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Sharon A. Sabatino
Rowan University

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RELATIONSHIP OF FAMILY INVOLVEMENT AND FUNCTIONING AMONG MENTALLY ILL ADULTS

by
Sharon A. Sabatino

A Thesis

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of
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Approved by________________________

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Sharon A. Sabatino

RELATIONSHIP OF FAMILY INVOLVEMENT AND FUNCTIONING AMONG MENTALLY ILL ADULTS

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Dr. Klanderman

Master of Arts in School Psychology

The purposes of the present study were to find a relationship between family/caregiver involvement in treatment of mentally ill adults that they care for and clients overall Axis IV and V assessments. Support and education groups were held at Family Service in New Jersey over a six-month period. The population (n=12) came from the Hattie Tallie program at Family Service. These clients and their family members/social supports and caregivers attended meetings for six months to gain education and to support each other in dealing with clients' treatment. Global Assessment of Functioning scores (Axis V) and Severity of stressors (Axis IV) were taken before these groups began and again at the completion of the six months. Correlation analysis revealed an overall maintenance of these scores throughout the six months. Research on family involvement and education for caregivers was discussed.

Acknowledgments

I would like to say Thank You to
my family and friends for all
of their support and encouragement.

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Chapter 1: The Problem

Need

Although there are many programs for mentally ill individuals that need support and education on their illness, their family and friends are rarely involved except to remind them to "take their medications." The researcher feels that there is a need for more involvement of family, friends, and main supports in the lives of people with mental illness. Also, the person with the psychiatric disability is not the only one affected in all this. In fact, it also takes a toll on the family and friends who are not being educated about these illnesses. There is a certain stigma that seems to come along with having a mental disease and by raising awareness and educating certain supports in the lives of these individuals that stigma could lessen. Involvement of caregivers will only increase awareness of mental illness and strengthen the relationship they have with their loved ones. Support groups are needed for caregivers and main supports to share their concerns, their successes, and their frustrations in supporting a family member with a serious mental illness. These groups should help the caregivers to gain insight into their loved ones' mental illness and as a result lessen stressors among these individuals.

Purpose

Many clients at Family Service may require a lifetime of treatment and support. Families, friends, and others involved in the clients' support network may need to learn to cope with a lifetime a challenges, frustrations, and cycles. There is a certain stigma that continues to negatively impact people with mental illness, their families, friends and extended support network as well (World Fellowship of Schizophrenia and Allied Disorders, 2002). This social stigma of mental illness makes it more difficult for those affected to cope with and accept the illness, intrudes on treatment and recovery, and intensifies the problems of family members who participate in care (The Mental Illness Education Project, Inc., 2002). With better understanding of the illness, family and friends can become knowledgeable and confident members of the treatment team. The purpose of this study is to increase the involvement of primary support systems in the treatment of their loved ones with the goal of finding a relationship with an increase in the clients' Global Assessment of Functioning (GAF) score and a decrease in the number of Axis IV stressors by number of severity.

Hypothesis

Relatives of people who are living with a mental disease sometimes do not understand all that goes on in the mind of a person with a disease such as schizophrenia or bipolar disorder. Education and support for the family and friends not only will increase the awareness of what particular mental illnesses are but will help them to understand what their loved ones go through. When there is an understanding among others, isn't stress reduced? Of the 226 adults receiving partial care services through

Family Service, 48% reside with their family. By providing additional education and support to these families and others are supporting the clients in the community, it will improve outcome to both the clients and the family members (WFSAD, 2002). The support group will create on-going opportunities to gain new knowledge, skills and insights as well as receive support. The group will also provide opportunities for socialization and a decline of the isolation that frequently develops under these circumstances. There will be a relationship between increased involvement of support systems within the treatment process, and the identified clients showing an increase in their GAF score and a decrease in the number of severity of their Axis V stressors.

The Independent Variable in this study is the involvement of the support systems such as family and friends. The Dependent Variables in the present study are the: GAF Score and Axis IV stressors.

Background

Family Service, which was incorporated in 1962, is a private, non-profit Behavioral Healthcare Organization accredited by the Joint Commission of Healthcare Organizations. They offer community-based preventative, therapeutic, and individualized supports and services to families, children, groups and individuals in New Jersey (Family Service, 2002). The mission of Family Service is to:

- Promote successful community living, emotional well-being and independent functioning,
- Provide individualized supports for greater direction,

- Meet changing consumer needs by fostering partnerships with our communities (Family Service, 2002).

Family Service offers a variety of program and services that meet the mental health needs of families and individuals. They support individuals with serious and persistent mental health problems, helping them to live more productive lives in their own communities through many services including: Adult Partial Care Programs, Integrated Case Management, Supportive Housing, Residential Services, and Consumer Run Self-Help Center.

The population chosen for the current study comes from the Hattie Tallie Program at Family Service, which is one of the many Adult Partial Care Programs at Family Service. The Hattie Tallie Program provides partial care services to Burlington County residents, ages 22 or older, who suffer from mental illness and who may be at risk of psychiatric hospitalization. The goals for the consumers of the Hattie Tallie Program include:

- Enabling consumers to make informed decisions about their treatment through education, information, and advocacy.
- Minimizing psychological discomfort and assisting consumers in maintaining their personal and social functioning in the community.
- Preventing or reducing psychiatric hospitalizations or inappropriate institutional care
- Promoting self-sufficiency in personal care and economic support
- Preventing or remedying neglect, abuse, or exploitation of adults unable to protect their own interests.
- Preserving, rehabilitating or reuniting families.

The Hattie Tallie Program offers a full range of services to meet the individual needs of the consumers including:

- A structured day-treatment program
- A safe, nonjudgmental environment
- Group, individual and family counseling

- Medication education and management
- Mental illness awareness and education
- Education to promote independent living skills
- Vocational skill development
- Recreation therapy
- Case management and advocacy
- Transportation

This program offers partial care services six days a week, five hours per day. On call emergency response is provided seven days a week, 24 hours a day.

Theory

Cognitive Behavioral Therapy is used during group sessions at this program. The fundamental ideas behind this theory are: an Activating event invokes a Belief thus causing an emotional and behavioral Consequence but by disputing A, B, and C above and learning to detect, debate, and discriminate, one can arrive at an effective philosophy of life which leads to a new set of feelings (Quijas, C.R., 2002). The cognitive-behavioral approach is of great value in helping families to tackle the main problems they face in caring for a person with mental illness. It is sensible to guide the family towards applying the techniques to a simple problem first so that they are likely to achieve success (WFSAD, 2002). This theory focuses on changing cognitions to produce the desired changes in behavior (Quijas, C. R., 2002).

Definitions

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem could be a negative life event, an environmental difficulty or deficiency, family stress, inadequate social support system, or other problem relation to the context in which a person's difficulties have developed (APA, 1994). Axis V is the Global Assessment of Functioning (GAF). Axis V is for reporting the clinician's judgment of the individuals overall level of functioning. This information is useful in planning treatment and measuring its impact and in predicting outcome. The reporting of overall functioning on Axis V is done using the GAF Scale. It is rated from 1-100 (American Psychiatric Association, 1994). The identified consumers were chosen because they have a GAF score of 50 or below and have Axis IV stressors. The support systems that will attend these support groups include family, friends, and caregivers of the identified consumers.

Assumptions

The Cognitive Behavior Model is one that works through a relationship between therapist, client, and group members. In this study, the researcher assumes that all involved in these groups are focused on gaining knowledge and open to understanding what a mental illness is. They also need to be open and honest and able to communicate their fears and their everyday challenges in order to gain support. It is assumed that these caregivers and the individual consumers are attending these support groups to get their inner needs met.

Limitations

Through attendance at the on-going support groups, families will meet and share experiences with others in their community who face the same daily challenges. One limitation to this study is that there is no way to guarantee all family and friends will show up for the support group meetings consistently or will share their feelings, experiences and emotions. The study can only be as strong as the participation level of the support groups are.

Overview

This study hopes to give the optimum amount of education to these family and friends and at the same time support them in their care giving efforts. With this additional education, caregivers will in effect lessen the stressors that the mentally ill individuals currently possess. Coming up in Chapter 2, there will be much research discussed over numerous types of support groups for family education and support. The researcher will also take an in-depth look at Axis V and how it is assessed. Some questions that have been debated over the years about Axis V are reliability of the GAF score and who is qualified to give this score to a consumer. Multiple resources give the pros and cons about family involvement with people who have a mental disease. In upcoming Chapters, the researcher will show how participation in these groups and in this study will reduce stressors among consumers and show that increased support will also raise their individual GAF Scores.

Chapter 2: Review of Literature

Introduction

Education and support are two important things that caregivers need in order to understand their loved ones illness and be able to give their family members what they need to lessen the stress that is present in their lives. In the growing mental health field, there are many programs throughout the United States that do provide education and support to people who are diagnosed with a mental illness. Many times the diagnosed individual has others who are involved in their treatment but rarely are these people educated or have support on a regular basis.

Support and Education

There has been much literature that has brought up many views on self-help and support/education groups for family members of mentally ill adults. During the past two decades, the deinstitutionalization movement has gained momentum and has resulted in increasing numbers of people with chronic psychiatric illnesses living in the community (National Health Strategy, 1993). According to Lehman & Steinwachs (1998) caregivers should not be under estimated since there has been much emphasis placed on community care since de-institutionalization. There has been an increased assumption that families will take on much of the responsibility for care of the person diagnosed with a mental illness (Brady, 1996). It has been estimated that approximately 40% of those discharged from psychiatric hospitals return to live with their family members, and another 30% to 40% are in regular (at least weekly) contact with family members (Manderscheid & Barrett, 1987). Much of the literature today emphasizes the role that caregivers play in the broad mental health spectrum (Young, 2001). This additional assistance given by family members means that it often involves the family unit in a long-term stress that threatens the physical, social and mental well-being of the family members and the individual with the disease (Dunne & Fitzpatrick, 1999). There are many needs that become unmet for both client and caregiver. Not only are there financial hardships but there are also disruptions to the household and social functioning (Young, 2001). Most of the existing educational programs pertain to adults with serious mental illness but there are not many offered for family members as well (Bisbee, 2000). Support and educational groups would help to decrease some of the burdens of caring for someone with a psychiatric disability. Through this, caregivers would not only increase their knowledge of services available but also would be given practical advice and suggestions for coping with difficult behaviors. New ways to think, to feel and to deal with life experiences emerge (Ellen, 2001). With support and education, family members learn to shift their perception of blaming themselves to view their relative's problems being due to a biological disorder also. (Brady, 1996). This in turn helps individual because lessen stress because awareness has been heightened (Young, 2001).

Many researchers have called attention to the impact on the family of caring for a seriously mentally ill member, and the potential of the family system for buffering some of the more harmful effects of mental illness (Lefley, 1996). Education and support groups have been known to ease some of the stress of caring for an individual with a psychiatric disability (Young, 2001). However, there is little empirical evidence that identifies particular family strengths, which can aid in coping with a chronic disability like mental illness (Coyne & Downey 1991).

Needs of Families

While recovery is a goal for people diagnosed with a mental illness, family members and supporters go through a different process (Baxter & Diehl, 1998). Hatfield (1987) suggests that family members go through certain phases of stress, coping and adaptation. Families have found that in order to cope with their relatives with serious mental illness, they need practical advice, information and education in such areas as symptoms of the disorder, behavioral management techniques and proper use and knowledge of psychiatric medications (Biegal & Yamanti, 1986). There has been limited research on the views of families so they can assist their ill relative rather than withdraw from their relative due to feelings of incompetence. The limited research that has been conducted on the views of families regarding mental health treatment has revealed considerable dissatisfaction with services provided (Holden & Lewine, 1982). In a study done by Solomon and Marcenko (1992), 97 patients of a long-term state psychiatric hospital that were being discharged were interviewed along with their family members and care givers. Each family was interviewed face to face, usually in the family's home. Some of the areas that were addressed in the interview were family background of psychiatric illness and problems with other disabilities; their views of hospital treatment of their relative; their relative's concerns regarding community placement; and history of mental health services. The second interview focused on satisfaction with treatment, their relative's readiness for community living and concerns regarding community living and adjustment (Solomon & Marcenko, 1992).

The results from the interviews showed that just over half (55%) of the families indicated that their relatives attended a mental health program. 20% did not know whether their relatives attended a mental health agency. Many of the families were unable to identify the specific program the clients attended, although several indicated that their relatives attended a vocation program (Solomon & Marcenko, 1992). Families caring for someone with major mental illness need to be included in their treatment and care (WFSAD, 2002). Generally, families were fairly satisfied with the agencies' ability to meet the needs of their relative and more satisfied than with services given by the hospital. Families were least satisfied with supportive counseling given to their relative. Over half (58%) felt that the agencies did not meet their needs at all in teaching them about medication, their uses, and side effects. Over half reported that the agency did not keep them informed about their relative's progress, asking their opinions about how their relative was doing, and/or did not provide them emotional support (Solomon & Marcenko, 1992).

The interviews with family members indicated that although family members were more satisfied with outpatient than inpatient care, that in either place, Education was rarely provided to the family members. Families indicated high levels of dissatisfaction with the hospital in terms of teaching them about medications, teaching them to help motivate their relative, provide practical advice on how to cope with their situation, providing assistance in crisis, and giving them emotional support.

The National Alliance for the Mentally Ill (NAMI) has done much research on family involvement and the mentally ill and has recently started the Family-to-Family Education Program (2002). In a survey on reports of treatment and Services Received, parents were asked about the services their child or children were currently receiving or received in the past. Some of the results were as follows: 46% of families who received early intervention services in the past felt it was of considerable value, however, 75% of families reported they never received early intervention services. Family support and home interventions were highly valued by families. Examples of early intervention services are wrap-around-services and in-home therapy. These services, when given, are seen as highly valued but unfortunately there seems to be a gap between the services provided and the needs valued by families (NAMI, 2002).

A study done in 1998 by Jeon and Madjar focused on answering the question, "What is it like being a caregiver for a relative with chronic mental illness?" Their research involved the phases of selecting a phenomenon of current interest to the researcher and nurses working in community mental health, investigating the experience of family caregivers as lived by them rather than as observed by others, reflecting on the main themes that characterize the experience and structure of family caregiving and describing the phenomenon through the use of researchers' and participants voices. Caregivers often have no choice but to take care of their loved one and are usually provided little education and support from the health care providers (Johnson, 1998). With education, caregivers will learn that their feelings are "normative reactions" given the trauma they are exposed to (Canadian Mental Health Association, 2002). In this study, fourteen family caregivers, contacted through community health centers and community support groups took part in the study. Their involvement in caring for a relative with chronic mental illness ranged from 6 months to 36 years (Jeon & Madjar, 1998). Study participants were interviewed individually on two separate occasions. The findings of the study focused on two themes: temporality, or the experience of lived time and relationality, the experience of being with others (Jeon & Madjar, 1998). According to the interviews, the strongest theme that drew on the experience of time, was taking each day as it comes. This related to the participants' experience of time as different from how others not engaged in the care of a relative with chronic mental illness experience time. They saw their time as less predictable and less certain. Unable to make long-term plans, they instead lived from day to day; the passing of time for them was interrupted by event sand situations related to the care of the ill relative (Jeon & Madjar, 1998). During interviews families reported they were often left alone trying to figure out what was happening to the ill relative, looking for causes to relate to the problems, and attempting to solve the problems on their own. Without clear understanding of what was happening or what, if anything, they could do, families were left in the dark. Taking each day as it comes involved more than passive acceptance of a person's situation. It required family members to learn how to deal with their loved one's behaviors and needs. Much of that learning becomes trial and error. It was reported in interviews that the amount and quality of information received from health professionals was often insufficient, whereas community support groups such as the Association of Relative and Friends of the Mentally Ill (ARAFMI) were more helpful, at least by those who attended the meetings and were able to seek help. Learning without support and education was often reported as a slow and frustrating process (Jeon & Madjar, 1998).

The second theme that was present during the interviews was relationality and family caring. It was reported that caregivers often experienced being torn between their ill relative and the rest of the family members who also needed attention and care. Most participants reported increasing pressure within their home and had an increasing sense that "their home was no longer regarded as a place of comfort (Jeon & Madjar, 1998)." Support groups helped a great deal for caregivers. The family members that were involved in community support groups were able to speak about the demands placed on them and felt that others understood their feelings and the effort they were making. For many, involvement in support groups became important in decreasing feelings of isolation and grief and in learning how to deal with other complexities (Jeon & Madjar, 1998). Caregivers reported much stress because not only did they have to deal with everyday stressors associated with their loved one but they also came in contact with problems from the health care system and the professionals who worked within. Health professionals were often seen as a "barrier" to what family caregivers considered to be necessary care and the best interventions for the ill person (Jeon & Madjar).

Overall, this study did show in depth that caregivers clearly do not have an easy job. If they seek help in their community it does help with being able to cope with the daily attributes associated with caring for an individual with a mental illness. Family members reported an inadequacy in education and training to deal with everyday care for their ill loved ones. This research suggests that their needs to be more education for caregivers of people with mental illness (Jeon & Madjar, 1998).

According to Davis (1987), the needs of families and caregivers are often ignored. In addition, social workers give family members conflicting messages. These mixed messages are characteristics of dysfunctional family systems. These patterns of communication between social workers and family members can increase stress in families and can jeopardize the support system of the mentally ill patient (Ferris & Marshall, 1987). In a study done in 1991 by Riebschleger, siblings of mentally ill individuals were interviewed by social workers. The sibling group consisted of 11 females and nine males, ranging in ages from 21 to 65. The study used qualitative research methods and there were eight phases: (1) onset of client's mental illness; (2) siblings' emotional responses and reactions; (3) effect of the chronic mental illness on the life of the participant; (4) historical and current interactions of the sibling with the mental; health system; (5) siblings' definition of mental illness and sources about mental illness; (6) reactions of friends and family; (7) family planning; (8) things that would facilitate personal and family adjustment to the mental illness (Riebschleger, 1991). Sibling recommended that social workers provide assistance in five major ways: include family in treatment team meetings, provide support and education, model clear communication, focus on family strengths and provide effective intervention for ill siblings. Thirteen siblings (65%) believes that they should be able to participate in client's family treatment team and be involved in tasks such as family assessment, intervention planning, and treatment phases. Ten siblings (50%) requested education and supportive intervention for various times, including transitions back into family life, client crisis, early case identification, and first client inpatient hospitalization. Five Siblings (25%) reported that social workers sometimes overburden family members in hospitalization admissions. They recommended that workers interact with family members for involuntary client hospitalization so that the workers could deal with the difficulties and emotions that follow in the client and family relationship (Riebschleger, 1991). Social workers should also address caretaking disputes within the family and make referrals to a support group for siblings to help them realize they are not alone in their pain and frustration and to help with grieving (Pilisuk & Parks, 1988). Some chapters of the Nation Alliance for the Mentally Ill sponsor support groups for siblings (State Alliance for the Mentally Ill of Michigan, 1988).

Overall in this study, Riebschleger, found that not only are the initial caregivers intricate parts in the treatment of the mentally ill individual but siblings too play an important role. This study did show that there is less stress in the home when everyone is shown more support and there is proper education.

Level of Functioning

The researcher on Global Assessment of functioning was very limited. Adaptive functioning and impairment are an important mental health outcome domain that is conceptually distinct from symptom to severity (Bacon, Collins, Plake, 2002). The GAF is the most commonly used measure of adaptive functioning/impairment in mental health settings (American Psychiatric Association, 1994).

In a study done by Frazier and Baker-Smith in 1997, the researchers used the Axis V scores (DSM IV) and functional assessment scores to predict the needed level of residential care. When residential placement is predicted by level-of-care, measures are usually a range of services provided within fixed program designs ranging from apartments to skilled nursing facilities. Such residential programs are generally designed to serve a fairly specific type of patient (Kramer, Massey & Pokorny, 1990). Consumers with lesser needs for supervision may be placed in apartments or congregate living with minimal supervision, while those with greater needs are placed in group homes (Frazier & Baker-Smith, 1997). Community residential settings are less restrictive than inpatient care and have the added advantage of promoting consumer satisfaction. If has been demonstrated that consumers who are satisfied with their living situation and feel that there is a "good fit" between their needs and environment make the best adjustment to the community and fewer hospitalizations and less stressors (Cournos, 1987). In this study a mental status exam from a licensed mental health professional, which includes a DSM IV diagnosis and Axis V score ranging from 0 (low) to 99 (high). They also receive a residential assessment and treatment plan done yearly. A survey was also given out to measure consumer opinion asking them to rate their familiarity with the content of their assessment, their agreement with the content of the assessment and their level of participation on the construction of their assessment. The study found that the predictions derived from the multiple regression analysis can be effective tools for identifying the needed level of care if they are reasonably accurate (Frazier & Baker-Smith, 1997).

In this study, the multiple regression analysis produced reasonably good predictors. It was reported that the GAF score is a good indicator of assessment and predictability when accompanied by other methods of assessment. It would not be as strong an indicator if used alone. The consumer opinion was generally positive. The majority of consumers responded positively when asked whether they were familiar with the content of the assessment, agreed with the content, and felt that their input into the assessment was respected (Frazier & Baker-Smith, 1997).

Summary of Literature

Since deinstitutionalization began in this country, families of seriously mentally ill have been required to assume an increasingly heavy burden of responsibility for the care and management of their loved ones (Aviram, 1990). About 80% of those discharged from inpatient hospitals are in close contact with their family members and depend on them for help in their daily lives (Goldman, Gattozzi, & Taube, 1981). Family members help out with medication monitoring as well as daily activities such as getting them out into the community. Many feelings manifest for both consumer and family member when this illness is present. Families must cope and start questioning how to handle these new found behaviors, etc (Baxter & Diehl, 1998). How can this be done with out proper education and support? Many of the studies discussed, reported that caregivers needs have been unmet. If caregivers needs are unmet, then their mentally ill family members most likely are not getting their individual needs met either (Young, 2001). Educational groups for family members are out there but according to the literature, the healthcare professionals are not always so eager to give out this information. When people do find these support/educational groups, they did report less frustration and stress in the home and were more able to understand what their loved one was going through (Riebschleger, 1991).

In the area of Global Assessment of Functioning there was limited research available. However in the study done by Frazier and Baker-Smith (1997) the GAF scale was shown to be a good predictor when accompanied by other tools used in assessing consumers.

In the present study, family involvement in support and educational groups was explored. Family members along with their loved ones who have been diagnosed with a mental illness will be attending these groups. The clients will be assessed using the GAF scale (Axis V) and reporting psychosocial and environmental stressors (Axis IV).

Chapter 3: Design of Study

Sample

The population that participated in the present study consisted of 12 Consumers diagnosed with a mental illness from Family Service's Hattie Tally Program. All participants had a GAF score of 50 or below and had an Axis IV in the area of primary supports. All participants were adults over 22 years of age.

Measures

Therapists/ trained clinicians recorded the Global Assessment of Functioning scores and present stressors at the time of onset of symptoms and start of treatment, during current treatment setting, frequency of treatment contacts, and with the use of psychotropic medications. Therapists also assessed the severity of numerous symptoms (including hallucinations, delusions, and suicidality). All assessments were based on both medical histories and personal therapeutic relationships.

Axis IV Stressors and the severity of stressors were tracked using the DSM-IV Criteria for stressors (1994). These stressors were assessed at the start of the support/education groups and again 6 months later when the groups were completed by a trained clinician. Axis V Global Assessment of Functioning scores were tracked using the GAF scale from the DSM-IV (1994). Increased family involvement and involvement in the support groups was also tracked by using an attendance grid.

Design

The present study was experimental and was predictive in nature. Family members along with the consumers diagnosed with a mental illness at Family Service attended education/support groups on every third Wednesday for 6 months. Attendance was taken at the beginning of each meeting. All involvement was voluntary and outcomes were kept confidential. Axis IV Stressors and Axis V GAF scores were evaluated at the start of their individual treatment and then again at 6 months. Consumers and family members gained education and support services provided by trained staff of Family Service of Burlington County.

The present researcher along with trained staff at Family Service identified consumers enrolled between 10/01/02 through 3/31/02 who had an Axis IV in the area of primary supports and GAF of 50 or below. A monthly support group was introduced for primary support systems such as care givers. Education groups were provided for support systems that included pre/post tests. Education groups consisted of:

- Oversight of Partial Care and Adult Outpatient Services
- Understanding: Schizophrenia and Depression
- Medication Education
- Substance Abuse and the Mentally Ill

Trained staff used an attendance grid to document number of support groups and education groups attended. Invitations were sent to all involved supports a month in advance so they were aware of the times and dates of the education/support groups. GAF and Axis IV were measured and documented. An overall tracking form to map out GAF and Axis IV scores and date of outreach was documented. A Pearson's Correlation was used to compare the differences in GAF and stressors over time.

Testable Hypothesis

The objective of the research was to find if increased family involvement (support and education) would show an increase of their level of functioning score (Axis V, GAF) and decrease in number or severity of their Axis IV stressors among mentally ill adults.

Null Hypothesis: No relationship will be found in GAF score as measured by family involvement and increased support/education.

No relationship will be found in severity of stressors as measured by family involvement and increased support/education.

Alternate Hypothesis: There will be a relationship between GAF scores and family involvement and increased support/education.

There will be a relationship between severity of stressors and family involvement and increased support/education.

Analysis

Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resource or other problem relation to the difficulties one has developed. When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant (DSM-IV, 1994).

Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. The reporting of overall functioning on Axis V is done using the Global Assessment of Functioning Scale. The GAF Scale may be particularly useful in tracking the clinical progress of individuals in global terms, using a single measure. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, "Do not include impairment in functioning due to physical (or environmental) limitations." (DSM-IV, 1994). The expressed purpose of multi-axial diagnosis in the DSM-IV (1994) is to assess clients along several dimensions, each of which contributes unique information. Axis V, the GAF, was designed to measure general functioning, which should predict treatment response and assist in treatment planning.

To control confounding factors such as age, marital status, employment status, living conditions, consumption of alcohol, duration of illness, duration of treatment, frequency of treatment contact, use of psychotropic medications, they met with a trained case manager on a weekly basis to document any concern, problem, or other issue involved with the above mentioned factors.

Consumers at Family Service also had counseling available to them during the days they attended the Hattie Tallie Program. Each individual meeting with the consumer was documented. If a consumer did not attend a Wednesday evening support/education group, an outreach phone call was made, which was also documented.

If consumers missed more than two evening support group meetings, a letter was sent regarding their lack of attendance.

Summary

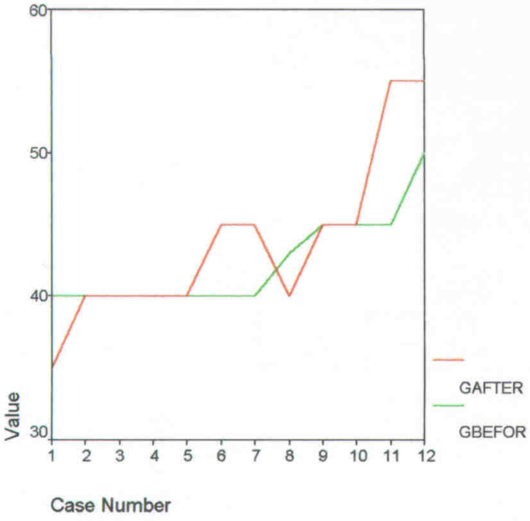
In the present study, Global Assessment of Functioning (Axis V) and Axis IV psychosocial and environmental stressors were assessed at the onset of the support groups and at the six-month mark. Trained clinicians at Family Service tracked these measures. These measures are important forms of assessment for the all-around treatment of the individual consumer. These axes not only cover functioning in a psychiatric setting but are also an important tool in predicting how a person will be able to function during daily living and in his/her community.

Chapter 4: Analysis of Results

Order of Presentation

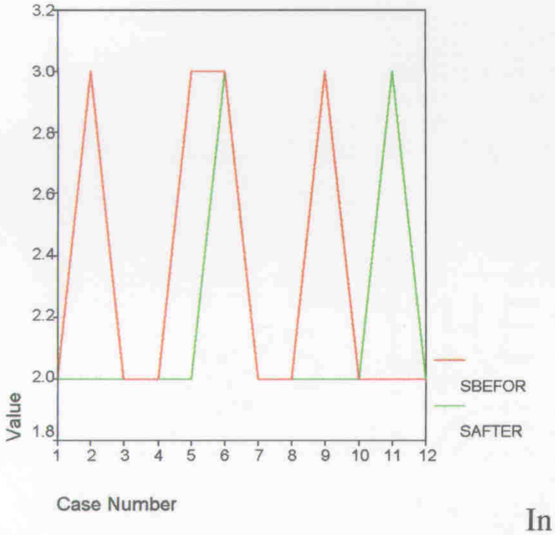
The support/education groups spoken about in this study were aimed to improve outcome to both the clients and the family members involved. The support groups were designed to help individuals gain learning, skills and much insight as well as support in their daily endeavors with the mentally ill. Each participant in the study had an increase in family participation. In the present study, Global Assessment of Functioning scores as well as Axis IV severity of stressors were taken before the support groups began and again after 6 months of receiving support/education from these groups. A Pearson's Correlation was used to compare the scores before and after the groups. The following data was found: The Global Assessment of Functioning correlation score was .003. The Axis IV (psychosocial and environmental problems) correlation score was .624.

4.1



In graph 4.1 and table 4.3, where there was a correlation score of .003, GAF was compared before the support groups with family and friends and then again after the six months. The relationship between the scores before and after was very minimal according to the graph. The graph was made on a case-by-case basis. By looking at the graph, participants 2 through 5, 9, and 10 had maintenance of a GAF score of 40 after the support groups. Participants 6,7,11 and 12 had an increase in their GAF scores after the support group. 2 clients in the study had a decrease in their GAF score. The mean GAF score before was 42.33 and after was 43.75. Overall, a majority of the participants either maintained their GAF score or had an increase.

4.2



In graph 4.2 and table 4.4, where there was a correlation score of .624, Axis IV scores before the support groups with family/friend participation and then again after the six months. The range consisted of severe, moderate, and mild stressors. Severe was given a 3, Moderate-2, and Mild-1. Before the support groups, 5 clients had severe stressors reported in their life. After the support groups that number went down to 2 clients reporting severe stressors. 7 clients maintained the same amount of stressors. The mean score for Axis IV stressors before was 2.33 and after was 2.17. There was overall a stronger relationship between stressors and family participation than there was when measuring GAF scores.

4.3	GAF Before	GAF After
GAF Before: Pearson Correlation Sig. (2- tailed)	1.00	.774** .003
GAF After: Pearson Correlation Sig. (2-tailed)	.774** .003	1.00

4.4	Ax IV Before	Ax IV After
Ax IV Before: Pearson Correlation Sig. (2 – tailed)	1.00	.158 .624
Ax IV After: Pearson Correlation Sig. (2-tailed)	.158 .624	1.00

**Correlation is significant at the .01 level (2 tailed)

Organization of Analysis Chapter

The hypothesis of the present study was: A relationship will be found between an increase of involvement among support systems of the identified clients at Family Service and the clients' overall GAF scores and severity of their Axis IV stressors. The null hypothesis for GAF was not rejected. There was no significant increase of GAF scores after the support/education groups. The null hypothesis for stressors was rejected. According to the correlation score of .624, there was a relationship shown between Axis IV severity of stressors and increased support/education by the family. Overall from the data collected, there was maintenance of GAF scores and Axis IV stressors.

Restatement of the hypothesis

Family members along with consumers diagnosed with a mental illness at Family Service were to attend education/support groups on every third Wednesday for 6 months. Attendance was taken at the beginning of each meeting. Axis IV stressors and Axis V GAF scores were evaluated at the onset of the groups and after the 6 months were up. A relationship should be present between an increase of involvement among support systems of the identified clients at Family Service and the clients' overall GAF scores and severity of their Axis V stressors.

Interpretation of Results

The researchers failed to reject the null hypothesis for Global Assessment of functioning because the correlation score was approaching zero. From the mean scores of the GAF before and after (42.33, 43.75), GAF scores went up 1.42 points after the six months of support and education groups. Clients seemed to maintain their GAF scores instead of having a decrease in overall functioning.

As for Axis IV stressors, the null hypothesis was rejected because the correlation score showed a relationship between family support/involvement and a decrease in overall Axis IV stressors. From the mean scores of Axis IV stressors before and after (2.33, 2.17), stressors decreased by .16. Clients seemed to also maintain their stressors instead of having an increase in the amount of psychosocial and environmental problems in their life.

Statement of Significance

According to the correlation score for Axis IV severity of stressors; there was a relationship between increasing in family participation and lessening the severity of the present stressors of the individual clients. The correlation score for GAF scores did not show a relationship between and changing score and family participation. There was an overall maintenance of scores for both Axis IV and V.

Summary

Overall, the relationship between GAF scores before and after the support/education groups did not affect the individuals GAF score. Scores did not increase due to increased family participation and involvement. There was however maintenance of the scores and very little decrease in the overall scores of the individual clients. The relationship between Axis IV stressors before and after the support/education groups did affect the client's individual stressor level. Scores seemed to decrease or be maintained due to family participation and involvement.

Chapter 5: Summary and Conclusions

Many clients at Family Service require a lifetime of treatment and support. For example, some are currently on medications and may be on them long-term. Family, friends and others involved in the client's circle of supports need to learn about these medications such as what they do, the side effects and the benefits of their medication. With the support and education groups provided by Family Service, family and friends were able to learn about mental illness. After participating in these groups, they were more able to understand what it is like to have Schizophrenia or Bipolar Disorder. They are now more able to empathize with their loved ones.

Since the clients at Family Service were also able to attend these support and education groups, they were able to increase their communication skills as well as learn of the worries and concerns their caregivers have. After these groups, the individual client and their circle of supports have gained awareness about what each other needs in their daily lives. These groups have helped the caregivers gain insight into their loved one's mental illness and as result helped to lessen stressors among these individuals.

These groups consisted of monthly support groups where caregivers were able to vent their worries and frustrations about their loved ones. They were also given support and feedback from people in the same position as themselves. There were education groups available for the family and the clients that included pre/post tests. Education groups gave way for people to learn about substance abuse and the mentally ill, schizophrenia, anxiety, bipolar disorder and medications that are given for certain disorders. They were given out reference and facts sheets on medications that were written in a way that the average person could understand what these medications do.

When speaking about these support groups, a question was asked about how it will affect the individual client. The present study hypothesized that there would be a relationship between the increase in family involvement and the increase in overall GAF score and a decrease in severity of Axis IV stressors. A stressor is any psychosocial or environmental problem. This could be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or person resource or other problem relating to the difficulties one has developed. The researcher's hope was to have a decrease in the severity of the stressors and believed that increased caregiver support would do just that.

Axis V, GAF scores were reported by a clinician. The individual therapist used his/her own professional judgment of the individuals overall level of functioning. This information was and will continue to be useful in developing and planning treatment and measuring its impact and in predicting outcome. When the identified clients function in society, they need support in their lives. It was predicted that if these clients' caregivers and family members gained education and attended support groups, there would be a relationship between increased support and an increase in GAF scores.

In the present study, there was no relationship present for GAF scores and increased participation among caregivers. There was however maintenance of the GAF scores after the support groups and very little decrease in the scores. The severity of stressors also was maintained after the support groups. According to the Pearson correlation, there was a relationship between participation among caregivers and a decrease in the severity of stressors.

The following conclusions were found during the present study: See tables 5.1,

N=12

5.1	Mean Score
GAF Before:	42.33
GAF After:	43.75
Ax. IV Before:	2.33
Ax. IV After	2.17

The mean scores for both GAF and Severity of Stressors seemed to be maintained throughout the six months of support/education groups. A relationship was not found between increased family involvement and overall GAF scores after the groups; the score being .003. However there was a relationship shown between increased family education/support and severity of stressors; the correlation score being .624. In this study, the researcher did find that after six months of family participation there continued to be an overall maintenance of both GAF scores and severity of stressors.

Discussion

When looking at the data and the results from the correlation, the relationship between GAF and family participation was not strong. However according to the data collected, GAF scores were maintained throughout the 6 months of attending the support/education groups. This finding, although not the original hypothesis, still holds some stability. Would these GAF scores have plummeted, had their not been educational and support groups for the clients' caregivers? Most of the clients that maintained their score did have a score of 40. At Family Service, if their score is lower than a 40, it most likely means that the individual client has been re-hospitalized. Since these clients were able to maintain their score, it shows that these clients did not need re-hospitalization and were able to function in their communities and at their day program.

For the overall severity of stressors of the 12 clients in this study, the correlational relationship was stronger than for GAF scores. This showed a relationship between severity of stressors and family involvement in one's treatment. 8 clients kept the same level of stressors before and after the support/education groups. Again maintenance of these levels must be mentioned because for a mentally ill individual, stressors can increase on a daily basis. Only with support and understanding from others, can one maintain this level of moderate stress in one's life (WFSAD, 2002).

Implications for Future Research

In the future I think that this study would have been more informative if there was a larger sample involved. Presently there were limited clients and family members involved due to transportation problems and the times that the meetings were held. I think that although 6 months does give time for people to learn about mental illness and the medications that go along with that, I think that the groups should have went on longer and also have ongoing support groups for the weekly events that caregivers encounter. I believe with ongoing support groups, clients and caregivers would be more able to understand each other through out the changing seasons and holidays. Each season can bring about new trials and tribulations for people with a mental illness. It would be interesting to see how their GAF scores and stressors changed throughout these months.

When speaking about the GAF scores and severity of stressors, it is important to note that a trained clinician gives these scores. Although someone who does have training in this realm gives the score, it is still a person's opinion and there is a question of how reliable that source is. In the future, other measures should be tested along with GAF scores and severity of stressors. Things such as medication compliance should be kept track of along with program compliance. All of these factors play an important role in the overall functioning of the individual.

Support and education play a major role in any kind of health matter. A person does not automatically learn about bipolar disorder like one is taught about cancer or diabetes. An individual suddenly diagnosed with a mental illness feels very alone, especially when he or she has no support or education on the illness. What better way to help that loved one than to be supportive and also learn and become aware about what may go on in that person's mind and how it effects his or her daily life. Clinicians and therapists around the globe need to strive to get caregivers, family, friends and any other supports they can find involved and educated about clients' illness and treatment. With support and education, I feel that a person diagnosed with any health problem will live a more fulfilled life knowing others care for them and are making the effort to learn about his or her illness.

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