The Directive Group:
Short-Term Treatment for Psychiatric Patients With a Minimal Level of Functioning

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This paper describes a three-level interdisciplinary group program for treating patients on a short-term psychiatric inpatient unit. Special emphasis is given to the lowest level group, the Directive Group, which addresses the needs of patients with a minimal level of functioning, a population that is usually neglected in terms of group therapy. The author developed the Directive Group based on her own clinical experience and later refined it using the model of human occupation as a conceptual framework. Therapists have modified and refined the program since its inception in July of 1977. The benefits and limitations of the program are discussed with applications for other health care settings.

Patients in short-term psychiatric inpatient units function at various levels and have a wide range of functional needs; they vary greatly in terms of their age, diagnosis, and background. This diversity presents great challenges to occupational therapy programming. There are relatively few resources published that address the problems associated with treating these patients in the limited time frame of the acute care unit. In addition, many acute care units employ only one occupational therapist so that there is no daily support from similarly trained personnel. Because the health care environment stresses accountability for staff positions, reimbursement, and professional autonomy, occupational therapy must not only offer a unique service to these patients within a limited time frame, but must also find effective ways to contribute and collaborate within an interdisciplinary team.

All inpatient psychiatric units provide some form of group therapy; their structure and content vary as determined by administrative factors and philosophical values (1). Brief hospitalization has accounted for improved social functioning and decreased rates of admission in some patients (2–3), but the specific forms of therapy that contribute to such benefits are not clearly defined. Based on a review of 10 years of group psychotherapy outcome studies, Parloff and Dies (4) recommend that clinicians resolve conceptual issues before proceeding with research questions. They suggest that the highest priority is to develop explicit definitions and descriptions of specialized forms and techniques of group psychotherapy.

This advice is appropriate for our field. Occupational therapy personnel in mental health are currently competing with many other professionals who use activities and lead groups. A recent survey found that 60% of the occupational therapists sampled use groups in all areas of practice (5). Our priority should be to specify what type of occupational therapy groups are best for which patients and to examine whether changes in behavior and improved functioning are due to therapists’ skills, techniques employed, duration of treatment, type of instrumentation, or theoretical assumptions.

Increasingly, short-term units are admitting more chronic psychiatric and elderly patients who, along with the acutely psychotic and organically impaired patients, are difficult to involve in the ward milieu because of their extremely disorganized, dependent, or disruptive behavior. During a brief hospitalization, these patients face the difficult task of reorganizing their behavior to learn or relearn the minimal skills necessary to perform routine daily activities.

In most settings these types of patients are treated...
with medication, structure, and individual therapy until they are sufficiently organized to join a psychotherapy group. Although some settings offer occupational therapy or activity therapy groups for these patients, this kind of treatment is not usually very important within the total group program. However, based on the author's experience, occupational therapists can expand their role in mental health by developing a framework for coordinating an interdisciplinary group program and taking a leadership position in treating the most disorganized patients on the unit.

This article presents an overview of a comprehensive group program developed on a short-term inpatient psychiatric unit and describes in detail the Directive Group, a specialized form of group therapy developed by the author for patients functioning the least well.

Beginnings of the Program

The new program was developed for the 34-bed inpatient unit of The George Washington University Medical Center. The unit offers a continuum of services, including day treatment and outpatient programs. Adolescent, adult, and elderly patients are admitted for evaluation and treatment of acute emotional problems. During a 2- to 3-week stay patients participate in a wide range of therapeutic services, including individual psychotherapy, primary nursing care, psychotropic medications, family therapy, and group therapy.

Nine years ago, perceiving program fragmentation and staff isolation, several staff members revised the original program. Using a developmental approach, we reorganized the existing groups to meet the needs of the patients functioning at different levels. The Directive Group, the most innovative part of the program, was created for the patients functioning at the lowest level. The following is a description of the program as it has evolved during the author's 6 years of coordinating it. Special emphasis is given to the Directive Group, which has since received public recognition (1) and withstood the test of time.

Research Support

Research supports the use of group programs for the remedial treatment of the acutely ill provided short-term treatment is part of a continuum of care (1). The most effective group programs and those most valued by staff members provide daily group therapy, monitor group composition, strive to decrease professional rivalry, and have an interactive focus (1).

In terms of specialized approaches for the minimally functioning patient, reviews of outcome studies generally agree that there is a lack of evidence to support the value of verbal, insight-oriented group psychotherapy for psychotic and schizophrenic populations (4, 6-11). Groups for this population are most effective when they rely on structured activity and reality-based approaches (6, 10). In fact, groups with intense interpersonal stimulation may be harmful (12). Furthermore, groups are more effective when combined with other forms of treatment, such as psychopharmacology and individual therapy (4). However, drugs and psychotherapy alone are insufficient for developing social and occupational skills (10, 13). This finding is important for occupational therapists promoting activity-oriented groups.

Theoretical Framework

Without a theoretical framework, the clinician lacks a coherent way to organize knowledge, ascribe meaning to observations, or predict outcomes. We used the model of human occupation, which describes individuals as complex, open systems who are in constant interaction with the environment and who maintain and change their behavior through action (14). We chose the model for several reasons. Since the model is based on general systems theory (15, 16), it is congruent with interdisciplinary views. At the same time the focus on occupational behavior delineates the scope of occupational therapy services and is consistent with the short-term unit goals of improving the patient's functioning and enabling him or her to return to the community. The model allows the therapist to integrate information from other professionals pertaining to such factors as the patient's environment or support system. Finally, the model enables the therapist to specify an organized approach to the diverse patient group in acute inpatient care.

We used the model in three ways. First, the model specifies a continuum of occupational behavior represented by three levels of arousal and accomplishment: exploration, competence and achievement (17, 18). Criteria for each of these levels were developed (19) and used to organize each group in the total group program. Second, the model serves to identify the variables necessary for assessing patient behavior and specifying treatment goals (20). Referral criteria were based on behavioral descriptions of the most typical patient problems addressed in each group and translated into the language of the model for consistency. Third, the model provides a way to conceptualize group treatment as the creation of therapeutic environments in which patients interact to learn about themselves and enact changes. The environment is created by titrating levels of arousal, enhancing internal control, stimulating interest and meaning in activities, and conveying expectations relevant to patient needs, goals, and roles (21).
Program Design

All groups in our setting are organized by three levels of arousal and demands for performance. The exploration level groups are organized at the simplest level of challenge to help severely disorganized patients develop basic process skills, perceptual motor skills, and communication/interaction skills. The group leaders select activities and organize the treatment environment; patients are required to participate in the scheduled group meetings.

Competence level groups are appropriate for patients who have basic skills but may need to integrate them into habit patterns. These groups are designed to help patients expand their skills and to identify goals, interests, and needs for meaning and action. As patients approach discharge, they begin to learn new ways to cope with problems experienced at home and in the community. Groups at the achievement level are designed to help patients integrate skills into daily life roles.

Table 1 illustrates how groups are differentiated by levels by each professional discipline. The purpose of the vertical dimension is to assure that the program has depth. Each level includes a number of groups, which are organized similarly but differ in content or focus. Therefore, groups are also planned to show variation along three horizontal dimensions (see Figure 1). The horizontal structure of the framework prompts consideration of the balance and range of groups. Together, the vertical and horizontal dimensions build a coordinated framework in which each individually designed group contributes to the group treatment program as a whole.

Referral Criteria

When patients are admitted to the unit, they are interviewed and evaluated by a psychiatrist and a nurse. Later, after meeting with the patients on rounds, in meetings, and informally, the interdisciplinary team members contribute to the master problem list and make referrals to groups. Each treatment group has a referral form itemizing specific referral criteria to match the patient’s level of functioning with the goals of the groups. In addition, patients are referred to groups whose content is relevant. For example, a patient with depression and a workaholic lifestyle is referred to a leisure awareness group, which has an overall goal of clarifying leisure values and increasing awareness of lifestyle choices.

The occupational therapy and therapeutic recreation staff assist members of the team to think clinically about the groups and make appropriate referrals. The referral criteria serve as an individualized initial assessment of patient functioning. Identified problems are translated into short-term goals and provide a way to measure outcome. The following discussion of the Directive Group provides an example of this assessment and treatment process.

The Directive Group

The Typical Patient

The Directive Group is designed for patients with varied diagnoses whose functioning is profoundly incapacitated. The group has included patients experiencing hallucinations, paranoia, catatonia, severe depression, organicity, hyperactivity, concrete thinking, or loose associations.

The model of human occupation provides a way of conceptualizing the dysfunctions of this diverse group of patients who have extreme difficulty functioning in the most basic of tasks and roles. They feel out of control, expect failure, avoid mastery experiences, and fear exploring the environment. They typically have difficulty identifying interests and goals.

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**Table 1**

<table>
<thead>
<tr>
<th>Level</th>
<th>Therapeutic Recreation</th>
<th>Occupational Therapy</th>
<th>Psychiatry/ Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration</td>
<td>Leisure Awareness</td>
<td>Assertiveness Training</td>
<td>Community Meeting, Supportive Group</td>
</tr>
<tr>
<td>Competence</td>
<td>Activity Planning, Evening Activity</td>
<td>Task Group</td>
<td>Supportive Group</td>
</tr>
<tr>
<td>Achievement</td>
<td>Leisure Awareness</td>
<td>Assertiveness Training</td>
<td>Task Group</td>
</tr>
<tr>
<td></td>
<td>Evening Activity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Figure 1**

*Occupational, Interpersonal, and Mind/Body Dimensions of Program Groups*
Their habits of self-care and time management are markedly disrupted. Although these patients may have had adequate habits prior to the acute episode, their current situation is characterized by extremely limited interpersonal and task-oriented skills.

**The Format of the Group**

The term **Directive** refers to the active and supportive way in which the group leaders elicit adaptive behaviors and structure the environment to assure maximum participation of all members. The purpose of the group is to assist patients in reorganizing their behavior to a beginning level of competence. In general, patients are ready to be discharged from the group when they actively participate and can sustain minimal interaction throughout the 45-minute session.

The group, consisting of 6 to 12 members, meets 5 days a week at a routine time and place. The sessions begin and end promptly to emphasize a realistic use of and attention to time. On the average, patients attend 10 to 15 sessions, depending on the length of their hospital stay and speed of recovery. Once referred, attendance is mandatory to ensure continuity of treatment. Regular attendance depends largely on the assistance of nursing staff, since most of the patients are initially too disoriented or confused to take on this responsibility.

The relationships and activities of the Directive Group occur in a playful arena, a safe environment, which encourages risk-taking in patients who are threatened by the possibility of failure (22). Patients are encouraged to move from passivity and internal preoccupation to goal-directed processes in which spontaneity and competence begin to emerge (23).

**Content of a Typical Session**

Each session of the Directive Group is complete within itself to accommodate the level of function and short stay of the patients. A session has four parts: orientation and introductions, warm-up activities, selected activities, and wrap-up.

The first few minutes are usually spent reviewing the purpose of the group and specific treatment goals. Members who have been in the group are relied on to explain the purpose of the group and give examples of activities they have enjoyed and found useful. Introductions are conducted to make patients realize that their presence is valued.

For example, a group session typically begins with a coleader asking a relatively experienced group member to help fill in the blanks on the blackboard. The board includes questions about the date, name of the group, its meeting time, its purpose, and the activities of the day before (or the previous weekend). Asking patients to call out the answers to the questions encourages them to focus on the activity and participate actively. This is usually followed by a balloon game in which each patient says the name of the person to whom he or she is throwing the balloon. The game is adapted by asking patients to choose a category, like cars or hobbies, and then to name items in that category.

The warm-up phase generally consists of 10 minutes of physical activity the complexity and vigor of which are based on individual capacities. Movement provides a simple, familiar, and shared experience without the stress of verbal interactions. Exercises also allow for participation in simple rule behaviors, such as taking turns and following instructions. For example, in a low-energy group, members seated in a circle are told to move as little as possible. The leader slowly lifts one finger and moves it up and down. As the members imitate the movement, the leader opens and closes his or her hand. Finally, both hands are in the act. By starting slowly and matching the pace of the group, more activity is gradually elicited from the patients. Soon a member agrees to lead a simple movement while the others follow.

The major part of the group session is spent in activities especially selected for each day. These may include a series of games, each lasting a few minutes, or one long activity. For example, a regular feature of the Directive Group is the decoration of a large monthly calendar, used as a tool to help members stay oriented to the day of the week and the month. Depending on the needs and interests of the group, the sequence of events roughly proceeds from movement activities to interaction with objects to interaction with people (24); the level of complexity increases from imitation to a few instructions to simple problem solving. Graded opportunities are available for leadership, decision making, expression of interests, helping others, and verbal interaction.

The last 10 minutes are spent in a verbal review of the activities and processes of the session. The leader lists on the board the patients' recall of the sequence of events, such as orientation at the board, name ball games, physical exercises, sit-down soccer, hangman, and the wrap-up. Then patients are asked to name the skills they used to perform these activities. With verbal structure, these patients are able to identify skills such as concentration, coordination, conversation, and having fun.

The wrap-up serves to attach meaning to the events of the group and provide feedback about each member's preferences and contributions. Because of the high patient turnover, group members must be helped to adjust to new members and say good-bye to old members during each session. A useful wrap-up activity is "Guess Who? " The patients answer questions like "Who was the first person in the group?" or "Who is wearing a red sweater?" or "Who laughed when we played sit-down soccer?" Such questions engage the patients' short-term memory, extend their attention, and create a supportive interactive focus.
The Coleaders’ Role

The group is co-led by an occupational therapist and a psychiatrist. The leaders provide ongoing training experiences for other staff members and student co-leaders.

Coleadership assures continuity of the group and consistency of meeting times. It provides security when a patient requires individual attention or assistance to leave the room in the event of out-of-control behavior. The severity of illness necessitates the presence of at least one other leader to counteract the patients’ powerful pull toward extreme passivity, disruptiveness, and disorganization. Coleaders also provide support for each other when the daily demands of the group for creative, patient, and individualized approaches become overwhelming.

Coleders plan activities, facilitate the assumption of group roles, and modify the structure of the group to meet the changing needs of the patients. Coleders must be flexible and able to adapt activities on the spot. For instance, based on the group’s level of attention, energy, and interaction on the previous day, the leaders plan a game of modified bowling. But the group shows no interest and does not respond to other alternatives offered. The leaders then engage the group in yelling “yes” and “no.” Breaking the action with humor gives patients a face-saving and empathic way to get involved.

As the main providers of feedback to the patients about the effects of their actions, the coleders encourage, cajole, limit, refocus, and challenge the group members. The main message is acceptance. There is a strong expectation that each member, when ready, will be successful and will be supported in all attempts to participate. Patients are offered choices whenever possible to enhance their sense of control and to encourage their expression of interests. The choices can be graded to offer progressively more control. For instance, patients can decide if they would rather play bean bag toss sitting or standing up; if they want to have relay races in a circle or by teams; if they would prefer one activity over another, like geography or the card game Uno; if they would like to make a method for keeping score; or if they want to suggest an altogether different activity based on their own experiences.

Physical Environment

Space is used to emphasize the expectations of participation. The room is fairly large and has tables and chairs that can be used as needed. There is a blackboard, storage cabinets, and a sink. Attendance is made clear by a daily list, which patients check off when they enter. The environment provides cues for role behavior, orientation in time, and performance.

Materials are used to engage patients’ interests and inclination toward activity. Care must be taken to select activities that are appropriate for the current low functional level of the patients but do not demean their self-esteem as adults.

Often word games allow patients to associate with the memory of more pleasant times and elicit responses that surprise everyone. For example, one day a group was playing an alphabet game in which each letter is matched with the name of a country with the corresponding first letter. When no one responded to the letter N, an elderly woman who was very depressed suddenly spoke up and said “Nepal.” Her accurate response was applauded by all.

By listening to the patient’s preferences during the wrap-up sessions and by observing patient responses throughout the sessions, leaders can develop a vast array of suitable resources. Other activities that have been used successfully include simple crafts (such as making a memo pad or small terrarium), parachute activities, basic food preparation, coloring adult designs, adapted common games (like balloon volleyball or wastebasket basketball), structured communication exercises, and memory games.

Individualized Goals

The most effective way to ensure the effective use of activities and interactions within the Directive Group is to individualize each member’s pattern of participation. Explicit and reasonable short-term goals are important for the patients as well as for the family members who may feel overwhelmed by the patients’ level of impairment. Confusion, anxiety, and concrete thinking make it difficult for these patients to conceptualize realistic goals for themselves. The coleders develop and review individual goals each week in staff meetings.

The Directive Group leaders identified a series of individual short-term goals that address the behaviors patients frequently exhibit in the group. The four main goals for the patients are (a) to participate in the activities of each session, (b) to interact verbally with others around the common tasks, (c) to attend the group on time and for the full 45 minutes, and (d) to initiate relevant ideas for group activities.

Specific steps have been delineated to help patients achieve these goals. For example, a withdrawn patient who has difficulty interacting verbally may first be given the goal to respond once to a question asked within the group. During the session the leader would be sure to provide the patient with an opportunity to answer a neutral question. The patient’s success in engaging may again be supported by other group members during the wrap-up by identifying patients who met their goal.

Patients who are paranoid or extremely disorganized may not even tolerate attending the group. For those patients, staying in the group for 5 minutes may be a reasonable first goal. If patients have to leave,
they are given support for the length of time they did stay and told they are welcome to rejoin the group as soon as they can.

A different kind of goal may be developed for an adolescent who has adequate skills to participate in group activities on a regular basis but complains about every activity, thus discouraging people from interacting with him or her. For example, a young man’s negativity is first accepted and then turned into a constructive contribution by giving him the goal to name at least one thing he did not like about the group during the wrap-up. It is likely that after a few days with such a paradoxical instruction (25), the young man will ask to mention something he liked, too. At this point he has taken some initiative. The next step would be to ask him to help lead an activity or make a suggestion.

Patients generally like having personal goals. Often they are written down for them on their own cards, which they show to their nurses or post on the doors to their rooms. The leaders consider the development and presentation of goals in the same way they analyze the use of games and other activities.

The positive feedback started in the Directive Group continues in other groups on the unit and in the community. Patients who meet the four main goals of the group are given a graduation certificate and are referred to other groups in the program. Some patients do not complete the program. These are patients who initially made substantial gains, but then failed to make further progress. They are given a certificate of participation and can be assessed for readmission to the group at a later date.

**Documentation and Outcome**

To monitor daily functioning, the patient’s performance in the Directive Group is assessed after every session using an ordinal rating scale, which corresponds to the four main goals of the group (see Table 2). A patient’s longest consecutive level of attention is rated from does not attend (1) to attentive throughout the entire session (5). The extent to which a patient participates in group activities and in verbal interaction is rated separately based on the amount of structure and support the patient requires. For most patients, initiation is the hardest response. Therefore, even slight indications in this area receive a high rating.

### Table 2

**Directive Group: Key Model Variables and Clinical Characteristics**

<table>
<thead>
<tr>
<th>Model Variables</th>
<th>Patient Problems</th>
<th>Referral Criteria</th>
<th>Group Goals/Individualized Goals</th>
<th>Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Subsystem:</td>
<td>Passive Confused</td>
<td>Unable to find room or meal tray</td>
<td>Participation in Activities</td>
<td>5 Cooperates actively in all group activities without assistance</td>
</tr>
<tr>
<td>Problems and Motor</td>
<td>Distractions</td>
<td>Unable to focus on a simple task for 5 min.</td>
<td>(showing active involvement)</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td>Hyperactive or slowed activity level</td>
<td>(focusing on activities)</td>
<td></td>
</tr>
<tr>
<td>Performance Subsystem:</td>
<td>Isolated Aggressive</td>
<td>Speaks infrequently</td>
<td>Verbal Interaction</td>
<td>4 Needs minimal assistance to cooperate actively in group activities</td>
</tr>
<tr>
<td>Communication/Interaction</td>
<td>Withdrawn Competitive</td>
<td>Monopolizes despite repeated feedback</td>
<td>(responding to question)</td>
<td></td>
</tr>
<tr>
<td>Skills</td>
<td></td>
<td>Makes inappropriate responses</td>
<td>(listening to others)</td>
<td></td>
</tr>
<tr>
<td>Habituation Subsystem:</td>
<td>Dependent Disoriented</td>
<td>Unable to stay in group for 5 min.</td>
<td>Attending Group (on time)</td>
<td>3 Needs consistent support and structure to assure involvement in activities (or demonstrates hyperactive involvement)</td>
</tr>
<tr>
<td>Habits</td>
<td>Disorganized</td>
<td>Has difficulty performing basic self-care</td>
<td>(dressed in street clothes)</td>
<td></td>
</tr>
<tr>
<td>Volitional Subsystem:</td>
<td>Unmotivated</td>
<td>Has difficulty identifying interests</td>
<td>Initiating Group Activities</td>
<td>2 Participates minimally</td>
</tr>
<tr>
<td>Goals</td>
<td>Resistant</td>
<td>Lacks goal directed behavior</td>
<td>(helping lead activity)</td>
<td>5 Attentive throughout entire session (45 min.)</td>
</tr>
<tr>
<td>Interests</td>
<td>Fearful</td>
<td></td>
<td>(explaining an instruction)</td>
<td></td>
</tr>
<tr>
<td>Personal Causation</td>
<td></td>
<td></td>
<td>(suggesting new idea)</td>
<td></td>
</tr>
</tbody>
</table>

*Individualized goals are shown in parentheses.

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Unit staff members are taught how to use the scale through participation in the group. By understanding the meaning of the scores, they can monitor their patients' progress and compare the individual participation of the patients in the group. In this way, small increments of change, not otherwise appreciated, can be noted. Additional information, such as monitoring effects from changes in medications or electroshock therapy, or indications of organicity based on a patient's responses within the group, is reported during team meetings and documented in the problem-oriented format in the patient's chart.

Using the rating scale, outcome measures for a 6-month period indicated that out of 146 patients, 129 (88%) improved their ratings on at least one of the four measures by 1 or 2 points. Over one half of the patients improved on at least two or three of the goals. About a quarter of the patients remained in the Directive Group until they were discharged from the hospital. These were generally the patients who required additional follow-up care in a nursing home or a day treatment program. Only a few patients (4%) appeared not to benefit from the group.

The behavior changes noted by the rating scale cannot be attributed only to the group because it is difficult to isolate the combined effects of medication, structure, and relationships. However, our clinical observation repeatedly revealed a marked difference between patient behavior in the group and elsewhere on the ward. The group is effective because it elicits and helps maintain more organized behavior.

Discussion

The comprehensive group program presented here can be the starting point for occupational therapists to analyze and reconceptualize other inpatient group programs. The systems approach integrates the special and unique contributions of each group and therefore has the potential for decreasing the professional rivalry that is typical of many inpatient group programs.

The group program gives patients an opportunity to reflect on and restructure their lives. Some patients increase their level of functioning to a new level, some return to their previous level of functioning, and some acquire enough basic skills to function in a transitional setting, such as a day treatment program, half-way house, or brief stays in the community.

A limitation of the Directive Group is that no follow-up has been done to determine, as the research suggests (26), that patients who attended the Directive Group are more likely to attend other groups because of their successful group experience. In our program, although no control group has been systematically studied, the Directive Group appears to enable patients functioning at minimal level to reorganize their lives faster than they could in other basic groups or with the help of medication only.

Conducting the group requires consistent, dedicated leaders and good cooperation with other staff members to help patients get ready for the group or to help them structure the remainder of their day. Interdisciplinary coleadership is recommended. Where this is not feasible, the alternative would be to have one identified leader and several rotating staff members or students. Based on our experiences, certain personality characteristics seem desirable in a leader. Patients respond best to leaders who are warm, enjoy being active and playful, and are not afraid of psychotic behavior. The leaders must be able to set limits in a supportive manner and be creative in developing goals and activities. It helps if at least one of the leaders is knowledgeable in group dynamics and psychopathology so that the meaning behind psychotic behavior is understood and appropriate interventions are made. The leaders have to guard against taking over and against being punitive, rigid, interpretive, or passive with patients to avoid the problems associated with countertransference.

During the author's 6 years of developing this group, certain principles emerged, which are recommended in starting a Directive Group. They are as follows:

- provide a predictable routine for patients through the organization of the group and sequence of events;
- develop realistic and individualized short-term goals for each patient;
- offer leadership and role models to patients for action, support, and collaborative interaction;
- create a playful arena which legitimizes the activities and interactions of the group and allows patients to develop skills and confidence;
- modify the physical environment and materials to foster patient participation and encourage spontaneity; and
- establish a baseline of patient group behavior, monitor daily progress, and document achievement of individual goals.

Within a supportive program, the Directive Group could be adapted to different patient settings. For instance, in a long-term care facility with chronically ill patients, the group would probably need a set duration of attendance before graduation so that the many patients at the same level could eventually attend. The Directive Group has been used successfully by other occupational therapists to help patients with head injuries, stroke, mental retardation, and chronic psychiatric problems, as well as for disoriented elderly patients in nursing homes. As part of a total treatment program, the Directive Group provides a first step toward self-direction.
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References