Contributions to the Development of Psychoeducational Approaches to Mental Health Service

(psychocurrency, day treatment, task hierarchy)

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The psychoeducational approach to psychiatric care is articulated, and the contributions of occupational therapists to this model in one day treatment program are described. An evaluation device (the Task Check List) developed by occupational therapists and used in psychoeducational treatment planning is presented; its use by occupational therapists and other staff is illustrated.

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During the past decade, an increasing number of psychiatric day treatment facilities have adopted educational procedures based largely upon principles of social learning theory, the contemporary label that incorporates concepts from learning theory and from behavioral and cognitive approaches to psychotherapy. Advocates of an educational approach to mental disorder often consider problematic behavior to be a consequence of skills deficiencies that may be replaced by more functional behavior through training experiences. Skill deficits relevant to psychiatric disorders include activities of daily living (ADL) long considered by occupational therapists a primary domain of interest and expertise. As early as 1970, Koestler (1) predicted that social learning theory as a conceptual model would become more significant to occupational therapy as a conceptual model would become more significant to occupational therapy as that profession extended its application into community settings. More recently, Mosey (2) and Conte and Conte (3) wrote in support of the appropriateness of applying the social learning model to the practice of occupational therapy.

Increasingly, occupational therapists and other professionals have become dissatisfied with the medical model of problematic behavior (for an excellent discussion of the medical model, see Sarason and Ganzer [4]). As Mosey notes: "It has become increasingly apparent that the medical model is a poor structure for considering the entire area of psychological dysfunction." (2, p 138) Many therapists see attractive alternatives offered in social learning theory.

The April 1974 issue of The American Journal of Occupational Therapy (AJOT) devoted a series of articles to a review of learning theories. In the October 1979 issue of AJOT, Goldstein, Gershaw, and Sprafkin (5) paid tribute to occupational therapists who early on used clinical intervention techniques based upon learning theory to teach ADL skills necessary for effective and satisfying daily living. They cite such notable contributors to the occupational therapy literature as Stein, Reilly, Diasio and Jones, Smith, and Tempone, Fidler and Fidler, and Mosey.

At the University of Washington, Harborview Medical campus, occupational therapists building upon these origins have been instrumental in the articulation of psychoeducational philosophy and programming since the inception of the Life Skills Program (LSP) in 1974.
The LSP is a psychiatric day treatment program within the context of a comprehensive community mental health center serving an inner-city catchment area of approximately 100,000 people. This paper will describe the LSP and the role of occupational therapists in the development, delivery, and assessment of this psychoeducational approach to mental health services.

The Life Skills Program

The Life Skills Program has implemented a psychoeducational model of service delivery based jointly on educational technology and social learning theory. LSP programming reflects the conviction that, in part, “Mental health is achieved through the learning of new adaptive skills (habilitation) and/or the unlearning of old maladaptive habits (rehabilitation).” (8, p 16) Similar programs exist elsewhere in the United States. Liberman et al. (9) describe the use of the “educational workshop” model in a day treatment program at the Oxnard, California, Community Mental Health Center. Spiegler and Agigian (10) employed such an approach at the Palo Alto Veterans Administration Hospital. Bakker and Armstrong (11) have used psychoeducational approaches in work with less seriously impaired populations. The LSP, however, is the prototype for the psychoeducational model of psychiatric day treatment with the seriously emotionally disabled in the Pacific Northwest.

The LSP serves a population of about 100 seriously psychiatrically impaired clients with an average length of stay of about 6 months. More than 50 percent of the active case load is diagnosed as psychotic, 30 percent as depressed, and the remainder as having a character disorder or as being neurotic, or both. The program is located in an inner-city area of largely lower socioeconomic residents of whom about one-third are from racial minorities. Approximately 25 percent of LSP clients have had no psychiatric hospitalizations, yet the average number of previous hospitalizations is 3.4 months and 15 percent are considered to be actively suicidal upon admission to the program. Pilot administration of the Kohlman Evaluation of Living Skills (12), given to all active LSP clients as part of another study, indicated some impairment in most areas of social living skills. Applying the social skills criteria of Phillips’ scale (13), 100 percent of LSP clients are assessed as “social skills deficient.”

LSP clients range in age from 16 to 70, but the majority are young adults with a mean age of 32. Havighurst describes young adulthood as “the fullest of teachable moments and the emptiest of efforts to teach. It is a time of special sensitivity and unusual readiness of a person to learn.” (14, p 52) Accordingly, the LSP format is that of a school with a monthly schedule of courses, seminars, and activity groups, organized by an occupational therapist who serves as the program coordinator. Each client is assigned to a Goal Attainment through Education (GATE) group, a name conceived by the clients to describe their daily “home room” group. Two additional structured learning classes or seminars complete the day’s program. The individual client selects classes from a variety of offerings according to needs and interests. These classes are taught by the regular staff of five (two nurses, an occupational therapist, a psychologist, and a vocational rehabilitation counselor) and by occupational therapy field-work affiliates as part of their practicum experience. Over the past few years, more than 100 different syllabi of structured learning classes have been developed and offered to LSP clients. Many of these materials have been disseminated to mental health centers throughout the Pacific Northwest.

Courses at the LSP are structured learning opportunities (5, 15) including both didactic and experiential approaches. The occupational therapy staff are particularly well suited to present an array of subject matter, ranging from money management to body movement and mechanics. Classes are often oriented toward specific problem behaviors or skill deficiencies such as Relaxation Exercises (using tapes and cassettes), Home Management Skills, Leisure Time Activities, and Prevocational Skills, all of which are well within the realm of occupational therapists’ preparatory training and teaching capabilities. Occupational therapists as well as staff from other disciplines are encouraged to further prepare themselves to teach classes directed at other client needs such as Memory Training, Effective Communications (using films, transparencies, slides for presentation; video for feedback; and other media such as clay or collage), Group Interactions (stressing activities), Coping with Depression, or Understanding Sexuality (see Table 1). Using their special talents, occupational therapists have contributed unique visual and other innovative teaching aids.

The psychoeducational model stresses the relevance of standard pedagogical approaches to the task of rehabilitation of the mentally ill. Accordingly, LSP staff prepare class...
syllabi outlining the rationale, overall goals, objectives, methods, daily lesson plans, homework assignments, and some form of evaluation or assessment. Patients/clients are called students in an effort to encourage their assumption of this role. Students are given notebooks and encouraged to take notes, keep handouts for future reference, and in all ways to assume a student role. Drawing further from educational technology, individual study is encouraged with those students whose particular needs indicate the appropriateness of some additional attention or coaching beyond what is possible or desirable in a classroom format.

A school nurse is available to help coordinate medication needs with the consulting psychiatrist. Some students would not benefit from the psychoeducational experiences provided without the aid of neuroleptics or antidepressant medication. Nevertheless, the LSP program is characterized as a “learning place, not a get well place.” Medications are offered as a potentiator of the learning opportunities available. Thus therapy is replaced by behavioral training and education in alternative life styles and problem-solving strategies. An educational model of mental health services based on principles of social learning theory and educational technology appears to be both timely and feasible, but the logistics of merging an educational model with the practical demands of mental health service delivery can be problematic.

A Hierarchy of Psychoeducational Tasks

To cope with the difficult interface between educational theory and technique and the practical demands of mental health practice,
the occupational therapy staff at LSP reviewed Hewett's (16, 17) hierarchy of educational tasks for its applicability and adaptability to the educational needs of LSP students. This hierarchy was the result of a need felt by the teachers at the Neuropsychiatric Institute of the University of California, Los Angeles, for a set of working hypotheses with which to formulate educational goals for emotionally handicapped children and adolescents. Hewett accepts the principle that a student's educational accomplishment proceeds in a hierarchical manner with skill development at earlier levels providing a necessary condition for success at subsequent stages. Each level of his hierarchy addresses the reciprocal tasks of student and teacher in the formation of a working educational relationship. In ascending order, Hewett's task hierarchy consists of primary, acceptance, order, exploratory, relationship, mastery, and achievement tasks.

A comparison of individual behaviors of LSP students to the characteristic behaviors of the seven steps of Hewett's educational task hierarchy revealed the relevance of the classification to the assessment of competencies and establishment of realistic treatment goals for LSP students. Some reformulation of the hierarchy was necessary, of course, to make it attentive to the learning tasks faced by adult psychiatric clientele. In order to facilitate this process, the occupational therapy staff developed a checklist that itemizes key behaviors at each task level. The instrument that emerged is called the Task Check List (TCL) and is presented in Table 2.

Preliminary research at the LSP has shown the TCL to possess satisfactory interjudge reliability when differences in familiarity

### Table 2: Task Checklist

<table>
<thead>
<tr>
<th>Directions: Circle number in appropriate column and add for total.</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. ENTRY LEVEL</strong>&lt;br&gt;States desire to attend&lt;br&gt;Stays through classes&lt;br&gt;Hallucinates/delusional&lt;br&gt;Is easily distracted&lt;br&gt;Stays on topic/coherent&lt;br&gt;Is disruptive/combative&lt;br&gt;Speaks &amp; acts at normal pace&lt;br&gt;Observes limits&lt;br&gt;Affect is appropriate&lt;br&gt;Threatens suicide</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>II. ACCEPTANCE LEVEL</strong>&lt;br&gt;Attentive&lt;br&gt;Suspicious, guarded&lt;br&gt;Answers questions&lt;br&gt;Engages others&lt;br&gt;Is rude or indifferent&lt;br&gt;Keeps appointments&lt;br&gt;Withdraws/lacks trust&lt;br&gt;Refuses feedback&lt;br&gt;Denies problems&lt;br&gt;Accepts contacts with staff</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>III. ORDER LEVEL</strong>&lt;br&gt;Appears neat and orderly&lt;br&gt;Follows rules&lt;br&gt;Adheres to schedule&lt;br&gt;Acts impulsively&lt;br&gt;Organizes tasks&lt;br&gt;Is rigid or compulsive&lt;br&gt;Follows directions&lt;br&gt;Complies with treatment&lt;br&gt;Is punctual&lt;br&gt;Attends regularly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>IV. RELATIONSHIP LEVEL</strong>&lt;br&gt;Seeks approval&lt;br&gt;Accepts feedback&lt;br&gt;Outgoing and friendly&lt;br&gt;Interacts with peers&lt;br&gt;Seeks reinforcement&lt;br&gt;Works productively 1-1&lt;br&gt;Give compliments&lt;br&gt;Receives compliments&lt;br&gt;Uses staff appropriately&lt;br&gt;Shares feelings with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>V. EXPLORATORY LEVEL</strong>&lt;br&gt;Asks questions&lt;br&gt;Seeks new situations&lt;br&gt;Makes suggestions&lt;br&gt;Tries new behaviors&lt;br&gt;Requests feedback&lt;br&gt;Initiates activities&lt;br&gt;Reveals feelings&lt;br&gt;Considers goals&lt;br&gt;Role plays&lt;br&gt;Expresses concern for others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>VI. MASTERY LEVEL</strong>&lt;br&gt;Makes decisions&lt;br&gt;Problem solves&lt;br&gt;Exercises good judgment&lt;br&gt;Sets treatment goals&lt;br&gt;Self-reinforces&lt;br&gt;Generates alternatives&lt;br&gt;Verbalizes spontaneously&lt;br&gt;Is able to relax&lt;br&gt;Exerts self-control&lt;br&gt;Takes notes/completes assignments</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>VII. ACHIEVEMENT LEVEL</strong>&lt;br&gt;Assumes self-responsibility&lt;br&gt;Completes tasks&lt;br&gt;Manages stress&lt;br&gt;Is able to abstract&lt;br&gt;Is self-motivated&lt;br&gt;Generalizes&lt;br&gt;Competent in ADL skills&lt;br&gt;Makes discharge plans&lt;br&gt;Seeks independence&lt;br&gt;Generates self-statements</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

**SUMMARY GRAPH**

![Graph showing summary of task levels](image-url)
### Table 3
**Educational Plan**

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Data</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to handle stress, depends upon children and halfway house. Lacks confidence in self. Uses self-defeating statements.</td>
<td>Expand social network. Look into independent living situation (low-cost housing?). Reinforce positive statements.</td>
<td></td>
</tr>
<tr>
<td>Mastery</td>
<td>Unsure of ability to problem solve and to make good decisions. At times has difficulty relaxing. Tends to put self down.</td>
<td>Schedule for problem-solving and decision-making classes. Help student generate self-reinforcing statements. Do 3x daily.</td>
</tr>
<tr>
<td>Exploratory</td>
<td>Hesitant to seek new situations or to incur risk due to past mistakes.</td>
<td>Give assignments in Exploring Community class that involve new situations and some risk. Reinforce with social praise.</td>
</tr>
<tr>
<td>Relationship</td>
<td>Relating well with peers, staff, and family.</td>
<td></td>
</tr>
<tr>
<td>Order</td>
<td>No significant deficiencies.</td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>No significant deficiencies.</td>
<td></td>
</tr>
<tr>
<td>Entry</td>
<td>No significant deficiencies.</td>
<td></td>
</tr>
</tbody>
</table>

with the client are considered. Judges (LSP staff) rated their familiarity with a client on a 5-point scale from “not at all” to “very” familiar with the client. TCL ratings show an interjudge reliability of .74 (p < .01) when the familiarity score is partialled out. Initial use of the Check List has revealed that exploratory level scores are consistently lower than those at the relationship level among LSP clients. This is not an unexpected development in comparing the sequencing of educational tasks faced by behaviorally disabled adults to those of children. It appears that, unlike children, LSP students are more experienced and skillful in interpersonal relations than in assuming the risks associated with behavioral experimentation. This observation led to reversing the sequence of the exploratory and relationship task levels on the TCL. In deference to an adult population, the label of the lowest level referred to as primary by Hewett was changed to entry level on the TCL.

The TCL assists LSP staff in identifying the functional educational task level or levels of each student and contributes to the articulation of an educational plan such as that displayed in Table 3. Class assignments, individual tutorials, case management methods, and medication evaluations and adjustments are elements of the psychoeducational treatment plan that relate to the behavioral skills deficits assessed by the TCL.

**Case Examples.** Table 2 illustrates the TCL of a 55-year-old divorced mother of six functioning well up to level 6, the mastery level, at which point her scores fall. J, the ex-wife of a prominent businessman in a small town, had successfully reared six children before her first hospitalization for manic-depressive illness. J rapidly progressed through levels 1 through 5 of the task hierarchy, demonstrating few deficiencies. But her recent multiple hospitalizations had undermined her self-confidence. Exploring new situations was difficult for her as were making decisions and problem solving. She had become dependent upon her older children and was unable to handle stress, yet she wanted very much to move out of a half-way house into her own living quarters and to become self-supporting. The stigma of being a “welfare” client was particularly demeaning to her sense of self. With input from the TCL, the psychoeducational plan illustrated in Table 3 was devised. Guided by this plan, the occupational therapist/teacher provided J with assignments in the Exploring Community class that entailed calling businesses for information, checking out bus schedules, and arranging for a class outing to an unfamiliar recreational facility. Building upon this success with increased self-confidence, J accepted the role of chair and organizer for a birthday luncheon and celebration for fellow LSP students. Problem Solving laboratory facilitated J’s recognition of the need to use medications if she was to remain out of the hospital. In all classes and activities, she was reinforced by both staff and fellow students for positive self-statements that gradually replaced her tendency to put herself down. Eventually she obtained a volunteer job and moved into her own apartment.

T, an intelligent 22-year-old youth, sustained brain injury in an auto accident. He demonstrated varied and severe behavioral problems and was functioning initially at the entry level as assessed by the TCL. He often came late to class, left early, was easily distracted, often disruptive, occasionally com-
bative, and generally had difficulty observing limits. His affect was frequently inappropriate and he especially tested the limits of the occupational therapy affiliates by approaching them in a whiny voice and offering the stereotyped greeting, “Do you love me?” The educational plan recognized T’s low attention span by limiting attendance to three classes per week. Appropriate responses were recorded and were reinforced by increased time with the therapist/teacher in an acceptable activity of T’s choice. Staying on topic was rewarded by allowing extra time at the close of each class for T to read one of his poems. Within 4 months, T was functioning at the order/relationship levels on the TCL; a specific new treatment objective was to measurably increase his receiving and giving compliments (identified as a low-frequency behavior by the TCL) in a variety of activity settings. This was effective in replacing the inappropriate remarks T made previously about himself or others. T’s long-range goal is placement in a work situation, an achievement-level task.

Subsequent educational plans developed with the aid of periodic TCL evaluations will work toward this objective.

An educational plan based on the TCL administered monthly, is developed for each LSP student as an aid in facilitating the learning of functional coping skills and activities of daily living. Assessment of the TCL is ongoing. At this point, we have found the instrument to be expedient and helpful in the relatively objective assessment of behavioral functioning as it relates to psychoeducational programming. The TCL has proved useful in identifying specific behavioral deficits and excesses, thus facilitating treatment goals and the specification of objectives.

Conclusion
The LSP has been evolving for several years toward conformity with the educational model presented here. Acceptance of the approach from both clientele and referring professionals has been excellent. Formal outcome studies demonstrating comparisons of this with more conventional treatment approaches remain to be conducted. Preliminary program evaluation data reported by Armstrong (18) and Armstrong et al. (6) are promising, however, and suggest that the approach is successful and ultimately will prove amenable to the rigorous evaluation of outcome so lacking in this field.

The role of teacher has been a fruitful one for occupational therapists at the LSP. The adaptation of Hewett’s educational task hierarchy for an adult population and the use of the TCL has facilitated this. The concept of psychiatric day treatment as a psychoeducational process based upon a combination of social learning theory and educational technology can be a useful alternative to conventional psychotherapeutic approaches. This model is consistent with occupational therapy’s basic philosophy of learning by doing. Our experience at LSP suggests that the psychoeducational perspective maximizes the contribution to mental health service delivery for which occupational therapists have been prepared.

REFERENCES
15. Hersen M, Bellack A: Social skills training for chronic psychiatric patients. Compr Psychiatr 17(4), 1976