

SHOULD TEACHERS TREAT ILLITERACY, HYPOCALLIGRAPHY AND DYSMATHEMATICA?

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Abstract

Generally, providers of psychosocial services now have rejected the view that interpersonal and emotional problems are best explained as analogs of *disease*, but rather have accepted the alternative view that they are *learning* phenomena. Still to be appreciated, however, is the implication of this change: that it is necessary likewise to reject the *clinical treatment* component of the medical model in favor of the *mass teaching* component of the educational model. Until this second step is taken, the providers of psychological services will continue to function deep inside the medical model and outside the educational model. This paper attempts to drive home that point by an allegory showing what might have happened had providers of intellectual services been led astray by the same sort of historical accident that led astray the providers of psychosocial services. Developments which might take place as the educational model takes firmer hold among professionals also are discussed.

Résumé

La plupart des gens responsables des services psychosociaux ont maintenant rejeté l'idée que les problèmes interpersonnels et émotionnels sont analogues à une *maladie*. Plutôt, on opte maintenant à interpréter ces problèmes comme des *phénomènes d'apprentissage*. Cependant, on oublie encore une conséquence de ce changement d'optique: on doit également rejeter le traitement en clinique du modèle médical et opter pour l'éducation du public telle que préconisée par le modèle de l'éducation. Avant d'avoir franchi cette deuxième étape, les praticiens continueront à évoluer à l'intérieur d'un modèle médical. Cet article attire notre attention à ce point par une allégorie qui illustre ce qui se serait passé si les enseignants avaient fait fausse route comme l'ont fait les praticiens en services psychosociaux. Enfin, on aborde les développements qui surgiront à mesure que les professionnels adopteront davantage un modèle apparenté à celui de l'éducation.

Should teachers treat illiteracy, hypocalligraphy and dysmathematica? No, they should teach people how to read, write and do arithmetic calculations. Should mental health professionals treat inferiority complexes, frigidity, or alcoholism? No, they should teach people how to acquire self-esteem, shed inhibitions when they wish to, and induce inhibitions when appropriate. It is as silly for providers of psychosocial services such as psychotherapists, counsellors, and psychiatric social workers — and psychiatrists when they are not providing medical services as such — to think in terms of medical analogs, as it is for teachers to conceive of their jobs as “curing” illiteracy.

It would be absurd for teachers to think of all their young charges as maladjusted and in need of *treatment* rather than *instruction*. Teachers do not, nor should they, consider themselves as correcting something that went wrong, but as providing a skill which the individual has not managed to acquire on his own, and which he/she

probably would never acquire if not specifically instructed. There is no reason for “mental health” workers to think their role any differently than does the educator.

Thinking in terms of medical analogies — in terms of dysfunction, of diagnosis, of treatment, and of cure has become so much a part of the thinking and daily functioning of mental health professionals that it is extremely difficult for most of them to think of their jobs according to any other set of concepts and strategies. Generally, when mental health professionals seek to help people who are emotionally troubled, interpersonally inept, or socially offensive, the only concepts, strategies, and techniques which come to their minds are based on medical practices, particularly those of the privately practicing physician.

Actually, on the rare occasions when the issue is brought into conscious deliberation, the great majority of psychosocial practitioners are willing to reject one major component of the medical

model: the *disease* analogy. Most are ready to agree that they no longer think it is necessary to use elaborate, extensive diagnostic probing with such psychic x-ray equipment as ambiguous stimuli, free association, or hypnosis in order to determine the basic "complex" underlying the individual's so-called symptoms. Nor do they feel it useful to use psychic surgery — e.g., dream interpretation and analysis of transference neurosis—to remove scar tissue presumably created by early traumas. Instead, they are willing to accept the idea that people's troubles, insofar as they are psychological at all (rather than problems of health or finances, for example), are due to *learned* reactions, attitudes, and expectations concerning others, oneself, and one's emotions. They are willing, when pressed even a little bit, to admit that if such troubles are generally learned, it must be true that theories, principles, terminologies, analogies, and strategies related to attitude formation, learning, motivation, emotion, and behavior, are much more likely to be pertinent than those which are related to disease. Thus, when they think about it, most mental health workers reject that component of the medical model which is based on analogs of disease. (Indeed, some have gone so far in this direction as to have thrown out the proverbial bathing baby by fighting the very plausible view that *biochemical factors may play a very important role in causing and remediating certain disturbances of the intellect and/or the emotions* — schizophrenia or severe depression, for example. In the author's view, it is as erroneous to conclude that because *most* emotional and interpersonal difficulties are learned, *none* can be manifestation of disease, as it is erroneous to say that because *some* are manifestations of disease, *all* are analogous to disease.)

The medical model is highly useful in fighting disease, whether the symptoms are emotional and mental or more obviously physical in nature. The difficulty arises when medical strategies, analogs and procedures are applied to what in truth are strictly psychoeducation procedures, as for example, in psychotherapy, family therapy, marital therapy, counselling, etc.

At one time education was reserved for the children of highly privileged classes, royalty, nobility, the landed gentry, etc. Tutoring was provided for individual children much in the manner that psychotherapeutic and counselling services are delivered today. It is at least conceivable that educators, rather than adapting the now taken-for-granted methods of mass education, might have followed procedural paths similar to those which medical practitioners followed. How might a typical case be handled today if educators had never adapted the strategy of mass education, but had instead continued to

follow a case-oriented approach? What kind of institutions might they have established instead of public and private schools? How would typical clients be handled? What would services cost and how would they be paid for? The following allegory attempts to answer such questions.

THE CASE OF ROGER B.

The Intellectual Health Center

The Intellectual Health Center where Roger B. is being treated is one of the more modern educational organizations. A group of pedagogists, previously in private practice, banded together to establish the center in the early 1970's. This group-practice situation allows the pedagogists to economize on office space and staffing, and permits them to hire their own social workers, psychologists, psychiatric consultants, and pedagogists. Saving on secretarial staff is particularly important because of the increased paperwork generated by the new payment plans.

Intake Worker's Report

Roger B. is a rather husky, good-looking, blonde male caucasian who walks with a steady gait, offers a firm handshake, and in general creates the impression of being a warm and personable 21-year-old. His vocabulary is fair, and he seems quite rational. However, his voice is often tremulous, his eyes tear up, he speaks very slowly and in a halting manner with his head bowed and at times he chokes up. He obviously is extremely depressed. Although he did not say so in his interview, I would not be surprised if he told me he was seriously contemplating suicide.

Roger has been extremely distraught for the past several weeks since his girlfriend, Betty with whom he has been going steady for three years, indicated that she wished to break off their relationship. According to Roger, his girlfriend admits to him that she is still deeply in love with him. However, Betty has reached the end of her patience. She feels she must look elsewhere to make a decent life for herself and for her children-to-be because Roger is unable to support himself, let alone a family. Under pressure from her family and, indeed, by her own considered opinion, she feels that she must be rational and realistic and break off their current relationship. Roger thinks that she should follow her emotions and her love for him rather than rational considerations. Nevertheless, he fully understands her sense of frustration and despair because he experiences the same feelings himself.

When asked why he was unable to find a job despite his conscientious efforts and a good labor market in this community over the past several years, Roger explained as follows: He is aware that because of the many new plants being built,

our town has an abundance of employment opportunities. He hears of many jobs for which he is qualified and which he feels he could perform well, but by the time he gets to the place of employment the jobs are almost always filled. Other people seem to be able to get to the employers days or even sometimes weeks ahead of him. He seems not to learn of these jobs until much later than others do. On those occasions when he has reached a place of employment and there are still jobs open, he has been given forms to complete. He tries to get around this by asking the personnel interviewer to discuss the matter with him so that he does not have to complete the form. However, they always refuse, indicating that they do not have time to do that. At that point the personnel officer usually takes his name and telephone number and indicates that he will call him if they can hire him. He never gets the call.

In summary, Roger is an appealing, good-looking boy who appears to be in good physical health but is emotionally troubled to the point where the danger of suicide has to be considered. Apparently a central aspect of his personal and interpersonal difficulties, particularly as these pertain to the break-up of a long-standing love relationship, have to do with his inability to secure employment. I am convinced that he was telling the truth about his prolonged and intensive efforts to secure employment. I therefore recommend complete pedagogical testing and a pedagogical interview. I doubt very much that any physical causes or severe psychological conflicts or inadequacies will be found. However, to be sure we can rule out these possible sources of difficulty, I also recommend complete physical, psychological and psychiatric examinations.

The Case Conference

Each week a number of cases are presented in staff conferences not only to make case dispositions, but also to provide training for those on the staff serving pedagogical residencies and pedagogical internships. Roger was lucky enough to have his case selected for presentation at the weekly Friday afternoon case conference. Some fifteen professionals and professionals-in-training were present.

After the social worker summarized the above intake report, the physician reported that vision, hearing and neurological functioning all were normal. Next the psychologist reported that he had administered various projective tests, intelligence tests and tests for organicity. His conclusion was that there were no thought disorders, no incipient psychosis, no characterological defects and no signs of minimal brain damage. Roger was slightly above average in intelligence. In agreement with the social worker's impressions, the psychologist concluded

that a severe depression was present and this was due to the impending breakup of Roger with his girlfriend and feelings of intense inferiority due to his inability to obtain work. The psychiatrist's report was in substantial agreement with the views of the psychologist and social worker.

Next the pedagogologist presented the report of his pedagogodiagnostic testing. The central finding of testing was the revelation that, although Roger was 21 years old, he had never taught himself to read! Once the testing had revealed this, everything fell into place (When he first called the Center, Roger told the secretary he thought that the cause of his troubles was his inability to read, but, of course, self-report data is not reliable.)

Treatment Recommendation and Prognosis

The Chief Pedagogiatrist, Dr. I.B. Rich, formulated the consensus. Not being able to read, Roger obviously could not read the classified advertisements and therefore did not discover the availability of jobs until after they had been filled by others. Even when Roger did get news of job openings promptly from friends or relatives, it generally arrived too late: his inability to read bus, subway, and street signs caused him to get lost. Finally, and this was perhaps the most serious difficulty of all, Roger could not read the employment applications and thus was unable to complete them. Understandably, busy personnel officers did not wish to take the time to read the forms to him.

Dr. Rich went on to make the following recommendations for Roger. Roger should be scheduled for a 50 minute pedagotherapy session for his illiteracy each week. The sessions will be conducted by the pedagogologist, Dr. I.M. Whelthy. The prognosis is that Roger could be expected to be reading well enough to get around town without assistance in six months, able to read simple job applications in nine months, and able to read more complex job applications in one year.

Before concluding the staff conference Dr. Rich spoke for a few minutes with great feeling about the rise in recent years of intellectual pathology such as Roger's. He attributed this largely to television, which is making young people less and less interested in teaching themselves how to read. Consequently, more and more of them suffer from illiteracy resulting in the kinds of symptoms suffered by Roger. To correct this situation, many, many thousands more pedagogiatrists will be needed. He indicated his feelings that it is essential that the government give more support immediately to graduate programs so that the necessary numbers of Ph.D.'s can be produced to meet this need. It would be tragic if teaching were to fall into the hands of people with only Master's degrees. That kind of lowering of standards might

eventually lead us down the road to socialized education.

Results of Treatment

On the proviso that Roger's treatments would be successful, Betty agreed to continue their relationship. The prognosis was correct and Roger did learn to read, and was able to obtain a job, nine months after beginning treatment. At that time he and Betty were married. Six months after that he received a promotion.

Cost

The cost breakdown for diagnosing and treating Roger's malady was: social work interview, \$45; psychological exam, \$75; psychiatric exam, \$100; pedagogical exam, \$125; medical exams, \$100; pedogiatric exam \$175; case conference (15 professionals at average hourly rate of \$18) \$270; fifty pedagotherapy sessions at \$35; \$1,750; total \$2,640.

Usually, the Intellectual Health Center collects 80½ of such costs from Blue Book, a private, non-profit, mutual Mind Insurance Firm dominated by pedagogues. Roger, being unemployed, was not covered by Blue Book. Hence, his fees were paid from a combination of government, and charitable sources: Educare, Educaid, Welfare, and United Community Charities.

A Relapse and Second Course of Treatment

Shortly after the promotion Roger suffered a relapse. He lost his job and Betty threatened to leave him even though she was five months pregnant. A full blown return of the original symptoms occurred and Roger returned to the Intellectual Health Center. Examinations by the psychiatrist, physician, psychologist, and pedogiatrist were repeated. All revealed results similar to those obtained in his earlier diagnosis and treatment. Pedagogidagnostic testing again revealed the source of Roger's difficulties.

Despite his success in learning to read during our earlier period of treatment, and expectations that he would do so, Roger had not taught himself to write! His promotion required him to write various kinds of reports. Consequently, as long as he could, he used various subterfuges to get others to do that job for him, hiding his difficulty and suffering a fear of exposure and embarrassment. Eventually, under various pretexts, he began to remain away from work and to drink heavily. He then lost his job. Betty, fearing a repeat of the failures experienced by Roger before they were married, threatened to leave him.

In accord with the Center's recommendation, Roger agreed to undergo weekly 50-minute pedagotherapy sessions for his chronic hypocalligraphy. In accord with recent trends,

those sessions were conducted in small groups. (The resulting economy is partially passed on to clients, thus the hourly fee was only \$25.) When Roger agreed to undergo treatment again, Betty happily agreed to stay by his side. Again, a favorable prognosis proved entirely correct. Within a year Roger was able to write well enough to obtain a job paying even more than the job he had before his second breakdown. His anxiety disappeared and he no longer drank excessively. Roger had obtained the new job immediately after his discharge. That was six months ago. Two weeks ago Roger's boss called him in and told him how very pleased the company was with the good work Roger was doing, and told him he was adding duties to his job which later would lead to much higher status and a very significant raise. It would pave the way for him to work in the accounting department. But, basic skills in arithmetic would be required. . . .

DISCUSSION AND CONCLUSION

Had educators not developed the approach they did, we would be stuck with massive problems due to underdeveloped, wasted, intellectual potential. If they too had followed the model used by medical practitioners, intellectual skills would come too late, too little, and at too much cost for society to bear. We are indeed fortunate that education evolved beyond individual-tutoring and developed a viable model for developing the intellectual skills of millions of people at reasonable cost. As far as we can tell, there was no more *rational* foundation for counsellors, psychologists and social workers to follow a medical model than there was for educators to do so — *only historical circumstances seem to account for that choice.* We shall elaborate this point after we discuss some of the essential differences between the educational and the medical models.

The differences between the real educational and medical models pervades all areas: thought and action, theory and research. We have elaborated on many of these differences elsewhere (Authier, Gustafson, Guerny, & Kasdorf, 1975; Guerny, 1977; Guerny, Guerny & Stollak, 1971/72; Guerny, Stollak, & Guerny, 1970; Guerny, Stollak, & Guerny, 1971). In the Medical Model of psychological practice we have: 1) client "abnormality", "dysfunction" or "maladjustment" which leads to 2) "diagnosis" which leads to 3) "prescription" which leads to 4) "therapy" which leads to 5) "cure". In the Educational Model of psychological practice we would formulate the same given set of facts, needs and helpful intervention in terms of: 1) dissatisfaction, curiosity or ambition which leads to, 2) value-clarification and/or goal setting which leads to 3) the selection of an appropriate standardized course of programmatic instruction which leads to

4) understanding, skill acquisition, self-control and competence which leads to 5) satisfaction and/or goal achievement.

In considering the application of the educational model it is very important to realize two things. First, the specific nature for helping people share their *personalities* — psychoeducation — bears only partial resemblance to the specific nature of instructional methods used for intellectual education in public schools and colleges. Effective psychoeducation requires that the instructional materials and methods make full use of the knowledge of psychodynamics and defense mechanisms that have been acquired by the *helping professions* during decades of practicing and studying psychotherapy. These requisite attitudes and skills are *seldom to be found* among teachers of traditional subject matter.

The second point to bear in mind is that psychoeducation is in no way limited to the theories, strategies or tactics employed by Skinnerians. To be sure some theoretical orientations, and clearly the Skinnerian approach is among them, lend themselves more readily to an educational approach, but the educational approach probably is broad enough to cover any theoretical orientation, even the Freudian (e.g., transactional analysis). Indeed, although Skinnerians and other behavior modifiers clearly have rejected the disease-based model in favor of a learning-based model, probably the great majority of them still are operating deep within the confines of the medical model in terms of the service-delivery system which they follow. In this regard they are more like physicians, than they are like educators or teachers: they wait for people to approach them rather than approaching their potential clients; they treat cases on an individual basis rather than using routinely scheduled systematic training programs; they impose stimuli and conditioning upon people rather than letting people play a decisive role in setting their own goals and; their criteria for success is the removal of a complaint rather than the acquisition of a generalizable skill.

This is not intended to deny the great contribution which the behavior modification movement has made to the rise of the educational model nor to deny the leadership role which many behavior modifiers have played and no doubt will continue to play in its development. Rather, it is to make the point that education and the educational model existed well before behavior modification and that many of the theories and methods which educators use precede and/or extend beyond those which are closely identified with behavior modification.

As suggested in the above discussion, the main components of the psychoeducational model may be described as follows. The practitioner seeks to

determine those emotional, interpersonal, and psychological skills which would be useful to great numbers of individuals in helping them to achieve their desired personalities and their interpersonal goals. The practitioner then seeks to design efficient ways to help people of all ages and in all kinds of settings (not just the traditional classroom) to build these skills into their emotional, interpersonal repertoires. The skills are then taught in such a manner that they can be used not only to solve current specific problems but also various problems which a person may encounter in the future.

As the psychoeducational model replaces the medical model the practitioner will need to independently construct such courses less and less frequently. *More and more* the practitioner will be able to draw upon a library of such programs developed by others. Such programs — for example, sexual training (Master's & Johnson, 1970), assertiveness training (Smith, 1975), fair fighting (Bach & Wyden, 1968), parent effectiveness training (Gordon, 1972), relationship enhancement (Guerney, 1977) have been emerging at an increasing rate of speed in the past decade. It is our hope that the next decade will see the development of many dozen more such courses and also the gradual change of support groups from relatively untutored, unstructured discussion groups to programs which in addition to offering emotional support, are designed to teach psychological skills appropriate to particular interest groups. By special interest groups we mean groups such as the recently-widowed, -divorced, -engaged, -handicapped, -married, -hired, -retired, etc.

Psychological programs can be conducted in public schools from kindergarten through college. But they also can be conducted (and are being conducted) in mental health centers, college counselling services, community guidance centers and family life centers. Such programs can also be sponsored by other institutions; by religious organizations, fraternal societies, corporations, and labor unions. The purposes they serve would be preventative as well as remedial. Indeed, preventative and remedial purposes often will be indistinguishable from one another, since people will no longer be required to label themselves as sick or maladjusted before seeking help and seldom would there be any reason to segregate those who do have serious problems from those who wish to acquire psychological skills simply to enrich their lives.

We return now to the question of why a model as inappropriate as the medical model should have been adapted by people who are providing an essentially educational service. Consider the phenomenon of imprinting made known to us by comparative psychologists. For example, at a

given crucial stage in its early development a duckling will learn to regard as its mother any larger animal with whom it is intimately associated. It will come to treat that animal — even a dog or a human — in much the same manner that most ducklings treat their true mothers. An analogous process seems to have taken place at a social level with psychologists in relation to physicians.

As psychologists emerged from universities under pressure of war-time needs, they emerged into facilities which were completely dominated by physicians. The entire reinforcement system — all the principles of identification and social pressure — made it inevitable that they would follow the lead of those physicians in the way that they set about helping people. Later, other mental health professionals modeled themselves after physicians for similar reasons—or, ironically, modeled themselves after the psychologists! In addition, of course, the earliest theorists whose views were followed in those settings were medically trained. It is not at all surprising that the psychologists never glanced back to see that their true mother resided all along, and still resides, in the schools from which they came. As the professions of the providers of psychosocial services mature, and the effects of the pseudo-parent wear off, the usefulness of the psychoeducational model will become more and more apparent. Just as at the beginning of the century, the medical model of service delivery superceded the delivery system based on a supernatural model, we expect that in the last part of the

century the psychoeducational model will replace the medical model in the delivery of psychosocial services.

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