Elderly persons with mental illnesses present a complex picture to geropsychiatry teams. Problems such as dementia, depression, and psychotic disorders are often compounded by nonpsychiatric problems. For example, health problems or physical disability, changing or stressed support systems, loss of major life roles, and impaired performance of activities of daily living all may exacerbate the impact of the psychiatric disorder on the older person’s life. The occupational therapist, with an eye toward functional skills and limitations and an educational background in physical, psychosocial, and environmental factors, can provide important information and insight to the multidisciplinary team as it strives to provide optimal services for this population.

This article describes the specific contributions of the occupational therapist to the mental health of the aged. On the basis of our clinical experience, we have identified three important outcome areas of occupational therapy intervention: preserving autonomy, enhancing integrity, and increasing personal and community safety.

Older persons with psychiatric disorders are often at risk of losing their independence at many levels, ranging from being deemed unable to choose where to live to being restrained in a geriatric chair. The occupational therapist can assist these persons in maintaining independent living (or in instituting the least restrictive measures necessary) and maximal autonomy.

The engagement or integration of older people within their life context is vital to their well-being and integrity. Detachment and inactivity are often seen among this population. The occupational therapist can contribute to the support system that is often required to enhance the integrity and productivity of aging persons.

Concerns about unsafe behaviors associated with psychiatric impairment are often paramount in the treatment of elderly persons. Measures taken to ensure safety may at times oppose the older person’s desire for autonomy. While the health care team sorts through the clinical and ethical questions surrounding these issues, the occupational therapist can help to support the older person’s autonomy while improving his or her safety.

Barriers to the provision of occupational therapy services to this population include limited resources, inadequate alternatives, an insufficient number of occupational therapists, need for an improved knowledge base in occupational therapy, need for quality assurance methods, and the underutilization of mental health services by the elderly.

Preserving Autonomy

Difficulties in performing instrumental activities of daily living are often experienced by persons with dementia, depression, or other psychiatric problems. These limitations raise a question as to whether a supervised setting may be required for such persons to function adequately.
These persons may be capable of living independently but may have one or two limitations in instrumental activities of daily living. A thorough evaluation of their ability to perform such instrumental activities as managing money, keeping house, preparing food, and managing medications along with an evaluation of external available resources (Williams et al., 1991) allows the occupational therapist to assemble information about their abilities and areas of difficulty as well as available informal supports needed.

Often, if a problem and its cause can be identified, a solution may be reached through adaptation or assistance that can postpone or eliminate the need for institutionalization. Once the nature of the problem is determined, various measures can be implemented. Examples of adaptations for the improvement of instrumental activities of daily living abilities are enlarged telephone buttons, compartmentalized daily medication boxes, and checkbooks printed in large type. Other physical adaptations may facilitate the client’s mobility or compensate for physical or perceptual difficulties. When more than adaptation is necessary, the therapist can refer the client with limitations in instrumental activities of daily living to services designed to support independent living, such as chore services, meal delivery services, and visiting nurses. These services often deter a move from the home to a nursing home or group home. To ease the caregivers’ stress, the therapist may refer the family to respite programs or adult day-care centers, which also may facilitate the person’s remaining in the home longer.

If the client wishes to remain in the home and has the requisite skills or resources, the therapist may advocate the client’s position to the family, the clinical team, or the legal system by proposing alternatives. In areas where services, living options, and other types of resources are limited or unavailable, the therapist can advocate for these persons by increasing public and government awareness of their problems and needs. Advocacy is a natural role for occupational therapy; our therapeutic tradition has been one of subscribing to the value of independence and respecting the individual’s right to choose (see Harvey, 1984, for a description of this role).

Chemical and physical restraints are used more often with the elderly than with any other population (Robbins, Boyko, Lane, Cooper, & Jahngren, 1987). Restraints are used to control behaviors considered to be dangerous or disruptive (e.g., falls, agitation). Recent legislation limits this practice and challenges the interdisciplinary team to find alternatives to controlling these behaviors (Omnibus Budget Reconciliation Act of 1987 [Public Law 100–203]). The engagement of a person in a meaningful task usually reduces his or her agitation, anxiety, and wandering by channeling energy in a positive direction, thus reducing the need for restraints. Selection and modification of an activity that will be both accepted by an agitated person and successful, however, can be difficult. Activity selection requires consideration of the client’s motivation, task simplification, and potential for risk if agitation escalates (e.g., the use of sharp or heavy objects is not wise when working with agitated clients). Engagement in activity can provide not only therapeutic value but also information on the precipitants of agitation, aggressive behavior, or catastrophic reactions. The therapist can share this information with other health care professionals and with caregivers to develop strategies to prevent these behaviors from recurring.

When people are restrained to prevent falls secondary to unsteadiness, poor judgment, or both, they may become physically deconditioned and thus more unsteady. Often, there may be treatable but overlooked reasons for the unsteadiness (e.g., orthostatic hypotension, sedation from psychotropic medications). Because the occupational therapist focuses on maintaining or improving function, he or she may be able to recommend interventions other than restraints. The risk of falling must be weighed carefully against the psychological and physical risks involved in the use of restraints.

Enhancing Integrity

Purposeful activity is essential to one’s integrity and well-being throughout the life span (Erikson, Erikson, & Kivnick, 1986; Smith, Kielhofner, & Watts, 1986). Withdrawal or disengagement of one’s usual level of activity can be a major consequence of mental illness. Due to performance deficits associated with mental illness (e.g., changes in memory, perception, energy level, or coordination), persons may develop increased expectations of failure, avoid activities, and thus experience a decline in their skills. The occupational therapist can interrupt this cycle by ensuring success or partial success in activities. Clients can thus regain a sense of productivity or even mastery, which in turn increases the likelihood that they will participate in future activities.

The loss of life roles, common in the aged, contributes to the exacerbation of a psychiatric disorder. By interviewing the client or using a role-oriented assessment tool such as the one offered by Oakley (1982), the therapist can gain insight into the current status of valued roles and how role changes have affected the client. This information, together with an idea of the client’s current abilities and limitations, allows the therapist to help the client reorganize roles, even through alternative means, if necessary (Levy, 1990). For example, with the move to a sheltered living situation, one may expect to lose the roles of home maintainer, hobbyist (e.g., gardening), and religious participant. Although these roles have been strongly valued and central to a person’s identity, they may no longer be assumed because the client believes that he or she can no longer participate in the activity. The therapist can help the client identify the importance of these roles and ways to continue practicing them. In
the sheltered facility, the client may be able to do his or her own laundry, have a window-box garden, or be escorted to religious services. With help in identifying the importance of valued life roles and support in continuing them, the client is less likely to lose those roles.

Anhedonia, or lack of pleasure in previously enjoyable activities, is a major symptom of depression and other psychiatric disorders and can disrupt activity patterns that are conducive to good health. Activities with successful outcomes are likely to improve the client's appraisal of his or her own abilities, facilitate a belief in his or her skills, and foster a renewed sense of pleasure from doing. A determination of the presence of anhedonia is diagnostically valuable in the identification of depression and in the differentiation of depression from dementia. Persons with depression may have the component skills needed to complete a task but may show little enjoyment initially. Conversely, persons with dementia will generally enjoy a task until their skills fail them and they are unable to continue. They then may provide a spurious excuse (i.e., "my hands are sore" or "I have other things to do") to avoid a sense of failure.

Group activities are efficacious in working with this population, not only because of the inherent therapeutic benefits of group process, but also because the therapist's use of time is maximized. Due to the clients' decreased initiation of and involvement in activities, the enlistment of their participation in a group activity becomes problematic without skilled and patient intervention. Persons with psychiatric impairments living in nonspecialized (e.g., nursing homes, retirement centers) or minimally staffed settings may never engage in the activities. Group leaders, therefore, must understand the dynamics behind a person's reluctance or refusal to participate as well as provide the time and support necessary to help the person over the hurdle of first attempting to participate. This process can be time consuming, especially with clients with dementia. Zgola (1987) described the difficulty that patients with dementia have in initiating activities as well as ways in which to facilitate engagement. She interpreted a client's refusal as being a "response to the stress resulting from an inability to conceptualize what is expected, a difficulty in initiating, and the fear of failure" (p. 70). Clear directions, concrete cues, and specific first-step instructions are some of the techniques that Zgola employed to get beyond a client's reluctance to engage in the group.

In selecting activities for clients with performance anxiety or deficits, the therapist may find it helpful to build on the clients' existing skills and special interests as well as to use familiar tasks rather than tasks requiring new learning. Compensating for mistakes rather than drawing attention to them is usually more therapeutically valuable in working with persons with depression or dementia. For example, by pointing out to a woman with dementia that she is redrying dishes that she has already dried, the therapist is augmenting the client's inability to remember. Conversely, by putting the dried dishes away, redirecting the client to the wet dishes, and acknowledging the client's contributions, the therapist will be more helpful in improving the client's feelings of self-worth and integrity.

In group activities, a playful and safe arena together with positive regard for the aged client provides an encouraging foundation for exploratory behavior and helps to minimize interpersonal failures. The therapist facilitates a therapeutic psychosocial environment by modeling playful behaviors, providing an atmosphere of acceptance, and minimizing the consequences of failure. We have found the Directive Group Therapy Model (Kaplan, 1988) to be most useful in maximizing performance and facilitating group process in lower-skill-level groups.

Increasing Safety

Elderly patients with cognitive impairment who no longer retain skills adequate to cope with the perils of everyday life may engage in a variety of unsafe behaviors (Howell & Watts, 1990). Risky behaviors, such as reckless or inattentive driving, unsafe use of heating devices, and careless smoking, may jeopardize both the client and the community as a whole. Other examples of risky behaviors include the mismanagement of medications, neglect of nutritional and health concerns, and consumption of spoiled food. Memory loss, inability to recognize or appreciate the consequences of actions, and lack of insight concerning physical or mental impairments may contribute to such behaviors. Restrictive decisions (e.g., selling the car, hospitalization) are often made by the family, medical team, or legal system and compromise the client's personal liberty. The risk of an activity and its consequences must be carefully weighed against other factors, such as whether the benefits of protection are worth the loss of autonomy (Watts, Cassel, & Howell, 1989). The discovery or development of measures that will improve safety with the use of the least restrictive means will yield workable solutions in such situations. The insights that the therapist lends to this search can help ensure that the goals of safety and autonomy are optimally balanced.

Functional assessment is of critical importance and is a key contribution of the occupational therapist in the assessment of safety issues. By using assessment tools and observing task performance, the therapist obtains information about the client's ability to maintain safe behavior and the likelihood of a risky situation recurring. For example, watching the client perform the simple task of making a cup of instant coffee allows the therapist to observe the client's judgment, memory, ability to understand the implications of abstract concepts (i.e., heat), coordination, and praxis. Does the client remember to attend to the pot without cues? Does he or she handle...
and pour hot materials safely? Does he or she turn off the stove when finished? Through observation, the reasons for an unsafe behavior like hazardous cooking can often be identified. For example, unsafe use of the stove may be due to problems with memory, awareness, judgment, or vision. Once the reason is ascertained, the therapist can recommend specific environmental adaptations or treatment to decrease the recurrence of the unsafe situation.

In the home or institutional setting, the occupational therapist can suggest critical environmental adaptations that may decrease the older person’s risk of harm to self or others. For example, the therapist can mark stairs and remove or tape down throw rugs to compensate for the client’s perceptual difficulties and to prevent falls, thus preserving mobility and saving costly medical bills. Adaptations to a stove unit also may improve safety. Marked dials for improved visibility or automatic shut-off features to compensate for forgetfulness are examples of such adaptations. Visible cues such as labels or pictures on doors or drawers may assist persons with memory or orientation deficits. The removal of items that could be misused by a person with cognitive impairment (e.g., poisons, sharp objects, weapons, heating devices) may also decrease the risk of harm. (See Skolaski-Pellitteri, 1983, 1984, for more information on this topic.)

Medication management can be important for the maintenance of safety and well-being. Elderly persons are prone to misuse both prescription and over-the-counter medications (Carruthers, 1986). They commonly have multiple medical conditions, each of which requires medication, thereby adding to the complexity of medication management. Additionally, because elderly persons are often more sensitive to medications than are younger people, there is less margin for error in the avoidance of side effects. The occupational therapist can assess the skills needed for the independent administration of medication, including the client’s memory, orientation to time, fine motor dexterity, vision, and understanding of possible side effects. This assessment may indicate the need for a supervised trial of self-medication. Adaptations such as pillboxes holding premeasured amounts, easy-opening containers, large print, and color-coded labels may facilitate the client’s independence in this task. Simplification (e.g., having the physician adjust times or dosages) may also improve the potential for correct medication use.

Another related role of the occupational therapist is to monitor functional performance as psychotropic medications are titrated (Allen, 1985). With the narrowed margin of effectiveness of such medications in the elderly, close monitoring can prevent improper medication or overmedication. Medication may have adverse effects on mobility, attentiveness, continence, communication, and cognition. These effects may be associated with akathisia, confusion, incontinence, sedation, and even delirium. The occupational therapy session provides a more natural environment in which to observe a person for a longer period than that usually provided in a brief visit with the physician.

**Barriers to Optimal Service Provision**

One cannot discuss occupational therapy in geriatric mental health without also discussing barriers to optimal outcomes of intervention. In the health and social service systems as well as within the profession, there is often a lack of sufficient resources to best meet the client’s needs.

Although the range of care alternatives for the elderly client has grown considerably in recent years, for most clients, options for services are inadequate in several ways. There continue to be, especially in rural areas, limited sheltered housing options, too few respite or day-care programs, and unavailable or sparse independent living services. There are often waiting lists of 6 months to a year or even longer for services. Because psychiatric admissions are often related to clients’ level of stress and the burdens placed on support networks, services need to be available on discharge to decrease the risk of readmission.

The shortened hospital stay resulting from efforts to reduce costs make time a limited resource as well. Elderly persons usually require a longer assessment period due to a slower response time, possible communication difficulties, and the often complex nature of their combined medical and psychiatric problems. These factors emphasize the necessity of an immediate focus on discharge planning, better coordination of inpatient and outpatient services, and maximization of patient contact hours. Gibson (1990) suggested structuring more frequent presentations of core activities, making documentation more efficient by moving from a narrative style to checklist formats, and minimizing “unnecessary, redundant or poorly focused activities” (p. 268).

Much debate exists concerning the expense and allocation of the nation’s health care resources. Resources for the elderly for housing, health care, and home services are limited and in danger of becoming more so. Discharge plans are often hampered by the lack of options, and creative or compromised solutions are often required. These solutions may not be in the elderly person’s best interest or even the most cost-effective. For example, an elderly person with a schizophrenic disorder may be able to return to an independent living situation but may need regular and predictable opportunities for socialization and assistance. If these opportunities are unavailable or inconsistent (e.g., a facility may experience a high staff turnover due to underpaid workers), the person may require rehospitalization.

An additional barrier to optimal service provision lies in the population itself. Many elderly persons do not seek treatment for mental health problems (Kale, Ouslander, & Abrass, 1984), and if they do seek treatment, it is often from their primary physician and for medications only. Such clients usually do not seek mental health services.
until a crisis occurs. If we can eliminate the stigma associated with mental health problems, more elderly persons may be willing to seek help.

The second set of barriers lies within the profession. The personnel shortage makes recruitment in this practice area difficult. Of the personnel available, few therapists specialize in mental health or gerontology, and even fewer in both. In fact, the total number of therapists in mental health and geriatrics combined is less than the number in either pediatrics or physical disabilities (Ezersky, Havazelet, Scott, & Zettler, 1989).

One reason that the geropsychiatric arena draws few therapists may be related to the idea of making a difference. Hasselkus and Dickie (1990) identified this theme as being of primary importance for therapists in achieving job satisfaction. Elderly patients are often seen as hopeless or not worth the effort. Those therapists who work with the elderly have come to realize that even limited interventions, although producing small functional gains, nonetheless can have a great impact on the person’s well-being. An additional 20° of motion in the shoulder may allow an elderly person to dress independently. Similarly, a boost in self-confidence may enable the client to visit the senior center or prepare a meal. A boost in self-confidence may enable the client to visit the senior center or prepare a meal.

Lack of visibility and understanding of occupational therapy services is too common among physicians and other support staff. Many geriatric evaluation teams have no occupational therapist on staff. Increased visibility of occupational therapy services within the referral setting and the education of team members concerning occupational therapy's role may help to remedy the situation.

The literature on occupational therapy in geriatric psychiatry is also limited. Comparatively few research projects within the profession have dealt with this domain. Because the population is aging and the number of persons with dementia and other psychiatric disorders is increasing, a better definition, understanding, and identification of occupational therapy contributions in this area is warranted.

Quality assurance, which is necessary for the maintenance of standards of care and reimbursement, is another challenging area in geriatric psychiatry. Conditions that are progressively degenerative (e.g., dementia) make it difficult for the therapist to set goals that reflect improvement. Even maintenance goals are ultimately impossible given the certainty of decline. With treatment, decline in abilities may be slowed, but there is currently no way to predict or measure this. Many useful and relevant treatment goals involving quality of life are difficult to measure (e.g., greater self-esteem, enhanced safety).

Conclusion

Geropsychiatry holds many challenges for the occupational therapist. Although it affords the therapist an opportunity to make an important contribution to the overall quality of elderly persons' lives, it presents obstacles. With the occupational therapist's training in creating innovative adaptive solutions, the possibility of meeting these challenges is enhanced. By expanding the knowledge base through research and disseminating that knowledge through the literature and educational curricula, we can help to improve the standard of practice. These efforts will also increase the visibility of the geropsychiatric specialty area within the profession. Higher visibility is of primary importance in continued efforts by the profession to recruit therapists in geriatric mental health.

The need for standardized, validated assessments for elderly persons with psychiatric problems will continue. Measures of abstract concepts (e.g., quality of life) are needed for quality assurance. Advocacy and education of the public and government to increase awareness of the growing needs of elderly persons with mental illness and their families will continue to be important issues for both the practicing therapist and the profession as a whole.

References


---

**Professional Publications from AOTA**

*Now available in Spanish!*

**Daily Activities After Your Hip Surgery**

*Janet Platt, OTR/L*

This AOTA best seller is now updated and revised, featuring both the anterior and posterior approach to treatment. If you treat patients who are recovering from hip surgery, this is an excellent teaching aid your patients can use to recall the techniques you taught them in the hospital after they’ve returned home. The clear illustrations demonstrate the proper techniques for dressing, bed positioning, bath, shower, and car transfers, housekeeping, and much more. The book’s format is designed to allow ample room to add individualized notes and instructions according to your patient’s needs. 20 pages, 1990. Spanish edition, 1991.

*Single copies:* $4.00 AOTA member $5.20 nonmember  
*Units of 10:* $30.00 AOTA member $40.00 nonmember

**An Annotated Index of Occupational Therapy Evaluation Tools**

*Ina Eifler Asher, MS, OTR*

Covers all OT practice areas by specialty. Includes critical aspects of standardized and non-standardized tests, their purposes and uses, and their advantages and limitations.

Evaluations covered include: Activities of Daily Living; Adaptive Skills; Cognitive Skills; Developmental Skills; Oral Function; Person-environment Interactions; Play Skills; Psychosocial: Roles and Habits; Sensory Integration; Visual-perceptual Skills; and Vocational Skills. 205 pages, 1989.

$18.00 AOTA member $24.00 nonmember

To order by phone with your MasterCard or VISA, call 1-800-SAY-AOTA (AOTA members) or (301) 948-9626 (nonmembers).