

The Psychoeducational Aspects of the Psychiatric Rehabilitation Approach

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INTRODUCTION

Historically, the treatment of persons with severe psychiatric disabilities has focused on causes and cures. The traditional intervention approaches have attended primarily to the client's symptoms or intrapsychic pains and conflicts. At times, these approaches have been guided by the assumption that rehabilitation is unnecessary if a client's symptoms can be prevented or reduced, or if the client can achieve therapeutic insights into the reasons for his or her difficulties. Many of these approaches have resulted in a reduction of symptomatology. Such a reduction has not, however, automatically led to improved rehabilitation outcomes, that is, a greater capacity to live, learn or work in a preferred setting (Anthony, Buell, Sharrat & Althoff, 1972; Ellsworth, Foster, Childers, Arthur & Kroeker, 1968; Gurel & Lorei, 1972; Strauss & Carpenter, 1974). For example, there appear to be no symptoms or symptom patterns which are routinely related to individual work

performance (Wilson, Berry & Miskimins, 1969) and little evidence to suggest that chemotherapy has direct effects on work performance (Engelhardt & Rosen, 1976). The field of psychiatric rehabilitation has emerged over the past twenty years as a response to the largely frustrated efforts of traditional treatment methodologies and deinstitutionalization policies to impact rehabilitation outcomes (Anthony, Kennard, O'Brien & Forbess, 1986; Farkas & Anthony, 1981).

This paper will present an overview of the psychiatric rehabilitation approach with specific attention to those components of the approach which utilize psychoeducational techniques. First, the basic rehabilitation model, and the psychiatric rehabilitation approach will be presented. Second, the research background for the psychoeducational techniques will be reviewed. Finally, the techniques themselves will be discussed.

Target Population

The target population of psychiatric rehabilitation are those persons who have become disabled due to psychiatric illness. There are several definitions of severe psychiatric disability which characterize this population, including the definition currently used by the U.S. National Institute of Mental Health

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(NIMH) (Stroul, 1984), the U.S. Rehabilitation Services Administration (RSA) definition of severe disability and Goldman's definition of the chronically mentally ill (Goldman, Gattozzi & Taube, 1981). Each of these definitions shares common elements, i.e., a *diagnosis* of major mental illness (e.g., schizophrenia, manic-depressive illness), which is of a prolonged *duration* (greater than two years), and a *disability* which significantly impairs role performance (e.g., student, worker, family member). It has been estimated that there are between 1.7 million to 2.4 million persons with severe psychiatric disabilities in the United States (Goldman et al., 1981).

Rehabilitation Model

The rehabilitation model, as practiced with severely physically disabled persons (e.g., people with quadriplegia, blindness, etc.) serves as a conceptual model for the basic goals and treatment process of psychiatric rehabilitation (Anthony, 1980). The basic philosophy of rehabilitation provides direction to the psychiatric rehabilitation process: i.e., disabled people need skills and support to function in the living, learning and working environments of their choice. Despite the differences between severe psychiatric disability and physical disabilities, the similarities provide a metaphor for psychiatric rehabilitation. Both groups of service recipients require a wide range of services, experience serious limitations in their role performance, may receive services for a long period of time and often do not experience complete recovery from their disabilities (Anthony, 1982).

Table 1 illustrates the concepts of impairment, disability and handicap which are applicable to both physical and psychiatric rehabilitation. The integrative works of Wood (1980) and Frey (1984) have brought conceptual clarity to these terms. As presented in Table 1, the impairment of structure or function can lead to decreased ability to perform certain skills and activities which, in turn can limit the person's fulfillment of certain roles. For example, an impairment might be the incapacity of the body to produce insulin for someone with diabetes. Diabetes may never result in a decreased functional capacity

for the person. Despite the fact that diabetes cannot yet be cured, a person with that disease may never experience a barrier or handicap that prevents his or her ability to live, learn or work wherever he or she may wish.

Typically mental health treatment has tried to develop interventions at the impairment stage. Somatic and psychological treatment efforts have attempted to alleviate the signs and symptoms of the pathology, such as thought disorder or loss of concentration. In general, treatment attempts are directed more toward minimizing sickness while rehabilitation is directed more toward maximizing health (Leitner & Drasgow, 1972). Eliminating or suppressing impairments, however, does not lead automatically to more functional behaviors. For example, chemotherapy may decrease a person's hallucinations. This may not allow the person to perform the skills necessary to hold a job — particularly if they never had those skills. Likewise, a decrease in disability does not lead to reductions in impairment. Learning the skills necessary to hold a job does not automatically lead to a reduction in hallucinations. Furthermore, chronic or severe impairment does *not* always mean a chronic disability or handicap. The impairment simply increases the risk of chronic disability and handicap (Anthony & Liberman, 1986).

Clinical rehabilitation focuses on improving the person's ability to function in everyday life, regardless of the specific impairment which may or may not exist. The assumption of clinical rehabilitation is that by changing a psychiatrically disabled person's skills or supports in their immediate environment, they will be more able to perform those activities necessary to function in specific roles of the choice (Anthony, Cohen & Cohen, 1984).

With respect to barriers which originate in the environment, psychiatrically disabled persons can be helped to overcome their handicaps through societal rehabilitation interventions (Anthony, 1972). Societal rehabilitation is designed to change the system in which the psychiatrically disabled person must function. Some examples of this type of system intervention are the development of alternative funding to create new housing for disabled and non-disabled persons and the development of

TABLE 1

The Focus of Rehabilitation

STAGE	IMPAIRMENT	DISABILITY	HANDICAP
Definition	Any loss or abnormality of psychological, physiological or anatomical function (resulting from underlying pathology)	Any restriction or lack (resulting from an impairment) of the ability to perform an activity in the manner or within the range considered normal	A disadvantage for a given individual (resulting from an impairment or disability) that limits or prevents the fulfillment of a role that is normal (depending on age, sex, social, cultural factors) for that individual
EXAMPLE:	Positive or negative symptoms of schizophrenia	Inability to follow directions on the job	Homelessness Job Discrimination
Interventions:	Clinical treatment (e.g., Psychopharmacology)	Clinical Rehabilitation (e.g., Functional Assessment; Skills Training; Support)	Societal Rehabilitation (e.g., Community Support; Consumer Advocacy; Vocational Rehabilitation policies)

Adapted from Center for Psychiatric Rehabilitation, 1984, (with permission).

regulations which mandate that educational institutions make reasonable accommodations to allow disabled students to participate in their classrooms. Clinical rehabilitations and societal rehabilitation intervention are not mutually exclusive (Stubbins, 1982). For example, changes were made in a vocational rehabilitation law in the United States, which established the principle of specifically requiring contractors who do business with the U.S. federal government to hire workers with disabilities (Stubbins, 1982). A person who suffers severe psychiatric problems is often in need of both assistance with society's economic and social limitations on their participation as a full citizen and in need of skill development and

support to overcome the psychiatric disability.

Psychiatric Rehabilitation Goal and Process

The overall goal of psychiatric rehabilitation is to assure that persons with psychiatric disabilities can perform those physical, emotional and intellectual skills needed to live, learn or work in the setting of their choice with the least amount of support from the mental health professions (Anthony, 1979; Anthony & Nemeck, 1984). The focus of psychiatric rehabilitation is, therefore, to help persons with severe psychiatric disabilities, successfully «choose», «get» and «keep» their preferred settings. The outcomes of a psychiatric

rehabilitation approach are measures of: 1) client behavioral change; or 2) client or society benefits (Anthony & Farkas, 1982). Such measures focus on whether or not clients can *do* anything differently in a particular setting as a result of their involvement in a psychiatric rehabilitation intervention and indicators of whether or not society and/or the client benefit from the rehabilitation intervention (e.g., client satisfaction, educational achievement, working status). The major methods by which these outcomes are accomplished, involve either teaching persons the specific skills needed to function effectively or developing community and environmental resources needed to support or strengthen their present levels of functioning (Anthony, Cohen & Cohen, 1983; Anthony & Liberman, 1986). The assumption of psychiatric rehabilitation is that by changing a person's skills and/or environmental supports, benefits will accrue both to the person and the society (Anthony, Kennard et al., 1986; Farkas, Anthony & Cohen, 1989).

TABLE 2

Phases of Psychiatric Rehabilitation

DIAGNOSIS

Overall Rehabilitation Goal
 Functional Assessment
 Resource Assessment

PLANNING

Assigning Priorities
 Determining Responsibilities for Interventions
 Monitoring Progress

INTERVENTIONS

Skill Development
 Direct Skills Teaching
 Programming Skill Use
 Resource Development
 Resource Coordination
 Resource Modification

There are three phases to the psychiatric rehabilitation approach. Rehabilitation Diagnosis, the first phase, enables the person

to choose a specific environment (e.g., living at home with their family). Only once the choice has been made does the diagnosis involve the person in an assessment of their critical skills and resources. The assessment identifies the skills and resources that they currently have or do not have in relation to being successful and satisfied in that chosen environment. The second phase of the approach, Rehabilitation Planning, enables the practitioner and the client to assign priorities to the deficits to be corrected and to identify the type of intervention which would best suit the particular deficit. The planning phase also involves assigning responsibility for the interventions and identifying timelines. The third phase of the approach, Rehabilitation Intervention, includes skill development, i.e., skill teaching, programming skill use, and resource development, i.e., resource linking, modification or creation of new resources (Anthony & Nemeck, 1984; Farkas, Anthony & Cohen, 1989). The core of the approach uses elements of Rogerian client centered techniques (Rogers, 1951) and human resource development (see for example, Carkhuff, 1969, 1983; Carkhuff & Berenson, 1976, 1977; Carkhuff, Berenson & Pierce, 1976; Friel & Carkhuff, 1974) to involve the person in making choices and increasing the likelihood of learning to act on those choices.

Contributions to an understanding of assessment and skill development techniques were made by behavioral analysis (see for example, Allyon & Azrin, 1965; Eysenck, 1960; Lovaas, 1964; Miller, 1959) together with the additions made by social learning theory (see for example, Bandura, 1969a; Bandura, 1969b; Krasner & Ullman, 1965; Meichenbaum, 1966; Paul, 1974) and lifespan developmental psychology (see for example, Erickson, 1968; Kohlberg, 1969).

While the psychiatric rehabilitation approach includes elements of all of these perspectives and is comprised of both interventions which seek to develop the client (i.e., skill development) and those which seek to develop the environment (i.e., resource development interventions), this paper will focus specifically on the psychoeducational aspects of psychiatric rehabilitation by discussing its major skill development interventions.

RESEARCH BASIS FOR PSYCHOEDUCATIONAL ASPECT

Research has provided the foundation for the psychoeducational techniques used in psychiatric rehabilitation. There are four basic types of research most relevant to the skill development or psychoeducational aspect of the psychiatric rehabilitation approach. These four types of research are:

1. Research analyzing the ability of persons with psychiatric disabilities to learn skills;
2. Research investigating the relationship between the skills of persons with psychiatric disabilities and their rehabilitation outcome;
3. Research investigating the relationship between skill development interventions and rehabilitation;
4. Research investigating the necessary components of skill teaching itself.

Ability to Learn Skills

Persons with severe psychiatric disabilities have problems in the intellectual areas of attention span, memory and concentration. In addition, the affective areas of anxiety, self control and particularly interpersonal functioning present difficulties in learning (Cohen, Ridley & Cohen, 1983). In developmental terms, a child with a psychiatric disability, vulnerable to attentional difficulties, may be further stressed by resultant peer rejection and social isolation (Asaranow & Goldstein, 1986; Cole & Krehbiel, 1984). This isolation then makes the learning process even more difficult. Further, the opportunities to practice interpersonal skills and other needed coping skills throughout the school years are often diminished because of the evolving cycle of learning difficulties, peer relationship difficulties and resulting isolation (Bellack & Mueser, 1986). In light of these barriers, a learning-oriented or psychoeducational approach seemed to many to be problematic. As early as 1974, however, Anthony and Margules reviewed studies which showed that persons with psychiatric disabilities could, in fact, learn a variety of useful skills. This review

(updated in 1981 by Farkas & Anthony) found evidence that physical, emotional and intellectual skills could be learned. Examples of such studies involve the skills of : personal hygiene (e.g., Weinman, Sanders, Kleiner & Wilson, 1970); use of recreational facilities (Harrang, 1967); physical fitness (Dodson & Mullens, 1969); interpersonal skills (e.g., Goldsmith & McFall, 1975; Pierce & Drasgow, 1969; Vitalo, 1971); socialization skills (e.g., Becker & Bayer, 1975; Bell, 1970); conversation and assertiveness (e.g., Hersen, Eisler & Miller, 1974; Finch & Wallace, 1977); problem-solving skills (Bedell, Archer & Marlowe, 1980); job-seeking skills (McClure, 1973) and general vocational skills (Shean, 1973). The body of research completed during the late 1960s and 1970s provided strong evidence that persons with psychiatric disabilities could learn skills.

Skills and Rehabilitation Outcome

The second body of research which provided the basis for the psychoeducational aspect of the approach was research linking skill learning with desired rehabilitation outcome. Anthony, Cohen and Farkas (in press) point out that most of the studies which have attempted to answer this question have focused on the relationship between work adjustment skills, interpersonal skills and vocational outcome measures. The results of these studies have been quite consistent. Work adjustment skills were found to be significantly related to future work performance (Bond & Friedmeyer, 1987; Cheadle, Cushing, Drew & Morgan, 1967; Cheadle & Morgan, 1972; Distefano & Pryer, 1970; Ethridge, 1968; Fortune & Eldredge, 1982; Griffiths, 1973; Miskimins, Wilson, Berry, Oetting & Cole, 1969; Watts, 1978). Whenever an overall measure of work adjustment skills was calculated, the total score was predictive of future work performance (e.g., Bond & Friedmeyer, 1987; Cheadle et al., 1967; Griffiths, 1973). Similar to these studies, ratings of interpersonal skills or social skills have been found to predict vocational performance (Green, Miskimins & Keil, 1968; Griffiths, 1974; Gurel & Lorei, 1972; Strauss & Carpenter, 1974). The consistent theme across these studies is that knowledge of social functioning can be used

to make inferences about clients' future vocational performance. In two of the few studies which investigated outcomes other than vocational performance, the focus was on hospital discharge. A significant relationship was obtained between ratings of life skills and discharge (Dellario, Goldfield, Farkas & Cohen, 1984). In other words, those rated as most skilled were most apt to be discharged. Another study found that among long-term psychiatric patients (average hospitalization period was 16 years), those who were given high ratings in life skills were also the ones who were identified as ready for hospital discharge, by both the hospital and the community, even though the lack of community resources resulted in their *staying in the hospital* (Farkas, Rogers & Thurer, 1987). Summarizing such studies, psychiatric symptoms have not been shown to relate to future work performance, while client skills do appear to relate. This suggests that an emphasis on the development of client skills can impact at least on future work performance and perceived readiness for discharge (Anthony, Cohen & Farkas, in press).

Skills Development Interventions and Rehabilitation Outcome

The majority of the studies of skill development are part of the behavior modification literature and do not focus on skills development with persons who have severe psychiatric disabilities (Hersen, 1979). Of those early studies undertaken with persons who have severe psychiatric disabilities, variability existed amongst the subjects in terms of which target behaviors were generalized, which target behaviors were maintained at the point of follow up and which techniques improved which behaviors (Hersen & Bellack, 1976; Jaffe & Carlson, 1976; Waldeck, Emerson & Edelstein, 1979). More recent studies have looked at specific teaching techniques and more specific outcomes. For example, many conceptual and experimental studies have been published on social skills training. This training is an attempt to (a) identify interpersonal dysfunction in the client's relationships, (b) identify specific social skill deficits, (c) examine the circumstances in which the dysfunction occurs, and (d) identify

the specific nature of the skill deficits. After this identification, highly structured educational procedures are used to address these deficits. The interventions focus on small units of behavior and emphasize a gradual approximation of the ideal with extensive rehearsal (Morrison & Bellack, 1984). In general, most studies of social skills training demonstrate effectiveness in reducing targeted specific social skill deficits in psychiatric clients. The efficacy of these interventions has usually been measured in pre-test — post-test and follow up role play assessments (Morrison & Bellack, 1984). The durability of social skills training has been questioned, although a number of studies report that the skills are often maintained over time (Monti, Curran, Corriveau, DeLancey & Hagerman, 1980). While social skills training has shown much promise (Lieberman, 1984; Lieberman, Mueser, Wallace, Jacobs, Eckerman & Massel, 1986) the observation has been made that it is most useful in the context of a comprehensive rehabilitation approach (Morrison & Bellack, 1984).

A number of vocational outcome studies have looked at the effects of training in specifically: job-seeking skills (Azrin & Philip, 1979; Eisenberg & Cole, 1986); decision-making skills (Kline & Hoisington, 1981) and occupational and work adjustment skills (Rubin & Roessler, 1978). Each of these studies reported improved employment outcomes for the groups of persons with severe psychiatric disabilities who received some form of skill training.

In summary, targeted skill development interventions do appear to have a positive impact on rehabilitation outcome.

Skill Teaching Components

While the research reviewed thus far indicates that clients can and do learn skills when are taught effectively, it is also clear that the components of effective teaching and the ability of the skills to be used in everyday life remains an issue. As Goldstein (1981) pointed out, there is a substantial difference between learning and performance. «Learning» asks the question — Can the client demonstrate the skill in a simulated environment? «Performance» asks the question — Can the client *use* the skill in

everyday life? Most skill development studies have focused on answering the first question. Anthony, Cohen and Farkas (in press) point out that the skill learning (or acquisition) versus skill performance (or generalization) issue is not unique to a skill development intervention. It has been estimated that the average generalization and maintenance rates for all psychotherapies combined is 14 percent (Goldstein & Kanfer, 1979).

Cohen, Ridley and Cohen (1983) reviewed the major problems related to teaching skills to persons with severe psychiatric disabilities and identified the important components of effective skills teaching. These include using a comprehensive methodology, learner involvement, and using follow-up techniques.

No single methodology of providing instructional information has been shown to be effective. Social learning theory (Bandura, 1969a) indicates the importance of didactic, modeling, role playing and feedback techniques when attempting to teach skills to persons with severe psychiatric disabilities. Educational literature (Authier, Gustafson, Fix & Daughton, 1981; Ivey & Authier, 1978; Lamb, 1976) underscores the importance of an instructional text, simulation exercises, structured discussion sessions and related didactic methods. Both sets of strategies are grounded in research. Both sets of strategies have been combined by Carkhuff and Berenson (1976) into a «teaching as treatment» approach. The concept of teaching as a preferred mode of treatment was based, in part, on the research of Pierce and Drasgow (1969) and Vitalo (1971) which focused on persons with severe psychiatric disabilities as subjects. «Teaching as treatment» includes the «tell», «show» and «do» strategies of social learning theories and structured materials utilized in the educational approaches. A comprehensive approach also includes repeated opportunities for guided practice («do») of individual segments of the skill to be learned, as well as opportunities to practice the entire skill (Bandura, 1969a; Sheffield, 1961) with specific feedback about the practice (Cohen, Ridley & Cohen, 1983).

Learner involvement is essential to effective learning. Repetition and practice do not ensure that the learner will incorporate the skill. If the

learner does not understand and desire the benefit from learning the skill, it is possible that the skill will be demonstrated in a simulated environment but less likely that the skill will be used. Lack of motivation is often reported as the reason that persons with severe psychiatric disability do not succeed. As Lewin said (1936), motivated behavior is a function of both the person and the environment. The teaching environment has to be organized to provide extrinsic reinforcement as well as to help the person discover the intrinsic reinforcement that accompanies performance. Learner involvement also appears to be related to the concept of «social facilitation» (Martens & Landers, 1969). Social facilitation is the effect that the presence of others has on a person's ability to learn. While low levels of anxiety in the presence of others seems to be helpful, high levels of anxiety do not. The implication for skills teaching with persons who have severe psychiatric disabilities may be that learner involvement is enhanced when individualized assessments are conducted to assess the person's learning anxiety and when the lesson itself is then either taught on a one-to-one basis or in a group depending upon the results of the evaluation.

Finally, learner involvement in setting goals and selecting the actual intervention itself maximizes the possibility of skill generalization (Cohen, Ridley & Cohen, 1983).

Providing follow-up to initial learning is essential to the eventual meaningfulness of the skills development intervention. If a person can only be taught to demonstrate the skill in a structured learning situation, then the usefulness of that lesson in terms of helping the person to reach his or her goal is seriously limited. Skill change must occur in the client's critical environment (Fishman & Lubetkin, 1980). In rehabilitation terms, the critical environment is the one in which the client has chosen to live, learn or work. Even if the skills are taught in the natural environment as one means of reducing the need to transfer learning, follow up to the learning phase is very important. In their review, Cohen, Ridley and Cohen (1983) summarize some principles of skill develop which enhance the possibility of generalization:

1. Use of natural reinforcers that are present

in the client's relevant or critical environment as a means to reward appropriate progress in training;

2. Provide support services in the relevant or critical environment as the client is learning the new skill;
3. Teach support persons how to reinforce client practice in the relevant or critical environment;
4. Gradually increase the delay in receiving the extrinsic reward;
5. Teach the skill in a variety of situations;
6. Teach variations of responses in the same situations;
7. Teach the rules or principles underlying the skill;
8. Teach self-evaluation and self-reward.

PSYCHIATRIC REHABILITATION SKILLS DEVELOPMENT TECHNIQUES

The Direct Skills Teaching Intervention (DST) developed by the Center for Psychiatric Rehabilitation (Cohen, Danley & Nemeč, 1985) was specifically designed to incorporate the research learnings about effective skills teaching. DST includes comprehensive methodologies, involves the learner in the process and follows up on the skills learned so that clients can not only acquire critical skills but also use these skills in their everyday life. Skills are viewed as a set of knowledge and behaviors that the client consciously uses or can choose to use for a specific purpose, under specific conditions, at some standard level of performance. The goals of DST then involve helping a client to learn the knowledge necessary to choose when and where to use the skill and to discriminate the level of performance or competence with which he or she is using the skill. In other words, DST does not seek to simply *shape* behavior in order to overcome a specific problem, but to develop expertise that can form the basis for generalization across situations.

There are four phases in the DST approach to skills development. These are: *Outlining the Skill Content*; *Preparing the Lesson*; *Involving the Learner*; *Following Up on Skill Use*.

Outlining the Content

Skill content is the knowledge necessary to perform a skill. In other words, it includes a definition of what the skill is, how it might be of benefit to the learner, what the specific skill behaviors are and the appropriate condition for use of the skill. The need for the skill itself is identified during the Rehabilitation Diagnosis process (i.e., choosing a specific environment in which the client wants to live, learn or work, assessing the skills and supports critical to the client's success and satisfaction there). In order to develop an effective skill content outline, the skills teacher has to understand the learning needs of the individual client(s) who will be learning the skill, as well as understand the *critical knowledge that is involved in successful performance of the identified skill*. This phase of the DST process is one of the ways in which the intervention distinguishes itself from other types of skill development. Many other types of skill development teach standard content for a standard group of skills (e.g., personal hygiene, social skills, budgeting). An effective teacher will have the ability to create the necessary knowledge for *any* skill that is assessed as critical — be it emotional, intellectual or physical. For example, if a client, Joe M., wants to live at home with his or her elderly parents, the skill of «Offering Support» to them may be critical in not only keeping the peace but in assuring that his parents have sufficient energy to continue to provide Joe with a safe place to live. Teaching is focused on the individualized critical needs of specific clients who wish to live, learn or work in specific settings.

Preparing the Lesson Plan

The basic techniques of «tell», «show» and «go» are incorporated into a structured and organized lesson plan. The actual content depends a great deal on the learner's previous experience with this skill, where, when and with whom the skill will be used, why the skill is important to the learner, and how much support is available for the learner to practice and master the use of the skill. It is possible for four clients to be grouped together, for example, because they all need to learn the skill of «Offering

Support». They may, however, vary greatly in terms of the context in which the skill must be used. The lesson planning phase then, incorporates not only the important content of the skill, but also the context for its use by the individual learner (if teaching is done one-to-one) or by the group (if teaching is done in a classroom setting). The structured systematic activities of the lesson plan is based on methods developed by Carkhuff and Berenson (1976). The activities allow the learner to connect his or her experience with the content being introduced; understand the skill as a whole; learn knowledge about each subunit or skill behavior of the skill; observe a demonstration of each skill behavior; practice each skill behavior and then put all the pieces together in an integrative exercise. Each exercise is followed by feedback designed to increase the learner's ability to discriminate his or her own performance as well as to identify corrective measures for subsequent practices. Whenever possible, the exercises and feedback processes are conducted in the relevant or critical environment itself. The development of such an extensive lesson plan before the lesson, frees the teacher to then focus totally on the important interpersonal relationships with learners.

Involving the Learner

Even well-planned lessons and well-structured activities cannot ensure that the learning process will actually occur. The strength of the teacher-learner relationship determines to a large extent the degree to which the learner actually learns. Good interpersonal skills (e.g., the ability to demonstrate understanding, to live clear directions, to share divergent assessments of performance) and the ability to modify the lesson in the moment based on accurate assessments of the learner's participation and progress are critical. Modifying the lesson may involve altering the place, changing the examples to fit the learner's style of learning, or substituting the types of practice exercises with ones that address specific learning problems.

Follow-up

DST ends with an assessment of the likely

barriers that the learner may have that prevent him or her from actually using the newly acquired skills on an everyday basis. These barriers may include the learner's lack of confidence in his or her ability, the lack of knowledge about how to apply the skill in a specific situation, the lack of resources to use the skill or the lack of forethought or planning to use the skill. For example, Joe may not be able to use his skill of Offering Support to his parents because when the moment comes for him to really do it, he may feel frightened and block out everything that he learned (lack of confidence). He may also find that when he tries to offer support in a specific situation (for example if one of his elderly parents falls down) he may not have a car that he can offer to use to take them to the hospital (lack of resource). The DST approach involves developing a series of steps that will help Joe to address each of his anticipated barriers to offering support at home. The program will include techniques that help to promote action — timelines, rewards, monitoring systems. The Psychiatric Rehabilitation approach may involve family members (if they wish involvement) in providing the follow-up by teaching them how to support the client's skill practice. In many ways, the follow-up activities are the most critical. Many skills that are learned are never used. Some learners experience high stress in learning new skills. Without follow up activities and the resultant support that it provides, skill teaching alone cannot ensure that the learners will be successful.

In summarizing the DST approach, it is important to recall that only those skills which have been assessed as critical to the client's wish to live, or learn or work in a specific setting are included in the skill development interventions. Further, only those skills which have been assessed as absolutely not in the client's repertoire are actually taught. Skills that are known, but not used successfully, are improved using follow-up or programming techniques. The DST interventions, along with the follow-up interventions then addresses the special learning needs of persons with psychiatric disabilities, develops new skills in the learner's repertoire, and addresses performance generalization in terms of the

learner's use of the skills in the environment in which they have chosen to live, learn or work. The interventions can be used with groups or on an individual basis. It can be used in a formal classroom setting or in the natural environment. The length of the lessons, the number of repetitions, the sophistication of practice sessions, the number of support persons involved, the length of follow-up time are all factors that vary with the individual learner, their strengths and deficits and their desired rehabilitation outcome.

SUMMARY AND CONCLUSIONS

Psychiatric Rehabilitation is an approach which utilizes the principles of physical rehabilitation with psychotherapeutic techniques. It incorporates both psychoeducational techniques (skill development) and environmental modification (resource development) to assist persons with severe psychiatric disabilities «choose», «get» and «keep» places to live, learn or work, with a minimal amount of professional intervention. The psychoeducational aspect of the approach bases its techniques on a foundation of research in psychology and education which indicates that clients can learn skills, regardless of symptomatology and that skill development techniques can impact rehabilitation outcome. While Direct Skills Teaching with its follow up techniques of Programming Skill Use, uses some methods similar to other interventions (for example, behavior modification, social skills training, psychotherapy), it is none of these. It differs in purpose and specific techniques. Its purpose is to help clients develop specific expertise in a area of competence unique to them and critical to «getting» or «keeping» an environment they have chosen. Its techniques include a complex variety of didactic, modeling, experimental, follow-up activities in the context of a strong interpersonal relationship that permits a systematic intervention to be delivered in a flexible, highly individualized manner. The Psychiatric Rehabilitation approach begins and ends with the client's perspective and partnership. The psychoeducational aspect enhances this

philosophy by providing the basis for growth-oriented techniques in the context of a teacher-adult learner relationship even for those persons who have the most severe psychiatric disabilities.

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ABSTRACT¹

Psychiatric Rehabilitation is an approach which

utilizes the principles of physical rehabilitation with psychotherapeutic techniques. It incorporates both psychoeducational techniques (skill development) and environmental modification (resource development). It includes a complex variety of didactic, modeling, experimental, follow-up activities in the context of a strong interpersonal relationship that permits a systematic intervention to be delivered in a flexible, highly individualized manner. The Psychiatric rehabilitation approach begins and ends the client's perspective and partnership. The psychoeducational aspect enhances this philosophy by providing the basis for growth-oriented techniques in the context of a teacher-adult learner relationship even for those persons who have the most severe psychiatric disabilities.

RESUMO

A Reabilitação Psiquiátrica é uma abordagem que utiliza princípios de reabilitação física associadas às

técnicas psicoterapêuticas. Incorpora técnicas psicoeducacionais (desenvolvimento de habilidades) e modificação ambiental (desenvolvimento de recursos). Inclui uma variedade complexa de actividades didácticas, de modelação, experienciais e de seguimento no contexto de uma forte relação interpessoal, permitindo que uma intervenção sistemática seja feita de uma forma flexível e altamente individualizada. A abordagem da Reabilitação Psiquiátrica começa e acaba com a perspectiva do cliente. Os aspectos psicoeducacionais acentuam esta filosofia, fornecendo a base para técnicas orientadas para o desenvolvimento no contexto de uma relação professor-adulto em aprendizagem, mesmo para aqueles com as mais graves dificuldades psiquiátricas.

¹ O Abstract e o Resumo são da responsabilidade da Redacção.