A Stress Management Program: Inpatient-to-Outpatient Continuity

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Stress is a factor in many modern illnesses. The development of coping skills to deal with stress is an occupational therapy goal for many patients. The program presented here uses stress management techniques to improve the situational coping skills of adult psychiatric patients. When discharged to the outpatient clinic, the patients in this program continue to learn and practice stress management techniques to increase relaxation and lessen anxiety. A case example is presented.

Recent statistics indicate that 75% of all medical complaints are stress related, including ulcers, stomach disorders, headaches, hypertension, insomnia, aches and pains, and many psychiatric disorders (Charlesworth & Nathan, 1984).

Uniform terminology (Hopkins & Smith, 1983) defines situational coping as the skill and performance to handle stress and deal with problems in a manner that is functional to self and others. This includes:

- Setting goals and managing activities of daily living to promote optimal performance.
- Testing goals and perceptions against reality.
- Perceiving changes and need for changes in self and the environment.
- Directing and redirecting energy to overcome problems.
- Initiating, implementing, and following through with decisions.
- Assuming responsibility for self and consequences of actions.
- Interacting with others: dyadic and group.

(Hopkins & Smith, 1983, pp. 899-907)

According to Selye (1980), the stress syndrome has three stages: (a) the alarm reaction (the fight-or-flight response), (b) resistance (the body's increasing adaptation to constant stress and illness), and (c) exhaustion (energy depletion that may result in serious illness or death). Occupational therapists treat patients at each of these stages.

Program Description

In 1983, the University of Texas Medical Branch hospitals (Galveston, Texas) incorporated a stress management program into their existing occupational therapy program, because of the mental health medical team's increased emphasis on the role of stress in illness. The program was part of a 12-bed open milieu therapy unit that emphasized family therapy. The stress management program was designed to develop and improve situational coping skills in adult psychiatric patients. Upon discharge, patients with a continued need to practice these skills are followed in the outpatient setting. The outpatient occupational therapy clinic receives referrals from throughout the hospital, but particularly from the inpatient psychiatry units at the time of discharge.

The following criteria were established for a patient's referral to the stress management program:

1. Recent experience of stressful life events.
2. Low stress tolerance.
4. Attention span of at least 45 min.
Information for criteria 1, 3, 5, and 6 was gained through interviews with patients; information for criterion 2 and additional information for criteria 1, 3, and 6 was gained through a review of charts; and information for criteria 4 was identified by a task performance evaluation.

Although evaluations are used to determine which occupational therapy groups are most applicable for a referred patient, the evaluation for the stress management program will be the focus of this paper. Before a patient begins the program, his or her medical chart is reviewed to determine current and past stressors and to identify parts of the stress management program that may be contraindicated. For example, isometric exercises are contraindicated for patients with hypertension and circulatory problems, deep breathing exercises are contraindicated for patients with chronic obstructive pulmonary disease, and visual imagery exercises are contraindicated for actively hallucinating patients.

The TAT Anxiety Scale (Krug, Scheier, & Cattell, 1975), a standardized measure, is used initially to assess anxiety; it is also helpful for reassessment. An initial interview is used to evaluate the effectiveness of the patient’s social and interpersonal skills and the extent of insight into his or her behavior. The lack of social and interpersonal skills is often a contributor to high stress in work, family, and everyday social encounters (Charlesworth & Nathan, 1984). A task performance evaluation (Mosey, 1981) is used to assess concentration, attention span, comprehension, and the ability to follow directions. A sensorimotor screening (Hopkins & Smith, 1983) is used to identify areas of muscle tightness, tone, conditioning, and strength. The Interest Check List (Matsumoto, 1969), Assertiveness Questionnaire (Bower & Bower, 1976), and Time Utilization Schedules (Larrington, 1970) are used to determine the patient’s satisfaction with his or her life situation and to assess the balance of work, play, and sleep activities. Blood pressure and pulse readings (Bunnet & Suddarth, 1982) can be taken before and after each session to evaluate the patient’s response to the stress management program as well as the program’s overall effectiveness.

After all of the evaluations are completed, a treatment plan, which may include the stress management program, is established. Goals that emphasize the development of adaptive methods of dealing with life stressors are identified. Individual goals are established, which might include (a) an improved ability to identify common life stressors, (b) an improved ability to identify personal life stressors and physical or emotional effects, and (c) an improved ability to achieve a relaxation response during stress management sessions and to integrate these techniques into daily life.

At the University of Texas Medical Branch at Galveston, occupational therapy patients are seen both individually and in task-oriented groups. Inpatient programming emphasizes the remediation of stress-related symptoms and group-oriented activities. The inpatient program consists of five treatment groups: exercise, assertiveness training, occupational therapy task, relaxation training, and stress management.

**Exercise Group**

Charlesworth and Nathan (1984) stated that exercise provides a way of releasing muscle tension and general physical arousal accumulated in response to stress. At the University of Texas Medical Branch, the exercise group is a progressive walking–jogging–running program that meets for 45 min five times a week. A 15-min warm-up exercise focuses on stretching and muscle preparation. The patients then go outside and walk, jog, or run for an assigned length of time and at an assigned speed. Pulses are taken before and after the exercises to determine tolerance to the physical activity, improved endurance, and whether more demanding exercise is appropriate.

**Assertiveness Training Group**

The assertiveness training group emphasizes improved methods of communication to express feelings, wants, and needs effectively, either verbally or nonverbally. This group focuses on activities that help clarify and encourage the practice of appropriate verbal and nonverbal communication. The treatment modalities that are used include group expression and self-expression through media, the identification and labeling of emotions, training in social skills, role-playing with feedback regarding communication styles, and training in assertiveness techniques (Bower & Bower, 1976). This group meets for 1 hr twice a week.

**Occupational Therapy Task Group**

The occupational therapy task group uses arts and crafts as treatment modalities. This group, which meets for 1 hr five times a week, gauges the patient’s ability to perform tasks within a social context and to deal with the related stressors. It is also used as a training modality for leisure skills and time management.

**Relaxation Training Group**

The relaxation training group focuses on decreasing muscle tension and improving the ability to relax by
teaching patients to use relaxation techniques. This group meets for 30 min twice a week. Patients are first taught appropriate breathing techniques and are encouraged to practice deep breathing, as opposed to shallow breathing. They then progress to slow rhythmic movements of the head, neck, shoulders, and arms. Progressive muscle relaxation techniques in which successive muscle groups are tensed and relaxed are performed. This technique helps the patient distinguish between muscle tension and relaxation. Autogenic techniques are also incorporated into the exercises; they promote vasodilation through the suggestion of heavy and warm feelings in the extremities. Autogenic techniques are especially beneficial for headache sufferers (Charlesworth & Nathan, 1984). Visual imagery exercises that focus on a favorite memory or pleasant place also are used (Charlesworth & Nathan, 1984). Autogenic training or visual imagery techniques are not recommended for patients who are extremely agitated or who have distorted perceptions of reality. A therapy set is included before and after an exercise to explain the rationale behind the technique and to encourage patients to include the activity in their behavioral repertoire (Peloquin, 1983, 1988).

**Stress Management Group**

**Inpatient treatment.** The stress management group meets for 1 hr once a week and is the keystone of all of the programming. Patients in this group are encouraged to identify their personal life stressors, their symptoms of stress, and the ways in which stress has affected their physical and emotional well-being. Specific stress management techniques are taught, and the patients are given homework to encourage them to practice these techniques outside of the group structure. Specific topics include time management and goal setting techniques; nutrition and exercise education; activities to improve attitudinal and behavioral awareness, such as values clarification (Simon, Howe, & Kirschenbaum, 1978); thought stopping; rational emotive therapy techniques (Ellis, 1975); positive self-talk (Lazarus, 1981); and role-playing. Although the importance of improved communication, exercise, and relaxation techniques as means for dealing with stress and stress-related symptoms are discussed, these topics are covered more thoroughly in the other groups. The attitudinal and behavioral awareness activities are usually covered when the patients have almost completed the program. Patients with low IQs or limited insight may have difficulty comprehending this material; we therefore recommend the use of the other treatment modalities for this population.

One example of an activity used in the stress management group is the Life Events Scale (Holmes & Rahe, 1967), which measures the psychological stress of life events and changes. The patient uses this scale to identify personal life stressors and how they may relate to his or her illness.

Tips for reducing stress (Woolfolk & Richardson, 1978) are also used. These tips help to educate patients about various attitudinal and behavioral changes necessary for stress reduction.

**Outpatient treatment.** As patients improve and are discharged from the hospital, outpatient occupational therapy is often prescribed as part of their follow-up treatment. Outpatient therapy is more individualized than group treatment. Electromyograms and skin temperature biofeedback may be used to provide objective data on relaxation responses (Danskin & Crow, 1981). Outpatient programming continues with the therapist and patient working on relaxation techniques and perfecting the ability to achieve a relaxation response. Patients are frequently given a home program that incorporates daily relaxation and stretching exercises. They are also given audiocassettes that include those techniques that the patient may have found to be particularly beneficial or especially relaxing. Patients keep logs of their daily stressors and their reactions to those stressors; they also rate their ability to induce relaxation as a response to a stressor. This log is reviewed with the occupational therapist and provides the patients with feedback of their progress and their ability to induce relaxation and lessen their anxiety levels.

The individual sessions focus eventually on time management and goal setting. Patients are given activity configuration tasks (Larrington, 1970) and are instructed to analyze how they use their time daily to meet their responsibilities and their goals. Values clarification exercises (Simon et al., 1978) are used to assist with goal setting. Patients are asked to arrange their daily schedules to accomplish the short-term goals that may contribute to the achievement of long-range plans. In arranging their daily schedules, the patients are taught the importance of regular exercise, good nutrition, relaxation, and leisure activities. Treatment modalities similar to those used in the inpatient program are also used.

This treatment is given for 2 hr a week for approximately 4 to 6 weeks, depending on the patient’s progress with the home practice program. Treatments become less frequent as patients become more proficient in handling their daily life stresses.

**Case Study**

The following case study illustrates the use of a stress management program and its results. Ms. J., a 32-year-old divorced black woman, became an inpatient after she attempted suicide with a drug overdose. She
had been living with her mother, grandfather, and brother and raising two teenagers. Her youngest child, age 15 years, was pregnant. The patient had had several previous psychiatric admissions since she was 16 years old and had made previous suicide attempts. The patient was hypertensive, had migraine headaches, and was obese. Her condition was diagnosed as major depression (American Psychiatric Association, 1987), and it was later found that she had characterological problems indicative of a mixed personality disorder.

The initial occupational therapy evaluation included an interview, cognitive assessment, and observation of interpersonal skills in a group setting. Ms. J. refused to cooperate with a full sensorimotor assessment.

Test results revealed that Ms. J. had much anger concerning family problems. Although she had good functional verbal skills, it was noted that she resisted communicating clearly with others, which often led to conflicts with family members and co-workers. Her daily schedule did not indicate a balance of work, rest, and play activities, but rather included as much as 20 hr of work per day in a convenience store. She reported having few social contacts outside of her family, often speaking to no one and having, as she stated, “blow-ups.” During these periods, she would act impulsively and often drive aimlessly or contemplate wrecking her car. She had no cognitive deficits on the task performance evaluation and no observable gross motor deficits on the sensorimotor evaluation (of which she did not complete the fine-motor, cross-midline, and imitating movement sections). She complained of feeling anxious and of having a poor self-concept. She appeared tense, angry, withdrawn, and resistive to group and, on occasion, dyadic interactions. Her insight was fair in that she recognized her behavior as self-destructive.

On the inpatient unit, some of the initial treatment goals devised for Ms. J. were as follows:

1. Increase ability to structure the day to include a balance of work, play, and leisure.
   (a) Be punctual for all scheduled appointments.
   (b) Develop a daily schedule to be followed on overnight and weekend passes.
2. Improve ability to identify and express emotions constructively.
   (a) Identify three occasions when she felt angry.
   (b) Identify situations in which she felt uncomfortable expressing herself.
   (a) Realistically assess quality of work on three occasions.
   (b) Make three positive statements about herself.
4. Improve ability to work comfortably in a group situation.
   (a) Initiate one conversation with a peer.
   (b) Ask for help from a peer on two occasions.
5. Improve ability to deal with stress more functionally.
   (a) Identify three current life stressors.
   (b) Identify how these stressors affect her physical and emotional well-being.

The patient’s program included exercise, relaxation, occupational therapy tasks, and participation in assertiveness and stress management groups to assist with the achievement of the specified goals.

Ms. J. was initially resistive to treatment. She often refused to attend groups and participated poorly when she did attend. After 2 months, however, progress on goals was noted. She was attending all appointments on a regular basis. She was developing varied leisure interests and showing an improved understanding of time management and the ability to balance work and leisure. She appeared less anxious and angry and was able to verbalize feelings of anger to staff and family in an assertive manner. She agreed to become involved in exercise and relaxation groups, with good results. Her interactions with peers and staff increased. Ms. J. initiated discussions in the clinic without prompting from the therapist (the second author). She identified her stressors and related these to her behavioral patterns, including her migraine headaches and explosive outbursts.

After 6 months of inpatient treatment, Ms. J. had successfully achieved her goals, with the exception of improving her feelings of self-worth and competency. Although her self-concept had improved since her admission, she continued to make derogatory comments concerning her self-worth and her ability to handle the environmental demands outside of the hospital. Ms. J. was discharged to outpatient follow-up for individual psychotherapy and occupational therapy. As an outpatient, she attended the occupational therapy task group and individual stress management sessions for a total of 3 hr weekly. She was seen by the first author over a 2-year period, with some interruption of treatment when she found employment and when her grandson was born. Treatment focused on continued relaxation training, time management and goal setting, assertiveness training, and improved attitudinal and behavioral awareness.

Ms. J. had initial setbacks in her ability to relax and to deal effectively with others in conflict situations. She began to work long hours, yet attempted to include more time for peers and socialization. She did not report experiencing her previous blow-ups and...
self-destructive feelings during stressful situations. She slowly improved her ability to relax and to practice assertive behaviors, and she began to establish goals for herself and to acknowledge her achievements when they were met. She moved from her mother’s house and became the primary caretaker of her grandson. She found a new job that provided increased health benefits and required fewer hours. Ms. J. was able to arrange her work schedule so that her day off coincided with her therapy day. She noted positive changes in her behavior and in others’ reactions to her. She stated she felt more content and better able to “get by and make it on a day-to-day basis.”

Six months after discharge from the hospital, Ms. J. was discontinued from the stress management sessions. She remained in the occupational therapy task group and in psychotherapy for 1 year. She was able to practice stress management techniques independently and to achieve a relaxation response on most occasions.

Although she continues to have occasional setbacks, Ms. J. has managed to make positive major life changes. She consistently incorporates leisure and relaxation activities into her daily routine. She is active in her church and participates in a church volleyball league. Her grandson, who is now 3 years old, was found to have leukemia, and she was able to respond functionally, arranging her work hours so that she can be at the hospital as much as possible. She returned to live with her mother after her grandfather died and her brother moved out. This has decreased the financial burden of her grandson’s illness and has provided her with additional caretaking support. Ms. J.’s oldest child is now 20 years old and is unemployed, but is the primary caretaker for his nephew during the day. The child’s mother dropped out of school and assumes no responsibility for the child. Ms. J. reported that the communication within her family has improved. She occasionally calls the outpatient occupational therapy clinic to chat or to request new relaxation tapes. She has maintained her present job for 2½ years without readmission to the hospital.

In conclusion, this treatment program was effective in improving Ms. J.’s ability to deal with stress and to develop adaptive coping skills. Patients with characterological disorders usually respond poorly to treatment, are frequently readmitted, and are unable to maintain employment (American Psychiatric Association, 1987). This cycle appears to have been broken with Ms. J.

**Summary**
The number of stress-related illnesses and dysfunctions has increased. To deal with stress, a person requires situational coping skills. For 6 years, the University of Texas Medical Branch has been operating a stress management program for adult psychiatric patients that starts in the inpatient setting and continues in the outpatient setting, where the patient is again confronted by situational stressors. Many evaluations are used in the development of an inpatient treatment plan. This plan may include exercise, relaxation training, assertiveness training, traditional occupational therapy clinic modalities, and stress management training. Outpatient treatment continues to focus on techniques learned in the inpatient setting in addition to individualized programming.

**References**

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