported helpful to identify, list and utilize healthy coping options that correlate to the intensity of the symptoms or problems experienced. Furthermore, identifying when and why one might prefer to use something that is calming versus alerting is also important. For example, using something perceived as alerting during an anxiety attack may worsen the symptoms experienced, although something alerting may serve as a healthy distraction during cravings to self-injure. This is a very individual process. Using group or individual sessions, occupational therapists may help consumers begin to reflect and identify the responses they have to different types of stimulation and experiences. During such sessions, many report it being the first time they become aware of the fact that what is calming or alerting for one person may not be the experience of another. Discussions about how this affects the individual, their relationships, and their roles often naturally unfolds.

Many programs throughout the country use individual crisis prevention tools such as the "safety tool." The safety tool is a specific questionnaire developed by the Massachusetts Department of Mental

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Health and it is used by mental health treatment facilities (NETI, 2003). It is completed during the initial nursing evaluation and is useful in treatment planning and facilitating the processes of trauma-informed treatment delivery. The safety tool should be adapted to be unit and population specific. It is a consumer questionnaire identifying potential triggers, sensory and interpersonal strategies upon admission so that a crisis may be averted or minimized (Carmen et al., 1996; NETI, 2003). Identifying specific sensory diet strategies and integrating these into an individualized treatment plan has been of benefit to many consumers (Champagne, 2003b; Champagne & Stromberg, 2004). The occupational therapist collaborates with the consumer, further exploring the information identified and assists in discovering additional strategies for use preventatively as well during and after occupational crises.

Trauma-informed care is defined as "mental health care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services" (NETI, 2003, p. 1). This definition also includes the clear understanding of the significance and relevance of each individual's trauma experiences and, therefore, to occupational therapy practice. When considering the majority of many mental health consumers have experienced some form of trauma (NETI, 2003), the importance of this understanding becomes clear and relevant to our practice. With this increased awareness, we become more empathetic and better able to offer meaningful therapeutic opportunities and environments. Trauma assessments should include, at a minimum, the type of trauma, the age when the abuse occurred, who perpetrated the abuse, and resulting symptoms (NETI, 2003). Assessment results and the consumer's report of effective strategies must be integrated into treatment planning and care delivery (NETI, 2003).

The ability and tendency to use self-injury as a mechanism to induce a dynamic state transition is a well-known phenomenon (Linehan, 1993; van der Kolk, 1997; Winchel & Stanley, 1991). Many persons with trauma histories engage in self-injurious behaviors (e.g., cutting, burning, head banging, swallowing objects, substance abuse) as a way to manage distress, negative thoughts, traumatic memories, and flashbacks (Linehan, 1993; Mazelis, 2003; van der Kolk, 1997; Winchel & Stanley, 1991). Some report that self-injurious behaviors have an immediate "orienting" effect that may be intense, calming, or alerting, whereas others report that self-injury is a way of escaping their thoughts, causing a physical and emotional numbing.

Occupational therapists working in mental health often engage in therapeutic exchanges in order to help facilitate a change in such self-destructive patterns of behavior. However, we must realize that these are often meaningful and very personal occupational patterns that serve a purpose for each individual. In some cases it is helpful to explore with the consumer the perceived significance of the self-injurious behavior(s) utilized, any rituals involved, and their perceptions of how and why it helps. Considering the pros and cons of change and brainstorming potential alternatives that may assist during the transition or change process is often useful. The consumer may consider, explore, practice, and determine a sensory diet, a particular sensorimotor modality, or both as useful strategies when trying to stop engaging in self-injury.

The literature suggests that people with anxiety perceive sensorimotor activities or environmental stimulation, which they perceive to be calming, as helpful in reducing symptoms (Kinnealey & Fuiek, 1999; Manheim & Lavett, 1989). Tschacher (1995) revealed that for many who experience depression, without the symptoms of anxiety, sensorimotor activities or environments facilitating relaxation might not be perceived as helpful. It is important to recognize that people are dynamic human systems who are continually changing and that those with psychiatric symptoms are no exception. We must continue collaborating with the consumer, reevaluating the perceived effectiveness of the activities the individual chooses to do or use to facilitate the process of self-organization and positive change, while modifying the sensory diet and treatment plan accordingly. The findings discussed help support the need to offer a full range of sensorimotor activities and environmental options as well as the need for further research.

Environmental Modifications and Sensory Rooms

Literature on sensory approaches suggests applicability across age groups, settings, and levels of care (Champagne & Stromberg, 2004). Until recently, the acute mental health care treatment environment has been overlooked or only minimally addressed (Brown, 2001; Champagne, 2003a). Health care settings often are overstimulating environments (Cmiel, Karr, Gasser, Oliphant, & Neveau, 2004). Davidson & Bar Yam (2003) revealed that environmental complexity is a variable influencing the cognitive functioning and general well being of older persons. Occupational therapists can assist organizations and consumers by collaborating on recommendations for environmental modifications, mental health settings being no exception.

Environmental modifications, including the creation and implementation of multisensory treatment rooms, are becoming more readily available within acute mental health care settings. The Massachusetts Department of Mental Health, the National Association of State Mental Health Program Directors, and the Joint Commission for Accreditation of Healthcare Organizations understand the need and support the skilled and responsible use of sensory approaches and multisensory environments, recognizing occupational therapists as the discipline qualified to provide the consultation services necessary to co-create and implement such approaches. These therapeutic places are specific to the populations served and preferably are those that can be re-created by most consumers after discharge. Within some hospital settings, the implementation and use of multisensory environments has contributed to other units requesting assistance from occupational therapists for environmental recommendations. Emergency and maternity departments are examples of units now creating sensory spaces or sensory carts with a variety of options for patients, which also promote continuity of care.

Many mental health settings currently offer multisensory environments. One of the many benefits of such a therapeutic place is the ability to offer a sensory supportive medium from which to engage in conversations regarding meaningful past and current experiences, at any age. When a consumer becomes unable to use the multisensory room for any number of reasons, assigning or allowing the signing out of safe equipment may be a useful option. In some cases, a consumer's room may be more easily modified to support trust and safety, further contributing to a person-centered culture and model of care (Bronson & Bundy, 2001).

Community Reintegration

As with any therapeutic approaches found helpful throughout one's admission, occupational therapists must ensure that the appropriate planning for discharge and follow-through occurs. Many consumers will require assistance with planning and follow-through to utilize sensory diets and the many other potential discharge recommendations. Whenever possible, families and caregivers must be a part of the therapeutic and discharge process and may be helpful in supporting continuity of care after discharge. It is important to discuss with the consumer and caregivers what has been helpful, the need to share and continue the work that has been started with outpatient providers, and to offer information regarding where to purchase any of the items found helpful or instructions on how to make them. Therapeutic places may be created in one's home environment and supplemented by self-created sensory kits. Creating a daily schedule is helpful for follow through with one's sensory diet.

Conclusion

There are many potential uses and areas of application for sensory approaches in mental health services. Sensory approaches are more readily received and accepted by organizations whose philosophy of care and practices are person-centered. An interdisciplinary approach to care will be necessary in order to consistently offer consumers a wide range of choices, and occupational therapists are instrumental in helping to develop the programming, environments, and staff trainings necessary to safely and responsibly offer sensory approaches. The research available and my experience suggest that, when used appropriately, the skilled and responsible use of sensory approaches is helpful to consumers and staff working with mental health populations. Within acute mental health settings it appears that increasing both the options available to those in occupational crisis states and staff education are variables that influence the decreased use of restraint and seclusion (Champagne & Sayer, 2003). Although future research is necessary to explore further the variety of methods currently being

utilized, sensory approaches are promising and applicable with appropriate modifications for a variety of ages, levels of care, and consumer populations (Champagne & Stromberg, 2004). ■

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