A Program of Life-Skills Training through Interdisciplinary Group Processes

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The interdisciplinary group processes/life-skills training program has been a consistent and systematic psychotherapeutic offering of the psychiatry service of the Veterans Administration Medical Center in Augusta, Georgia, since 1979. Current group offerings consist of 13 specialized groups. Research findings suggest that a variety of the life skills can be acquired within a relatively short period of time. There is evidence that this comprehensive program of life-skills training is effectively and efficiently utilized with a population of hospitalized psychiatric patients.

The interdisciplinary group processes/life-skills training (IGP/LST) program is a psychoeducational training program which was developed at the Veterans Administration Medical Center (VAMC) in Augusta, Georgia. The training program is a holistic care model in that it incorporates the social, physical, spiritual, and psychological domains of health care as prevention and remediation of problems. This program, like other psychoeducational models, is based on the premise that treatment must be rapidly and effectively focused on assisting individuals to develop or to improve specific life skills (Authier, Gustafson, Guerney, & Kasdorf, 1975; Gazda & Brooks, 1980). Fundamental to this approach is the identification of coping skills and therapeutic strategies for improving these skills in persons with psychological or emotional problems.

The IGP/LST program is a departure from the medical treatment model from the standpoint that it utilizes multiple impact training, a model for teaching/training in life skills to patients with psychiatric

conditions. According to Gazda and Powell (1981), multiple impact training is not therapy in the traditional sense. As the term implies, the impact is multiple, but the multiple interventions are not necessarily different varieties of traditional therapy. More precisely, the interventions involve simultaneous teaching/training in those life skills, found deficient or lacking in clients. Life skills are the life-coping skills consonant with the developmental tasks of the basic human development processes, namely those skills necessary to perform the tasks for a given age and sex in the following areas of human development: psychosocial, physical-sexual, vocational, cognitive, moral, ego, and emotional.

History

The IGP/LST program that was implemented five years ago at the VAMC is an outgrowth of an interdisciplinary group process program begun nine years ago. A clinical nurse specialist (the author) and a clinical psychologist recognized a need for the staff to make a concerted effort for the purpose of developing a systematic plan for providing group therapy and for teaching group process theory and techniques. While some staff were experienced group therapists, others were leading groups with little or no preparation. Some therapists had a theoretical framework for their group psychotherapy; many did not. Through observation of groups it was found that leadership styles varied with the personality of the leader. It was difficult to identify group process theory and principles in practice. Premature self-disclosure seemed to be the most important single criterion for determining lack of success of a group session.

Since there was no evidence of research on groups, it was impossible to determine if there were any therapeutic outcomes from these ventilation groups. The monopolistic or silent member was frequently the focus of the groups. Examining group membership over a period of time revealed many group repeaters. The recycling effect promoted rehashing of many of the same issues. Since patients talked more about their disease entities than about their problems, it was impossible to assess any positive effects of groups. It was consequently open to question whether any learning took place in such groups.

One factor that influenced the lack of systematic group offerings in the early 1970s was that psychiatric treatment at the VAMC was geared toward crisis intervention and long term psychiatry rather than being programmatically based. Thus, it was felt that more emphasis needed to be placed on group psychotherapy as a primary modality of treatment instead of treating it as an incidental ward activity. An inter-

disciplinary group with representatives from social work services, the psychology service, nursing service, psychiatric service, chaplain service, and occupational therapy service became the core team for writing and implementing a group process program. A counseling psychologist from a nearby university served as consultant to the team.

The experienced interdisciplinary team launched a program that was designed to offer systematic group therapy, train staff, and perform research. Human relations development training, which was the first specialized group offered, has continued to be the underpinning of the IGP/LST program. Relaxation therapy, reality therapy, transactional analysis, and an activity group were offered during a 16-week period. The basis for selection to the specialized groups was an evaluation group that met four times a week. After a minimum of four sessions, individuals were referred to a specialized group that enabled them to work on their chief problem areas. During the first year the core team staffed both the screening group and specialized groups and was receiving an average of 50 consultations per month.

Because of demands for additional groups and an increasing number of program activities, it became necessary for three staff members to serve in coordinator roles. Assertiveness training, reality problem solving, alcohol counseling, and vocational self-actualization were added to the group offerings.

The IGP/LST program fulfilled vital treatment functions as an approved station treatment program; however, the program was deficient in several ways. The coordinators and the consultant recognized the fact that individuals who are experiencing difficulties (assumed to be nonorganic) in functioning at home, on the job, and/or socially are lacking in one or more basic life skills. The most potent form of psychological assistance appeared to be to teach life skills to individuals with debilitating deficits in one or more (usually more than one) generic or basic life skills. Because staff members' assignments often require them to be generalists, they frequently do not have the time to develop their special interests and skills. Thus, it was felt that professional staff who have specialized skills should be given the opportunity to develop their area(s) of expertise.

Trainers

The IGP/LST staff is a textbook example of an interdisciplinary treatment team. There is an *esprit de corps* among the trainers. The nurses, psychologists, chaplains, recreational therapists, corrective therapists, social workers, dietitians, and occupational therapists have

formed a team amalgamation that has brought about change in the delivery of psychiatric treatment at the Augusta VAMC. The university consultant has served as encourager, resource person, active participant, adviser, and excellent role model. The coordinators' varied professional experiences as well as their mutual respect have contributed to their leadership effectiveness. Voluntarism, which is the chief method of securing staff, has seemed to strengthen the solidarity of the program. The camaraderie among the trainers has resulted in the development of a cadre of staff who have further expanded the treatment/training program.

Life-Skills Groups

The IGP/LST program now consists of 13 groups. These include interpersonal communications/relationships, assertiveness training, rational-emotive therapy, exploring leisure time, physical fitness, weight management, purpose-in-life, reality-oriented problem solving, stress awareness, yoga, relaxation, vocational development, and the introductory and screening group. According to a recent study (Brooks, 1984), the four generic life-skills areas are: interpersonal communication and relationships, problem-solving/decision-making, fitness/health maintenance, and identity development. These four generic life-skills areas are practiced in the settings of family, job, school, and community.

Certain life skills may be taught more effectively and efficiently in sequence, while others are more effectively learned concurrently. Reality-oriented problem solving and the growth group should precede all the life-skills groups when patients have not been able to identify their problems through the interdisciplinary screening process. Assertiveness training and rational emotive training should typically follow interpersonal communications/relationships skills training. Relaxation training, stress awareness, and yoga occur concurrently with physical fitness and weight management or follow them. Leisure time training should be concurrent with vocational development or follow it.

The trainers of life-skills groups have developed instructional modules for each of their groups. Table 1 outlines the 12 sessions of the interpersonal communications/relationships module, while Table 2 describes the objectives and procedures for conducting this module. Trainers utilize didactic lectures, role playing, videotapes, interviews, modeling and demonstrations. The effectiveness of most groups is systematically assessed. Members receive pre- and post-test batteries of questionnaires. Comments from trainees and staff are elicited to deter-

mine the progress of trainers. Interviews, videotaped constant role interactions, and video feedback are also useful as measures for training. Evaluation of outcomes is measured by self-report questionnaires, performance on written material and experiential exercises, and participation in discussion sessions. Behavioral objectives are evaluated at the conclusion of the training.

The most effective procedure for screening individuals for the life-skills groups has been the *introductory/screening group*. Generally patients attended at least four sessions. Through the screening process, patients' strengths and deficits were identified and a more effective referral system became operational. This procedure served to prepare patients for the specialized groups. Because of lack of staff to lead the introductory/screening groups, they were temporarily discontinued.

TABLE 1—Module for Improved Interpersonal Relationships and Communication

Sessions	Interpersonal Communication Life Skills
Lesson I	Overview Introduction to training Pretest Discussion of ineffective styles of communication Definition of help, helpee, helper
Lesson II	Self-report questionnaire Setting training goals Exercise in perceiving feelings Practicing good attending behavior Responding to content of helpee's requests
Lesson III	Perceiving and communicating warmth, empathy, and respect Videotape Modeling Practice Video feedback
Lesson IV	Continuation of perceiving and communication facilitative skills of warmth, empathy, and respect Discussion of global scale
Lesson V	Perceiving and communicating concreteness, genuineness, and self-disclosure Videotape Modeling Practice Video feedback

(table continues)

As a result, the ward team staff began to screen most of the patients for life-skills training. Staff members are familiar with the life-skills training groups available and they evaluate patients' needs based on their deficits in one or more of the life-skills areas. In the screening process, patients are encouraged to appraise their life-skills strengths and weaknesses and to volunteer for those training groups in which they show deficiencies. Participants for specialized life-skills training groups are selected by ward team staff consultation, patient requests, and trainer referrals. Individuals who are highly anxious, actively psychotic, or markedly confused are excluded from the groups.

The introductory/screening group was recently reactivated under the leadership of staff members from the social work and psychology

Table 1 *continued*

Lesson VI	Continuation of practice of concreteness, genuineness, and self-disclosure Modeling Practice Video feedback
Lesson VII	Perceiving and communicating confrontation and immediacy Discussion Videotape Modeling Practice Video feedback
Lesson VIII	Continuation of practice of action dimensions, confrontation, and immediacy
Lesson IX	Review of all eight dimensions Videotape of all eight dimensions Modeling Practice
Lesson X	Continuation of practice utilizing the helping model Video playback Using global scale Problem solving
Lesson XI	Problem solving Identifying a problem Outlining a course of action
Lesson XII	Evaluation of goals Self-report questionnaire Posttest Certificates

TABLE 2—Life-Skills Group

I. *Name*: Interpersonal Communication Life-Skills/Relationships Group

II. *Purpose*: To teach individuals how to attend, listen, and respond effectively to other persons who seek to engage in conversation with, to interact with, or to seek help from them.

III. *Objectives*:

A. The trainee shall, during a five- to ten-minute role play, in which the trainee serves as helper:

1. Demonstrate consistent appropriate attending behavior,
2. Demonstrate responses to content and feeling on an interchangeable level, and
3. Give one or more responses that exceed the interchangeable level.

B. The trainee shall, during an extended interaction, in which the trainee assumes the helpee or help-seeker role:

1. Actively seek help,
2. Volunteer personally relevant feeling and content as part of self-exploration,
3. Suggest options or a plan related to problem solutions.

IV. *Procedure*:

A. Selection of trainees/group members: Members are selected for interpersonal communications life-skills training who are having difficulty relating to family members and significant others. These problems of communication are illustrated in such things as difficulty in listening for feelings, improper attending, cross-transactions, and withdrawal.

B. Group size: Ten to twelve.

C. Schedule: Training groups meet four times a week for one and a half hours over a three-week period.

D. Description of training: Training follows the model of Gazda, et al. (1975) adapted from earlier work of Carl Rogers, Charles Truax, and Robert Carkhuff. This model is described in G. M. Gazda, R. P. Walters, and W. C. Childers *Human Relations Development: A Manual for Health Sciences* (1975).

In the Gazda, et al. model, training includes the use of lectures on the essence of the model, given live or from videotape. Trainees spend most of their training time practicing appropriate attending, listening, and responding skills with each other. These skills are modeled by the trainers, and trainers also monitor trainees' practice. Video tapes of practice sessions are analyzed by trainees and trainers.

services. The purpose of the reactivated group is to screen some patients for the specialized life-skills groups and to provide experience for low functioning patients in a small group setting to ready them for successful participation in higher level groups. It is expected that individuals will identify life-skills deficits that might be remediated by referral to one or more of the specialized groups. Individuals are referred to the specialized groups appropriate to their needs and their readiness for training. They are afforded the opportunity to learn basic attending skills, self-disclosure, feedback, and problem identification and clarification skills that allow them to make maximum use of the higher level skills groups. Because of the nature of this introductory group and the fact that it is open-ended, as many as 15 group members may attend.

Assertiveness training is designed to teach the individual to think, feel, and act more assertively. The ultimate goal is to empower the individual to be more effective at constructively resolving interpersonal conflict. Trainees are assisted in differentiating between passive, aggressive, and assertive interactions. They learn to recognize their rights and to demonstrate assertive responses in brief interactions. The group, which meets for two weeks, usually consists of 12–15 trainees.

The general purpose of the *rational emotive therapy* group is to decrease depression and anxiety (self-blame), hostility (blame of others or the world around one), and irrational behavior by decreasing irrational thought patterns and beliefs and replacing them with more rational ones. Group members are taught skills that will help them to observe and recognize their irrational beliefs and thought patterns, to understand the relationship between their irrational beliefs and their emotional and behavioral problems, to challenge and dispute their irrational thoughts and beliefs, to learn to replace their irrational thoughts with more rational ones, and to learn to act upon their new, more rational beliefs instead of upon the irrational ones. The group meets for three weeks and is generally composed of 8–10 trainees.

The purpose of the *reality-oriented problem-solving* groups is to facilitate the development of insight into the emotions and behavior patterns of group members and to help them to develop more satisfying means of dealing with their problems. The trainer creates a supportive climate in which group members bring up personal problems and concerns. They are encouraged to explore their feelings around these concerns and are confronted with the need to take responsibility for their life situations and behavior. Feedback is provided through comments of other group members and through viewing of the videotapes. Role playing is used to increase awareness of specific instances. This open-ended group

usually consists of five to eight members and affords individuals who have attended other life-skills groups an opportunity to practice their newly acquired skills.

The *purpose-in-life* group is designed to assist veterans in determining the meaning in their life and in relating this to the reduction of problems such as loneliness, anxiety, grief, loss of self-worth, and depression conditions that are frequently associated with a lack of purpose in life. The group is led by chaplain service staff members who teach patients problem-solving skills focusing on the behavioral dimensions of anxiety, loneliness, grief, loss of self-worth, and depression. The training model of Crumbaugh (1971) serves as the foundation of this group.

The general purpose of the *stress awareness* group is to teach the individual ways to become attuned to his or her stress level, to engage in preventive exercises, and to make sound decisions that will aid in the management of stress. Upon completion of stress awareness training, trainees will have identified causes of stress in their lives and their reactions to them and will have participated in various stress reduction exercises such as yoga, progressive relaxation, autogenic training, and guided imagery. They also explore the relaxation response to control the fight or flight reaction, learn how to do physical exercises to reduce the effects of tension headache, a stiff neck, shoulder and back tension, and explore lifestyle changes that can reduce the effects of the causes of stress in their lives. During the two-week course of training the trainer demonstrates and verbally leads individuals through the use of yoga postures and controlled breathing techniques.

The *physical fitness* group enables individuals to develop the knowledge and skills necessary to perform proper physical exercise. Each veteran involved in this group receives special instruction, training, and guidance in such areas as: physical exercise and its value in achieving and maintaining good physical health; techniques and training tips used in exercise routines; and the exercise value of various recreational activities. Each participant is closely supervised and monitored during the initial sessions. Increased independence is stressed as trainees become more knowledgeable concerning the various aspects of their training. Individuals are encouraged to continue their involvement in some form of physical exercise after discharge from the program. The small group consists of eight members and meets five days a week.

The *weight management* group permits individuals to develop and apply the knowledge and skills necessary to make wise food choices. At the completion of nine classes the participants recognize the benefits of a proper diet to good health and well-being. They are able to describe a nutritionally adequate diet as related to weight control and the evalua-

tion of proper and improper weight loss programs. The trainers utilize behavior modification techniques in order to get the members to achieve their desired weight loss.

The purpose of *relaxation training* is to assist persons to attain a state of increased physical relaxation during their waking hours and to help them learn how to fall asleep easily at night. The training thus works to alleviate anxiety and inappropriately high physical tension in response to stress. Trainees learn to produce relaxing mental visual images, to discriminate between states of muscular tension and relaxation, to readily sense muscular tension in early stages, and to induce in themselves states of physical and mental relaxation.

The group devoted to *exploring leisure time* is designed for the primary purpose of teaching individuals ways of utilizing their free time constructively. Upon completion of the two-week training group, individuals learn the need for balance between work, leisure, and sleep, choose social events and activities to meet their needs, become aware of available resources for recreation, and evaluate their own leisure activities and plans.

The purpose of the *vocational development* group is to assist trainees in making appropriate occupational choices, developing job-seeking skills, and learning effective employee relationships. Individuals learn resources for seeking jobs, practice effective job interview skills, discuss desirable work habits, and focus on employer-employee relationships needed to resolve critical incidents.

The *growth* group is designed to encourage members to accept responsibility for themselves and their behavior, to learn to express feelings appropriately to others, and to give effective help to group members. The group provides a fairly nonjudgmental and supportive atmosphere in which individuals can strive toward increased insight and increased self-esteem. Members focus on interpersonal interactions of both a confrontive and supportive nature to facilitate recognition and acceptance of responsibility for personal problems. This group affords opportunity for trainees of specialized groups to practice their newly acquired coping skills.

Research on Life-Skills Groups

The earliest study conducted on the effectiveness of the IGP/LST program focused on human relations training for inpatient peer-helpers (Balzer, 1974). The objective statistical data collected immediately following the study failed to demonstrate that such training was therapeutically significant in comparison with the effects of con-

ventional methods of treatment. The descriptive data, however, strongly suggested evidence of greater therapeutic gain for the experimental groups. The capstone of the study was that four patients who completed human relations training were able to function as coleaders with professional staff in group therapy.

In a study conducted by Powell and Clayton (1980), positive effects of life-skills training, particularly interpersonal communication, were evident two years after training. The experimental group also had 50% fewer hospitalizations and were more likely to be involved in productive activities.

May (1981) studied the effects of life-skills training utilizing a multiple impact training model, i.e., concurrent training in more than one life-skills area. Training was conducted concurrently in interpersonal communication, purpose-in-life, and physical fitness/health maintenance. The control group received traditional psychiatric treatment. Patients participating in the two-week program of life-skills training demonstrated significantly higher ratings of interpersonal communication and meaningful purpose in life than did patients in the control group. Additionally, the study suggests that a comprehensive program of life-skills training can be effectively and efficiently utilized with a population of hospitalized psychiatric patients. A two-year follow-up indicated, however, that neither skill-based training nor traditional insight-oriented therapy emerged as superior to the other on measures of rehospitalization rates, employment, self-reported diet and exercise patterns, and patient satisfaction. The limited number of subjects who could be contacted on follow-up (32% of the experimental population, 54% of the controls) raises questions about the representativeness of this sample in comparison to the original study population.

Conclusion

This program is an outgrowth of the interdisciplinary group process proposal that was approved as a station treatment form in 1976. From an average of 60 consultation requests per month in 1979, the program has grown to the point that nearly 2000 consultation requests were processed in 1983. Current group offerings consist of 13 specialized groups. Serving on the team over the years have been staff members from the following services: social work, dietary, psychology, nursing, chaplain, psychiatric, occupational therapy, recreational therapy, corrective therapy, and media. The *esprit de corps* of this interdisciplinary group of mental health professionals serves as an example of the type of progressional cooperation necessary to promote sustained group training of high quality.

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