SYMPTOM MANAGEMENT EDUCATION FOR THE
CHRONIC AND PERSISTENTLY MENTALLY ILL

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Abstract

Six chronic and persistently mentally ill clients of Stevens County Counseling Services (SCCS) were placed into a symptom management education group. The clients were diagnosed with schizophrenia or bipolar disorder. All had been hospitalized at one time, were taking psychotropic medications and had been clients at SCCS for at least five years. The clients met once a week for approximately one hour for a total of three months. The class was taught by a psychiatric nurse practitioner student. The University of California at Los Angeles, Social and Independent Living Skills modular program was used. A review of research literature provides the background for discussion of the benefits of symptom management. The long term goal of decreased in-patient hospitalization will be evaluated on a yearly basis by the administration of SCCS.
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Purpose

The purpose of this paper is to present the advantages of implementing a symptom management education program in the community mental health, out-patient setting. Stevens County Counseling Service (SCCS) has not provided an education program for its chronic and persistently mentally ill clients in the past. The following review of literature demonstrates that clients who receive education about their illness and improve their coping strategies, have reduced hospitalization rates, decreased cost of care and improved quality of life.

The Problem

Chronic and persistently mentally ill people often have difficulty with independent living. They lack social skills, have difficulty finding employment and are often isolated due to their illness (Liberman et al., 1993). These deficits generate a negative atmosphere for stable mental health. Often medications are missed, self-care is neglected and their mental state deteriorates. If the decline continues, a hospital stay becomes necessary for stabilization (Hunter & Storat, 1994).

Significance of the Problem.

In-patient psychiatric hospitalization programs usually provide symptom management education for the chronically mentally ill. Unfortunately, the hospital environment and shortened stays do not provide enough education for independent living. Clients are discharged without sufficient training to prevent future relapse. Psychiatric hospitalization is expensive and detrimental to the already fragile self-worth of the client. Repeated hospitalization creates instability by loss of social contacts, homelessness and hopelessness (Eckman et al., 1992).
Review of Literature

Background and Significance

In the 1950's the newly discovered psychotropic medications produced a mental health revolution. Patients could experience relief from psychotic symptoms. They continued however to be housed in institutions where treatment was inadequate. Reform for the mentally ill came when Congress passed the Community Health Center Act in 1963 (Keltner & Folks, 1997). This act profoundly changed the way the mentally ill were treated. Community mental health centers were created and the institutionalized population dropped by 75 percent. (Wilson & Kneisl, 1992). The mentally ill were released to the communities to live free and independent lives.

Communities were ill prepared to meet the needs of these people and many chronically mentally ill became homeless, unable to adapt to life outside of an institution. (Perese, 1997). The psychotropic medications that brought relief of symptoms also brought a backlash of noncompliance, partly due to their expense on limited incomes but mostly due to their undesired side effects. No longer were caregivers administering the medications and the mentally ill had a choice not to take them. (Keltner & Folks, 1997).

Psychosocial rehabilitation has emerged as a necessary adjunct treatment for the chronically mentally ill along with psychotropic medications. Bachrach (1992), defines psychosocial rehabilitation as, “...a therapeutic approach to the care of mentally ill individuals that encourages each patient to develop his or her fullest capacities through learning procedures and environmental supports” (p.1456).

Relapse

Psychoeducation for the chronic mentally ill has been beneficial in decreasing relapse rates (Delaney, 1998). The goal of psychoeducation is to help clients learn more about their mental illness and how to management it. Programs include medication
education, symptom management and coping skills. Studies have shown that clients receiving psychoeducation are more compliant with their medication and therefore experience less relapse (Hogarty, 1993).

The importance of environmental factors and meeting the needs of patients is important in prevention of relapse. Case managers and those who are involved in the care of these individuals focus on restoring hope, patient’s strengths and improvements in their quality of life (Bachrach, 1992).

Payson, Wheeler, and Wellington (1998), determined that out-patients in a community mental health clinic, needed education programs that included medication information, problem solving skills, life enjoyment activities and ways to deal with loneliness and depression. These needs are important factors in prevention of relapse.

Socialization

The chronically mentally ill have poor social networks. They have often experienced negative interactions with family and peer relationships therefore have little motivation to expand their social world. Social skills are poorly developed in this population and long term relationships rare. (Biegel, Tracy, & Song, 1995).

One of the benefits of clients attending the symptom management group is meeting other clients and increasing their social network. Communication skills are taught and practiced in role play sessions. Information is exchanged between clients outside of the learning sessions which improves their communication and social skills. (Liberman, 1988). The clients are encouraged during sessions to develop relationships beyond their health care providers. Allowing trusted people to understand the client’s warning symptoms prior to a relapse could prevent re-hospitalizations. (Liberman et al., 1993).

In a study done by Yurkovich and Smyer (1998), the chronic mentally ill reported
that they felt they had lost control of their lives. One way patients avoided loss of control was by maintaining relationships. However, a great deal of effort and patience for both the mentally ill and their friends and families is involved.

**Medication Compliance**

Studies have shown that medication noncompliance increases the risk of relapse (Delaney, 1998). The denial of mental illness, medication side effects and the use of alcohol and drugs are frequently factors in medication noncompliance. Further, in a study by Delaney, patients taking psychotropic medications were placed in different treatment modalities. By creating a supportive environment with vocational and educational rehabilitation, patients reduced their rate of recidivism over those just maintained on psychotropic medication. Patients on oral psychotropic medications were more compliant than those on injectable psychotropics, when they attended the clubhouse rehabilitation program (Delaney, 1998).

Hogarty (1993) notes in his study of patients on oral psychotropics and those on depot psychotropics showed little difference after two years in relapse rates. Psychosocial rehabilitation along with depot psychotropic medication however, had relapse rates of 20 percent in the first year compared with 38 percent of the medication only group.

**Cost Effectiveness**

Psychoeducation reduces relapse, thereby reducing cost of care. Novacek and Raskin (1998) revealed that poor recognition of warning signs increased the likelihood of relapse and the use of expensive mental health services. Patients were unable to foresee warning signs, used emergency services, 22 percent versus 12 percent and inpatient hospital services 16 percent versus 6 percent. Patients that were able to recognize warning symptoms had treatment costs 42 percent less than those with poor recognition. Barton (1999) concluded that 50 percent of cost of care is reduced by psychosocial rehabilitation.
Coping Skills

The chronically mentally ill have difficulty dealing with stress. Psychoeducation programs teach clients how to manage stress. Clients are assisted in understanding what is particularly stressful to them. Second, they are taught to develop alternative coping methods. Third, they are assisted in developing an emergency plan, then following it. (Hogarty, 1993).

Definition of Terms

Bipolar Disorder

Bipolar disorder is characterized by episodes of mania and depression. A manic episode can develop over days and the individual may become psychotic. The depression can be profound and debilitating. The mood variations may be separated by time or happen within days or weeks. (Tomb, 1999).

Schizophrenia

Schizophrenia is a mental illness which includes thought disorder, delusions or false belief systems, hallucinations, disturbances in emotions and behavior. For a patient to be diagnosed with this disorder, he/she must have had occupational, interpersonal and self-supportive deterioration for at least six months and have had episodes of active psychosis. (Tomb, 1999).

Psychotropic Medication

Medication used for the treatment of mental disorders affect the mind or modify mental activity (Anderson, 1994). They reduce psychotic behavior and help control anxiety (Fortinash & Holoday-Worret, 2000).

Warning Signs

Warning signs are symptoms that warn of an impending relapse. They are can be
felt a few days to several weeks before a relapse. Possible warning signs are; disrupted
sleep, change in appetite, mood changes, suspicious or overly religious thoughts, isolative
or intrusive behavior (Liberman, 1988).

Relapse

A relapse is defined as an episode when a client’s adverse mental symptoms
become overwhelming. The individual must go to the hospital to stabilize their mental
illness (Liberman, 1988).

Persistent Symptoms

Persistent symptoms are symptoms a chronic and persistently mentally ill person
experiences on a daily basis.. They can be symptoms such as mild paranoia, auditory
hallucinations or depression (Liberman, 1988).

Psychosocial Education

This is an educational program for the chronically mentally ill that is systematic
and curriculum based. It’s goal is to empower the client toward self-sufficiency and
recovery (Barton, 1999).

The Program

SCCS clients are well monitored by case managers, a psychiatrist, a psychiatric
nurse practitioner and community partners. The team works together in maintaining client
mental health and prevention of relapse. To continue its success, the administration
determined that a program for its chronic and persistently mentally ill clients should be
developed.

The administration chose the UCLA Social and Independent Living Skills Program
because of this program's history and record of success. The modules are simple to follow,
workbooks for clients are provided and accompanying video tapes demonstrate each
concept (Liberman, 1988).
Materials

SCCS ordered and paid for the program modules developed by UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation. SCCS made available a television monitor, video tape player, chalk board and writing tools for the group to use.

Promotion

SCCS case managers in Colville and Chewelah were personally contacted by the nurse practitioner student. The program’s purpose, content and effectiveness were explained. They were assured that the program would enhance the therapy client’s were already receiving. Appropriate clients were considered, based on need for this type of education, attention span, stability of their illness and physical abilities.

Case managers agreed to discuss the program with their clients and forward names of potential candidates. In addition, flyers were posted in both lobbies of SCCS in Chewelah and Colville, inviting clients to participate in the program.

The Work Plan

SCCS case managers in Colville and Chewelah were asked to refer appropriate clients. Appropriate clients were defined as chronic and persistently mentally ill persons that require medications, assistance in daily living and have had previous hospitalizations for their illness. In 1998, 27 clients in Stevens County were diagnosed with psychosis and 39 with bipolar disorder. (SCCS, 1998).

Approximately ten clients could be accommodated in a group. They will meet on a weekly basis for three months for approximately one hour. Transportation will be provided by Community Partners, staff that assists clients with their living situations.

Follow-up Care

Follow-up care will be provided by the case managers assigned to each client and feedback or concerns can be handled by the Community Partners. The program materials
can be reinforced on an individual basis or classes repeated if several clients are having
difficulty. In addition SCCS will begin a building program for a transitional living facility
to house those recently discharged from psychiatric hospitalization. This program will be
incorporated to facilitate client’s return to the community.

**Personnel**

Group leaders need to have knowledge and experience with the chronically
mentally ill. Social workers, psychologists, therapists, case managers and nurses are all
appropriate for this teaching module. In this particular three month program a psychiatric
nurse practitioner student will lead the group and be assisted by a SCCS case manager.

**Facilities**

SCCS in Colville, Washington was the site for the program. The East Conference
Room was reserved for the group on Thursdays at 1:30 p.m. until 3:00 p.m. from February

**Budget**

The symptom management module program has been purchased by Stevens
County Counseling Services for approximately $400.00. They will provide the blackboard,
TV, VCR and transportation of clients. Refreshments are provided by the group leader at
approximately $7.00 per week.

**Group Beginnings**

**Recruitment**

Approximately twenty clients were approached to join the program. They were not
initially enthusiastic. It was difficult convincing those with social phobias and paranoid
traits that a group situation would be beneficial. Case managers were invited to join their
clients for several sessions, if that would assist participation.
Transportation

SCCS employs Community Partners that provide clients with transportation to appointments and activities. The Community Partners were called upon to provide transportation for any client with those needs.

Participants

Initially six clients came to the first group session. By the third week, two had dropped out and two additional clients agreed to participate. These six have actively been involved in the group process.

The Program Content

There are four modules in the Independent Living Skills program. Participants are provided with workbooks and the group facilitator has a training manual. Each module contains definitions, goals, examples, role play interactions and visual examples shown on video tape. The program was developed by the UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation. This program has been used in numerous studies as recorded in psychiatric research journals (Liberman et al., 1993).

The first session is focused on improving communication skills. This involves eye contact, volume of speech, body language and facial expression. Clients are encouraged to give feedback to the role-playing exercises and the group facilitator encourages improvements.

One week later, the first skill module is introduced. It involves understanding warning signs. Questions about how the client last relapsed, symptoms that occurred before relapse, how they dealt with their symptoms were asked (Liberman, 1988).

The second module deals with coping with persistent symptoms. Clients focus on their own individual symptoms and discuss coping options to keep these to a minimum (Liberman, 1988).
The third module considers everyday emotional mood variations. Clients are helped to become aware that everyone has ups and downs as a normal part of living. This is a difficult concept for some to learn due to the fact that clients also are dealing with persistent symptoms and medication side effects (Liberman, 1988).

The last module deals with avoiding drugs and alcohol. Role playing reinforces the concept of refusing drugs from people that are pressuring them to use. Alternatives and plans are discussed for making wise choices when clients feel the need to use substances during a personal crisis (Liberman, 1988).

Implementation

Each Thursday at 1:30 p.m., members arrived in the conference room where materials and refreshments were provided. Members spent approximately ten minutes engaged in social conversation before the lesson began. Depending on the lesson, either role playing, video demonstration or chalk board was used to reinforce the key concept.

The graduate psychiatric nurse practitioner student teaching the class, reviewed the previous week’s lesson and introduced the new lesson. One of the SCCS case managers co-facilitated the class and will be teaching the program during the next session.

Program Modifications

The lesson material was used as written, with the exception of the “In Vivo” Exercises. “In Vivo” lessons involve a staff member and the client in the community, to demonstrate what has been learned in the classroom. These lessons involve activities such as going to the dentist, asking questions of a doctor or interacting socially with others. The client has the advantage of the staff member for support. SCCS already provides such assistance with its case managers and community partners, therefore this section was not used. In addition, the role playing was not video taped as indicated in the program. Clients view their own responses and see the changes in their behavior over
time. Case managers were consulted and the nurse practitioner student made the decision not to use the camera due to confidentiality and the client’s discomfort with it.

**Client Response**

Most client’s were enthusiastic about the material. Discussions were often animated as client’s related their experiences of relapse, hospitalization and difficulties with medications. The nurse practitioner student’s primary function was to redirect the conversation to the lesson material, as client’s grew more comfortable sharing information. Redirection was often challenging, when a client would express delusional thoughts and other members would join in.

The members of the group were given a pre-test to determine their level of knowledge about their illness. Most had deficits in understanding the difference between medication side effects, ongoing or persistent symptoms and severe symptoms.

The role-playing aspect of the program was difficult for the group. The leaders demonstrated a scenario such as a client describing his uncomfortable symptoms to a therapist. The group members took turns with the nurse practitioner student, who played the part of the patient. Each group member took turns playing the part of the therapist. This role reversal of acting as the therapist was awkward for them. They needed coaxing by the co-leader as to their responses and a great deal of encouragement. Interestingly, when the nurse practitioner student, in the patient role, complained of having uncomfortable symptoms, the group member, in the therapist role, would often tell the patient to go to the hospital. Which is of course, the whole point of this education program, to keep them out of the hospital.

One of the lesson plans involved writing down relapse symptoms and alternative coping skills rather than heading for the hospital emergency room. The group was to share this information with trusted friends or family members. It became obvious that the
only trusted people in their lives were staff members of SCCS. This lack of support network was seen as a critical need for these clients and the leaders began encouraging the building of friendships within the group.

Results

Informal Response

Group participants expressed positive remarks about the program. They shared with their case managers that the material was useful and they looked forward to attending. They also acknowledged the positive social interactions that have taken place during the group.

Follow-up

SCCS administration will follow up with these clients during the year and evaluate results, including hospitalization rates, crisis interventions and behavior changes. Long term follow-up will continue with case managers. All written work by group members will be retained in client’s charts.

Of critical importance was the “Emergency Plan”, filled out by the group members. This is an up-to-date reference that each client will have at home and one in their chart, to assist in providing efficient care during a crisis.

Discussion

The program itself was constructed specifically for the chronic and persistently mentally ill and was easy to implement. The difficulty in running the group was keeping the clients on task. Clients that are actively psychotic, or who have learning disabilities are easily distracted. It was therefore, advantageous to have two leaders because of this phenomena. The case manager assisting the nurse practitioner student was knowledgeable in regard to the group’s histories and behaviors. It was extremely beneficial when dealing with difficult situations and misunderstandings.
The Social and Independent Living Skills Program works well in conjunction with present services provided by SCCS for the chronically mentally ill in Stevens County. The entire staff was supportive of the program, its leaders and the clients. A longitudinal study of client outcomes using the program as written should be studied. This program deserves systematic study to determine its value to this community.
Symptom Management

References


