THE PSYCHOEDUCATION MODEL: DEFINITION, CONTEMPORARY ROOTS AND CONTENT

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Abstract

Psychoeducation is a therapeutic approach under which the psychological practitioner's functioning is viewed not in terms of abnormality (or illness) diagnoses → prescription → therapy → cure; but rather in terms of client dissatisfaction (or ambition) → goal-setting → skill-teaching → satisfaction or goal achievement. The contemporary roots of psychoeducation are traced from an early era serving to set the stage for psychotherapy as an educational process, to the behavior modification era, to the community mental health era. Content of psychoeducation is discussed in terms of general skills (i.e., communication skills, interpersonal skills, relationship skills, etc.) and specific skills (i.e., coping with frustration, sexual satisfaction, handling aggressive impulses, etc.). It is concluded psychoeducation content is limited only by the imagination of the persons seeking help and by the ability of the psychological practitioner to be innovative and creative enough to design a systematic program for teaching clients the psychological self-help that will make their lives more fulfilling.

Résumé

La psychoéducation est une approche thérapeutique qui n'aborde pas la démarche du psychologue dans une optique d'anormalité (ou maladie) → diagnostic *recommendations* → thérapie → guérison, mais plutôt dans l'optique du client insatisfait (ou ambition) → choix de buts → enseignement d'habiletés → satisfaction ou l'atteinte du but. On trace l'évolution de la psychoéducation depuis le temps où elle servait de fondement à la psychothérapie en tant que processus éducationnel, à travers l'époque de la modification du comportement jusqu'à l'ère des services établis pour promouvoir la santé mentale de la communauté. On élabore le contenu de la psychoéducation selon des habiletés d'ordre général (i.e. les compétences alliées à la communication et aux rapports interpersonnels) et des habiletés d'ordre spécifique (i.e. faire face à la frustration, à la satisfaction sexuelle, au contrôle d'élans aggressifs, etc.). On conclut que le contenu de la psychoéducation ne peut être limité que par l'imagination des personnes en quête d'aide ou par l'habileté du psychologue à être assez innovateur et créateur pour élaborer un programme systématique qui amènera les clients à se suffire et à poursuivre une vie où règne l'épanouissement.

Before discussing the content "taught" under an educational model of counselling, which is the theme of this issue of the *Canadian Counsellor,* it seems appropriate to define psychoeducation, trace its contemporary roots, and discuss its reasons for coming into being. A definition seems especially important since many rather diverse definitions now exist. The definition promulgated by Guerney, Stollak, and Guerney (1971), who were among the founders of the psychoeducation movement, appears most fitting. They suggest the following:

> The practicing psychologist following an educational model is one whose work would derive directly or indirectly from a concern not with "curing" neurosis and not with eliminating symptoms (or complaints) and not with intellectual growth per se but rather with the teaching of personal and interpersonal attitudes and skills which the individual applies to

> solve present and future psychological problems and to enhance his satisfaction with life. (p. 277)

The psychoeducation model, therefore, views the role of the psychological practitioner not in terms of abnormality (or illness) diagnosis prescription therapy cure; but rather in terms of client dissatisfaction (or ambition) goal-setting skill-teaching satisfaction (or goal achievement). Likewise, the client is viewed as a pupil rather than a patient.

The roots of the psychoeducation movement have been delineated elsewhere (Authier, Gustafson, Guerney & Kasdorf, 1976); thus, I refer the reader to that article for a more detailed discussion. Suffice it to say that counselling and psychotherapy have been construed as educational processes for many years, but only within the last decade has a concentrated effort

been made to bring the counsellor's role in line with its educational base. Early proponents of psychotherapy as education (Shoben, 1949; Dollard & Miller, 1950; Murray, 1954; Mower, 1950; Rotter, 1954) appeared more content to theorize than to put their theories into practice. In fact, several years elapsed befor theoretical principles were applied to clincial problems (e.g., Wolpe, 1958, 1965, 1969; Lazarus, 1960, 1961, 1963; Krasner, 1962a; Krasner 1962b; Ullman & Krasner, 1965). In contrast to the earlier theoretical era, psychotherapy as an educational process during the clinical application era was characterized by a series of techniques, such as counter-conditioning, adversive-conditioning, operant-conditioning, behavioral control, stimulus control, etc., all of which were designed to remove patient symptomatology. This long awaited practical application of learning principles to clincial problems served as the first force of the psychoeducation movement, but because of its narrow emphasis on the "patient","symptom alleviation", "cure", and, in essence, adherence to a medical model, this behavior modification era for the most part seemed to avoid consideration of the cognitive, emotional and interpersonal domains of the client. Indeed, an adherence to the medical model prevented the behavior modifiers from conceptualizing their roles as teachers with ability to educate their "patients" in these latter domains. However, despite their failure to speak of themselves as teachers, it is readily apparent that the teaching function of behavior modifiers ranges in complexity from explaining the rationale and application of a procedure to serving as a consultant or program coordinator to the client via directly instructing him/her in self-control techniques. Of course, the latter approach epitomizes the therapist as a teacher in that it embodies learning how to learn, the final goal of most educational processes. Behavior modification thus simultaneously highlighted therapy as an educational process and the deficiency of a medical model for such an endeavor.

Indeed, the inadequacy of the medical model, especially in the area of preventive mental health, was obvious and perhaps comprised the second force leading to the adoption of a psychoeducation model. Although behavior modification raised the issue indirectly, Szasz (1961a, 1961b, 1966) was among the first to directly question the appropriateness of a medical model for treating the "mentally ill". In essence, he noted that the medical model was used to instill societal and cultural values, and in so doing, he made helping professionals aware of the danger of foisting their own value systems on others in the guise of making them mentally healthy. An educational orientation, which includes the student's right to choose what he/she will learn can only benefit from this increased awareness.

More recently, others have questioned the utility of the medical model for dealing with those who are considered "emotionally disturbed". Rioch (1970), for example, specifically questioned whether traditional psychotherapy was appropriate for treating a person suffering from an emotional disturbance. She noted that the medical model lacked respect for the patient in that it didn't call for patient involvement; yet she suggests that patient involvement is most crucial when helping someone who is emotionally disturbed. Operating from a more empirical base, Ulmer and Franks (1973) suggest that many of the assumptions of the medical model are inappropriate when caring for people who are socially incompetent. They state:

> Proponents of this model believe that someday these deviant physiochemical processes will be understood and that treatment will be based upon the application of suitable medical techniques. But to date there is no clear evidence that the vast majority of emotional disturbances are related primarily to "organic malfunctioning". (pp. 95-96)

Such imperfections as noted above may in fact be the variables responsible for researchers failing to find traditional approaches of psychotherapy to be effective. Eysenck's (1952) now classic study, for example, demonstrated that only 44 percent of all patients undergoing traditional psychoanalysis improved as compared to 72 percent who were only treated custodially by general practitioners. A few years later, Levitt (1957) in working with children likewise found the "cure rate" for untreated populations to be about equal to those treated by more traditional psychotherapeutic approaches. He concluded: "The results do not support the hypothesis that recovery from neurotic disorder is facilitated by psychotherapy" (p. 195). It was this kind of conclusion drawn from this kind of data, therefore, which led to the growing disillusion and dissatisfaction with the medical model and which provided the second major force for the psychoeducational movement.

A third and the most contemporary — and perhaps the most prominent — force of the psychoeducational movement has been the community mental health movement. Hobbs in 1964, and again in 1966 with Smith, was among the first to state the virtually unanimous conviction that the psychological practitioner's long range answer to psychosocial problems lay with prevention rather than with remediation. If prevention was to be accomplished, it was obvious that a more direct teaching approach would need to be taken, not only in terms of providing more manpower by teaching paraprofessionals counselling skills, but, as will be discussed later, more directly teaching those in need of help the kind of psychological content necessary for them to help themselves. The former point was highlighted in Miller's

(1969) presidential address to the American Psychological Association (APA) when he stated: "There simply are not enough psychologists even including non-professionals to meet the need for psychological services. The people at large will have to be their own psychologists and make their own application of the principles that we establish" (p. 1071). This notion of "giving psychology away" has been voiced more recently and with greater frequency by Guerney (1969, 1970, 1971), Carkhuff (1971), Ivey (1974), Alschuler and Ivey (1973), and Lincoln (1975). Of these, the latter two are particularly significant as they discuss teaching psychological self-help in the classroom, thus epitomizing an eventual goal of psychoeducation.

As alluded to above, an offshoot of the need for preventive mental health was the paraprofessional movement. This movement had a most significant impact on the psychoeducation movement as we know it today, since it called upon counsellors to develop methods for training paraprofessionals in counselling skills. To accomplish this goal, it was necessary to design effective short-term training programs with wide applicability. A major strength of the training programs which were developed to meet this need was their structured emphasis on systematic experiential exercises designed to teach specific interpersonal skills.

Psychoeducation, quite logically, follows from systematic counsellor training in that if paraprofessional counsellors can be taught the interpersonal skills which are often seen as attributes of good mental health (Maslow, 1955; Jahoda, 1958) then certainly these skills can be taught to the public and perhaps even to those labeled as "psychiatric patients".

Research evidence demonstrating the effectiveness of psychoeducation with the latter population, considered by many to be the most difficult to teach, will be discussed later. For now, suffice it to say that both behavior modification and the more directly conceptualized forms of psychoeducation have demonstrable effectiveness as therapeutic modalities. These positive research findings constitute a strong endorsement of the psychoeducation model. This is especially true in light of the questionable effectiveness of more traditional therapies. Moreover, a now classic study which compared a psychoeducation model with a more traditional approach including chemotherapy found the psychoeducation model to be superior (Pierce & Drasgow, 1969). In conclusion, then, various research efforts suggest a psychoeducation model for "teaching" behavior change even for the most "recalcitrant" is a viable therapeutic alternative. Cumulative research findings also are a confirming force in the psychoeducation movement.

Perhaps the major beauty of the psychoeducational model is that the content (i.e., the skills to be learned) is limited only by the imaginations of the persons seeking help and by the ability of the psychological practitioner to be innovative and creative enough to design a systematic program for teaching his/her clients what they want to learn. The description which follows, therefore, is not an exhaustive list, but rather a discussion of a few of the more common psychoeducation models and the content which they emphasize. Since the content of most skill training programs can be classified as general or specific, this discussion will follow that format.

General skills training programs are those which emphasize counselling skills, communication skills, interpersonal skills, relationship skills, etc. These programs are often mere extensions of counsellor training programs. Two of the more common counsellor training programs which have been adapted to the psychoeducation model are those developed by Carkhuff (1969a, 1969b) and Ivey (1971). Carkhuff's program has been adapted by several practitioners in order to teach the interpersonal skills of empathy, respect, concreteness, genuineness, self-disclosure, confrontation, and immediacy to such diverse groups as psychiatric inpatients (Pierce & Drasgow, 1969; Vitalo, 1971), parents of emotionally disturbed children (Carkhuff & Bierman, 1970), college students (Berenson, Carkhuff & Myrus, 1966), Head Start Teachers (Bierman, Carkhuff & Santilli, 1969), groups consisting of teachers and parents representing different races (Carkhuff & Banks, 1969), and others. Ivey's (1971) program has been used to teach similarly diverse populations — psychiatric inpatients, (Donk, 1971; Ivey, 1973; Orlando, 1974), students (Dimattia, 1970), psychiatric outpatients (Haase, Forsyth, Julius & Lee, 1969; Gormally, Hill, Otis & Rainey, 1975; Galassi, Galassi & Litz, 1974)—but emphasizes less global communication skills, such as attending behaviors, open-invitation-to-talk, paraphrasing, minimal-encourages-to-talk, reflection-of-feeling. To detail the adaptations of these two counselling training programs to the various patient training programs is not warranted here. However briefly, adaptations of both involve teaching a variety of communication skills by explicit instruction and feedback in graded practice. The "therapist's" role is, therefore, conceptualized as that of a teacher who uses behavior shaping with emphasis on verbal reinforcement. Often, role playing in dyads or triads is used and both programs use audio and/or video feedback as an additional teaching modality. Clearly, then, the programs as adapted for "patient" populations is psychoeducation in its truest form.

Step Group Therapy (Authier & Fix, 1977), which blends group therapy with a behavior

therapy approach, is another psychoeducation program designed to teach general content. The program consists of teaching nine communication skills in a series of three steps to groups of patients who are promoted from one group to the next by demonstrating competency in that particular set of skills emphasized at each step. That is for a patient to move from Step I to Step II, he must demonstrate competency in sitting with a relaxed posture, appropriate gesturing, appropriate eye contact, and appropriate verbal following: from Step II to Step III, he must demonstrate competency in asking open-ended questions, reflection of feeling, and making questions into statements; and finally, to be promoted from Step III to discharge status, he must be able to demonstrate competency in the use of the interpersonal skills of confrontation, feedback, and self-disclosure. The program uses written definitions of the skills, model tapes, didactic instruction and most importantly a counsellor who acts as a teacher by using the above modalities along with reinforcing successive approximation of the use of the skills by the patients.

General content also has been emphasized in marriage counselling. Guerney and his associates (Collins, 1971; Rappaport, 1971; Ely, Guerney & Stover, 1973) have been instrumental in adapting a psychoeducational approach to this field. Their Conjugal Relationship Enhancement Program explicitly teaches the roles of "speaker" and "listener" and the various communication skills involved in each role. Weiss, Hops and Patterson (1973) also teach basic communication skills to their married couples. Additionally, they teach the more specific skills of contracting and negotiating.

Other programs that seem to have the blend of general communication skills and more specific skills are those that focus on parent-child relationships. Gordon's (1973) Parent Effectiveness Training is the best known in the area as it teaches both basic communication skills as well as specific parenting skills. Another program which teaches both general and specific parenting skills is that developed by Patterson and Gullian (1968). Bizer (1971) has developed a similar parenting training program. Other psychoeducation programs with both a general and specific skill emphasis are too numerous to discuss here. Suffice it to say the teaching modalities are and need to be similar to those discussed above if psychoeducation is to be epitomized.

Of those psychoeducational programs, which teach more specific skills, probably Structured Learning Therapy is the most widely known. Indeed, Structured Learning Therapy (Goldstein, 1973) was specifically designed to fill the void discussed earlier between the public demand for psychological services and the number of psy-

chological practitioners available to meet this need. Moreover, the program was designed to meet the needs, lifestyles, and environmental realities of the lower class since traditional methods of treatment have proved grossly inadequate and inappropriate for this population. Regarding the approach designed to meet the needs of the lower class patient, Goldstein (1973) states:

> One such approach appears to be what we have termed Structured Learning Therapy, in which explicit focus can be placed upon skill training — via the use of modeling, role playing, and social reinforcement — to enhance patient autonomy, assertiveness, internal controls, role taking abilities, sense of mastering social interaction skills, accuracy of affective perception and communication, tolerance for frustration and ambiguity, and a host of other useful behaviors in which he may be deficit. (p. 69)

A study conducted by Gutride, Goldstein and Hunter (1973) with 120 psychiatric inpatients further demonstrates the specific nature of the skills taught by Structured Learning Therapy since the goal of the project was merely to increase social behavior. Results demonstrated that SLT patients improved more on this dependent variable than did a no-training control group or patients receiving social companionship therapy. Another specific skill taught by SLT has been that of independence (Goldstein, Martens, Hubben, VanBelle, Schaaf, Wiersma & Goedhart, 1973). In a series of three studies this group was able to significantly increase independent behavior for two neurotic outpatient populations and one psychiatric inpatient population. Needless to say, numerous other therapeutic applications of SLT have been made, since it was designed specifically for that purpose.

Before turning to order similar approaches which have been successful in teaching skills to specific populations of people, it should be noted that SLT in its most recent form includes a transfer of training phase (Gutride, Goldstein & Hunter, 1974) and this explicitly psychoeducational approach to training may be the key factor in its purported effectiveness. Indeed, this would seem to be a most important step in any psychoeducational therapeutic endeavor and perhaps the feature tending to make these models more effective than traditional models of therapy. Such a direct learning approach teaches trainees skills which will help them cope with stress when they are back in their home environments. This is contrasted to psychoanalytic and other more traditional approaches where the patient gains insight perhaps but is not taught skills to cope with those problems which continue to arise in spite of the insight. As such, it appears that the teaching of coping skills is an important adjunct to more traditional therapeutic approaches and of

course this is a major thrust of the psychoeducational movement.

The examples above have focused mainly on specific skills taught to psychiatric impatient populations. Obviously, other psychoeducation models have been employed to teach specific skills to non-psychiatric populations. Hunt and Azrin (1973) for example, working with alcoholics use a *psychoeducational approach to teach specific skills* such as those required for getting a job. The assertive training program developed by Rathus (1973) to train volunteer college women is still another program with a specific skills emphasis. This program teaches such specific behavior as talking about oneself, accepting compliments, looking people in the eye, greeting, and others.

Specific psychologocial skills taught in the classroom is one of the most promising developments within the psychoeducation movement. Gum, Tamminen and Miller (1973) are among the founders of this phase of the psychoeducational approach and epitomize the counsellor as a teacher of psychological self-help especially as it pertains to the developmental tasks of children and adolescents when they state:

> . . . counsellors should spend less time in "putting out fires" and should attempt to become a force for the facilitation of the full development of persons within the school environment . . . doing all they can do . . . facilitate change (such as promoting) the full development of individual students. (p. 647)

In this vein these authors have designed "Developmental Guidance Experiences"designed to teach specific skills ranging from learning physical skills necessary for ordinary games for the six year old to learning to discuss *feelings* about sex roles for the adolescent. Other specific skills taught in the classroom using a psychoeducation model have been achievement motivation (McMullen, 1973) mastery in language (Palomares & Rubine, 1973) and awareness (knowing our feelings, thoughts and actions); mastery (self-confidence) and social interaction (knowing other people) (Bessell, 1970).

Psychoeducation has also been used in work with the same age groups in a more social context. Specific skills related to race and sex for example, are emphasized through psychoeducation workshops with young adults (Anderson & Love, 1973; Delworth, 1973). As previously suggested, then, it is apparent that the specific skills emphasized and the populations taught under a psychoeducation model are limited only by the imaginations and creativity of the participants involved.

The life skills education course for adult learners developed by Adkins (1970, 1973) quite aptly demonstrates this point. His approach is particularly important since it highlights psychoeducation as a preventative measure in that

most adults have not had the advantage of psychoeducation during their school years. Moreover, Adkins' approach appears to combine the roles of teaching and counselling thereby epitomizing what psychoeducation is all about. Adkins (1973) states:

> In many respects, the life skills program employs a combination of methods regularly used by excellent teachers and counsellors which are not often faithfully carried out by average teachers and counsellors relying solely on their own resources . . . therefore, through life skills, an effort is made to provide a series of pre-planned but open-ended structured learning experiences which with accompanying materials can be implemented by typical adult education teachers or counsellors. (p. 3)

Adkins goes on from here to list the characteristics which he believes a fully developed life skills curriculum would have. If psychoeducators keep these criteria in mind when developing psychological self-help programs designed to meet their trainees' specific needs or desires then certainly "pure" psychoeducation as a therapeutic modality will occur.

It would be an injustice not to mention at least a few of the rather classic specific skills training programs that closely approximate a psychoeducation model. Masters and Johnson (1970) training designed to increase sexual satisfaction is one such program. Maultsley's "ABC's"adaptation of Ellis' (1961, 1963) Rational Emotive Therapy to teach people about their specific *irrational thoughts* and how to modify these thoughts is another such program. Krumboltz and Thoresen (1969) and Mahoney (1974) adapt a psychoeducation model to teach specific skills such as a strategy for controlling problem behavior and problem solving and decision making. D'Zurilla and Goldfried (1971) have used a psychoeducational approach to teach specific problem solving skills. Meichenbaum's (1969) methods of teaching schizophrenics "healthy talk" is still another rather classic psychoeducational approach deserving mention. Essentially, Meichenbaum uses operant conditioning to help the schizophrenic give himself spontaneous instructions such as "be coherent," "be relevant,""give healthy talk," etc. Finally, still other specific skill training programs are those developed to help people cope with frustration (Giebink, Stover, & Fahl, 1968), handle aggressive impluses (Gittelman, 1965), depression (Lewinsohn, Weinstein & Shaw, 1969; Libert & Lewinsohn, 1973) and even to fight fair within the marital relationship (Bach & Wyden, 1969).

It is obvious from all of the above that the psychoeducator model can no longer be denied. Indeed, it is beginning to permeate every phase of life, from the child to the adult, from the normal to the "abnormal". The growth of the psy-

choeducation model promises to meet the demands of the public and the call for "giving psychology away" since the most effective way to help people is to teach them to help themselves. Ulmer and Franks (1973) best summarize the movement of psychoeducation as a way of meeting the public demand in mental health facilities when they state:

> Traditional insights into psychotherapy and the medical model have little relevance to mental health facilities viewed as essentially social training institutions for disturbed and disturbing persons with limited social competence. If training for community living is indeed the major function of so-called mental health facilities, it would be as well to change their name to *behavior-social training programs*. (p. 95)

While these authors are only suggesting an integrated four-level training program ranging from state and community mental hospitals at level 4 to an out-patient clinic at level 1, the psychoeducational tone is there and all that need be added are levels beyond outpatient clinics, such as self-growth clinics for the "normal" population, psychoeducation classes for school-age children, and finally, continuing education in various life skills. In conclusion then, the answer to the query: "What are the skills, knowledge, values, and moral norms that are important for the counsellor to 'teach'?", is whatever content will help the trainees' to lead more fulfilling lives.

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