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Craig Ravesloot Ph.D.

University of Montana Rural Institute - Research and Training Center on Disability in Rural Communities

University of Montana Rural Institute
scholarworks-reports@mso.umt.edu

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Recommended Citation

Ravesloot, C. (2014). Peer support in managing psychiatric symptoms of rural adults with mobility and sensory impairments. Missoula: The University of Montana Rural Institute.

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July 2014

Research Report

Peer Support in Managing Psychiatric Symptoms of Rural Adults with Mobility and Sensory Impairments

Little is known about the mental health of people with disabilities who live in rural America or the potential benefit of providing peer support services for these individuals. Stress diathesis models of psychiatric disorders suggest the challenges of living with a disability in rural areas may predispose individuals to higher rates of psychiatric disorders (Monroe & Simons, 1991). In addition, rural mental health service providers struggle to meet the needs of rural individuals with primary psychiatric diagnoses, and they may not be trained to assist people with disabilities who have secondary mental health conditions (New Freedom Commission on Mental Health, 2003).

Peer support provided by Center for Independent Living (CIL) staff may help rural adults with disabilities reduce the impact of psychiatric symptoms. Peer support was pioneered by "the rolling quads" who supported each other in advocating for service and support access. Recognizing the importance and role of peer support in living with a disability, the IL movement formalized peer support as a core service with original funding through the 1978 amendments to the Rehabilitation Act of 1973. The purpose of this study was to examine the utility of peer support for supporting the needs of rural adults with mobility and sensory impairments who were experiencing psychiatric symptoms.

Methods

We randomly selected 6,000 households from the general population in three rural zip codes of three states (California, Kansas and Montana) and solicited participation of individuals with either a physical or sensory impairment. We surveyed those recruited (n=166) on five occasions over 15 months; we received usable returns for all five data waves from 113 individuals. To recruit survey participants into a peer support program, CIL peer staff telephoned all respondents immediately following wave three.

The University of Montana Rural Institute

RTC

RURAL

Research and Training Center on
Disability in Rural Communities

RTC:Rural
52 Corbin Hall
The University of Montana
Missoula, MT 59812
Toll Free: 888.268.2743
Fax: 406.243.2349
TTY: 406.243.4200
rtcrural@mso.umt.edu
rtc.ruralinstitute.umt.edu
Alternative formats available

Table 1. Health conditions reported most frequently

Health Condition	%
Neck or back pain	68
Arthritis	59
Eye/vision problems	42
Hypertension	34
Fractures/joint injury	31
Hearing problems	23
Lung or breathing problems	21

Based on all returns, participants were 54.4 years old, 59.4% were women, and 17.4% were veterans; on average, they had 13.8 years of education. Participants were predominantly Caucasian (82.8%) with Native Americans overrepresented (14%) due to the location of one community. Participants reported a variety of health conditions and impairments (see Table 1). Those recruited for peer support (n=10) were not statistically different on any of these demographics from those who were not recruited.

Measures

In addition to demographics, we collected the Symptom Checklist 90-R (SCL-90-R) that measures nine psychiatric symptom dimensions: somatization, compulsiveness, uncertainty in social settings, depression, anxiety, hostility, phobic anxiety, paranoid thinking and psychoticism. The Global Severity Index (GSI) is the average rating across all 90 items.

Procedures and Intervention Development

We collaborated with the Center for Psychiatric Rehabilitation at Boston University to adapt peer support training materials for psychiatric populations served by CILs. We designed these materials to instruct peers using distance

training methods. The training content was presented in three sections labeled: Peer Training, Peer Support Training and Peer Specialist Training. Peer Training (three sessions) introduced the concept of peer support and provided ideas on how to use personal disability experiences to support others. Peer Support Training (six sessions) involved specific skill development including (1) active listening, (2) inspiring,

(3) limits and boundaries, (4) working with grief, (5) self-care and (6) motivating change. Finally, the Peer Specialist Training (three sessions) included information about common psychiatric conditions experienced by people with other impairments including depression, anxiety and crisis management.

These peer support training materials were developed in three tiers to allow new peers to train within their comfort level and to minimize potential reluctance to participate in the full 12-session training. Additionally, this structure allowed CILs to have alternative peer specialist content to the psychiatric conditions content. For example, CILs could include Living Well with a Disability facilitator training so peers could work with people on health promotion (see livingandworkingwell.org).

We trained CIL peers to deliver the intervention using webinar technology (WebEx). Lay peer specialists completed the 12 sessions with a CIL staff member who had already completed the training course. Following training, CIL peer providers were paired with individuals from the longitudinal study who indicated they would participate in the peer support study.

Results

Results showed statistically significant within subject effects ($\alpha < .05$). Individuals who received peer support (n=10) reported a 22%

increase in their overall symptom severity on the SCL-90-R just prior to recruitment (i.e., Time Period 3); symptom severity returned to baseline following the intervention. No statistically significant effects occurred across the other time periods for the recruited group or across any time period for the group that did not receive peer support (see Figure 1).

Results indicated that the individuals who participated in peer support experienced higher than usual psychiatric symptoms just prior to their participation when compared to their responses at other time periods and when compared to individuals who did not receive peer support. Interestingly, the overall symptom severity reported by the study sample was somewhat higher and had greater variability than the general population used for norming the SCL-90-R (see [Psychiatric Symptoms poster](#)). Although results indicated a decrease in symptoms over time for the group that did not receive peer support, the change was not statistically significant. Lastly, visual inspection of change scores for the group that received peer support indicated that the within subject change was largely a function of individuals with average symptom severity at Time Period 3 improving to below average symptoms at Time Period 4.

Discussion

Results from this study indicated that peer support could play an important role in managing psychiatric symptoms experienced by rural adults with disabilities. By collecting data over

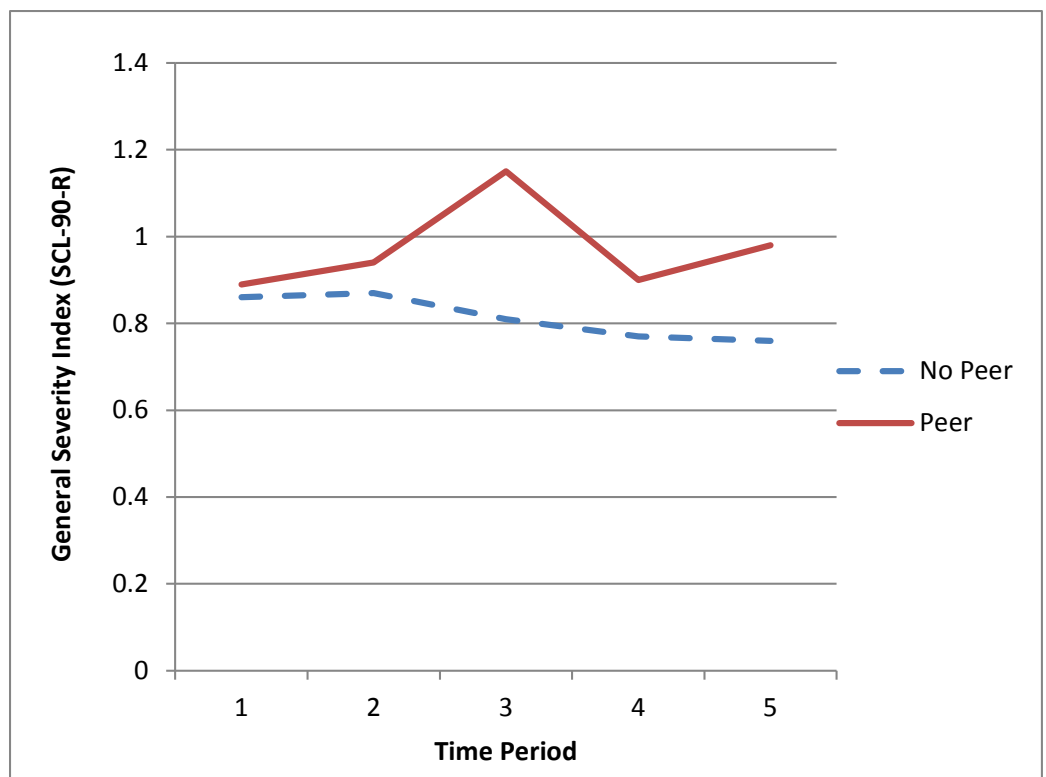


Figure 1. Participants who did or did not receive peer support

15 months, we were able to observe the natural course of symptoms reported by a population-based sample of individuals with disabilities. In general, the average symptomatology for this sample was slightly higher than the general population, which may reflect the stress associated with living with a disability.

Half of those who received peer support reported substantially lower symptom levels at the next measurement period. Peer support helped some individuals when symptom levels were elevated; it also lowered some symptom levels from the group average of people with disabilities to the average reported in community samples of people from the general population (see [Psychiatric Symptoms poster](#)).

The other half of the peer support recipients reported little change in GSI scores either before or after the peer support intervention. Future research should use a controlled experimental design and recruit more individuals to examine in greater detail those individuals who benefit from peer support services to guide rural independent living practice.

References

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Prepared by: Craig Ravesloot

For additional information please contact:

Research and Training Center on Disability in Rural Communities; The University of Montana Rural Institute; 52 Corbin Hall, Missoula, MT 59812-7056; 888-268-2743 or 406-243-5467; 406-243-4200 (TTY); 406-243-2349 (Fax); rtcrural@mso.umt.edu; rtc.ruralinstitute.umt.edu

Suggested citation:

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© 2014 RTC:Rural. Our research is supported by grant #H133B080023 from the National Institute on Disability and Rehabilitation Research, U.S. Dept. of Education. The opinions expressed reflect those of the author and are not necessarily those of the funding agency.

