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A RESPONSIBILITY MODEL FOR THE PRACTICE OF PROFESSIONAL SCHOOL PSYCHOLOGY: PSYCHOEDUCATIONAL THERAPY[1]

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Summary: This paper discusses from first-hand experience the need for, and development of, a program of psychoeducational therapy within a school system. Conditions in the schools that support and influence the therapy, as well as therapy characteristics, are considered in some detail. Reasons are delineated that make this a responsibility model of school psychology practice. The therapy program is part of a larger supporting thrust in intervention, features of which are briefly referred to.

Psychoeducational therapy evolved as an alternative to the diagnostic-consultation model of school psychology practice. Psychoeducational therapy also evolved as an alternative to the practice of therapy in the clinic, especially the clinic outside the school system. The diagnostic-consultation model of school psychology practice usually resulted in a written report of findings and recommendations; the psychologist's responsibility normally ended in conferencing with school personnel about the report, without provision for systematic follow-up. The consultation phase of this model meant that the psychologist worked directly with the teacher, parents, and other school personnel on pupil or other types of problems and only indirectly with the pupil; a session to discuss with the teacher or other appropriate individual the identified problem and to suggest a strategy or two usually terminated the psychologist's responsibility. An outgrowth of the diagnostic-consultation model was the accepted, routine practice of referral to outside agencies and/or clinics that provided treatment outside the school system for which the school psychologist had no responsibility.

This model of school psychology practice was more often than not unsatisfactory. From the viewpoint of the school psychologist, it was totally unacceptable because it did not discharge the responsibility for assisting classroom teachers and for helping the child in the classroom. From the viewpoint of school personnel, it was as equally or more unsatisfactory because frequently the recommended solution to the problem called for continuing psychological treatment which was not being provided anywhere.

Thus, a need evolved for responsible intervention within the school setting itself, with access to and skill in utilizing the variables within that setting in favor of the pupil (Jackson & Bernauer, 1968; Jackson, 1970). The diffi-

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culties and the disappointing results of limiting the school psychologist's role to the diagnostic and consultation model not only created a sense of futility in the psychologists themselves, but caused school personnel to press for follow-through and intervention within the school system to change the behavior and/or learning set of the child (Milwaukee Public Schools, 1967). More recently it has been noted (Nickerson, 1973) that there are compelling reasons for the school to become the preferred setting for intervention with children experiencing emotional difficulties.

SCHOOL CONDITIONS THAT SUPPORT PSYCHOEDUCATIONAL THERAPY

There are many conditions in the schools that support the practice of psychoeducational therapy: (1) receptivity among school personnel for it, (2) potential attitudes and skills in school psychologists for providing it, (3) availability of the pupil to the psychologist for continuity of intervention, and (4) compatibility of psychoeducational therapy with the primary activities of teaching and learning in the school.

PSYCHOEDUCATIONAL THERAPY BUILDS UPON POSITIVE SCHOOL CONDITIONS

Psychoeducational therapy is in the schools because it can take advantage of the foregoing positive conditions in the service of children and youth in the following ways:

1. First, the school psychologist can work frequently with the pupil in the natural setting rather than infrequently in the isolated, unnatural setting of the clinic. In the school setting where he acts and reacts on a natural, routine, familiar basis the pupil is more likely to feel comfortable and to perceive the psychologist as an accepted part of his daily routine, with corresponding ease for the psychologist in establishing and maintaining rapport. There is the opportunity for the psychologist to work directly in the classroom when appropriate. There is greater accessibility to teacher conferencing and opportunity for continual feedback exchange between teacher and psychologist.
2. Second, the school psychologist can practice systematic observation and screening of pupils that allow for preventive intervention.
3. Third, the psychologist as therapist can make use of the many positive resources, material and human, to be found in the schools. For example, teachers and nonprofessional personnel can be involved in the therapeutic network of reinforcing experiences for the child. Access to parents is easier at school than at the clinic because of the positive image the therapy can have in the regular educational setting.

Integrating the therapy with the pupil's daily living results in greater integrity in his over-all functioning.

CHARACTERISTICS OF PSYCHOEDUCATIONAL THERAPY

Because psychoeducational therapy is conducted in the schools, it takes on

a certain set of characteristics. No one school of therapy has been incorporated exclusively into psychoeducational therapy. Rather, psychoeducational *therapy comprises any of the many therapies–psychodynamic, rational, or behavioral–that can be fitted into our program procedures schema.* Psychoeducational therapy is not, for example, contradistinctive from psychotherapy; the relation of the latter to the former depends upon the adaptation that the latter goes through within the program. The psychologist is free to employ any therapy he knows and is skilled in so long as he assimilates the particular therapy into the schema.

The procedural schema into which therapies must fit consists of the following:

1. Initial diagnosis, with hypotheses that flow from the diagnosis, which suggests the treatment method of choice.
   a. Individual therapy
   b. Group therapy
   c. Facilitative therapy. Facilitative therapy is defined as assistance given the child or small groups of children in developing cognitive, sensory-motor, or affective skills under the supervision of the psychologist and conducted, within a supportive relationship, by aides, teachers, peers, or others.
2. Determination of goals and objectives which must relate to learning and behavior of the individual as pupil or student.
3. Setting and adhering to limits that are school appropriate.
4. Managing the process and techniques of therapy consistently with an explicitly stated therapy rationale, including in-process shifts when needed.
5. Termination of therapy as a joint decision of the psychologist, child, and school personnel who work with the child.
6. Evaluative reporting of progress and/or results.

CONDITIONS OF STRUCTURE AND FUNCTION IN THE SCHOOLS THAT INFLUENCE PSYCHOEDUCATIONAL THERAPY

There are certain conditions of structure and function in the schools that influence in specific ways the practice of psychoeducational therapy. The school is an orderly environment. Organization is firmly established and clearly defined. Operations are predictable. The daily agenda is open and public, not private. Therapy, to be viable within this instructional frame, needs to fit into the total setting. The privacy of therapy must be respected but the presence and accessibility of the therapist to school personnel washes away some of the mystical qualities attributed to therapy.

More specific ways in which the actual practice of the therapy is influenced by the school's structure and function include the following:

1. Techniques of therapy are influenced. For example, those techniques that disturb the order and predictability of the school cannot be employed. Level of noise must be controlled. Fire play cannot be allowed. Venting or acting out that might cause the pupil to return to the classroom excited and hyperactive has to be regulated.
2. Quality of the therapist-pupil interaction is influenced. A certain dis-

tance tends to be maintained between the therapist and the pupil. This is effected in a number of ways. The therapist here is not likely to explore the depths of the student's private life; the pupil rarely exposes as much of himself as he would in some other settings. Facilities most often do not afford that degree of withdrawal by therapist and pupil from the razzle dazzle of the on-rushing world to the quiet seclusion of especially designed therapy rooms where presumably they can reflect, act, and relate undisturbed by others. Thus, the relationship has to be established and maintained in the presence of competing stimuli of the real world. However, the changes in the pupil(s) that result from this situation will allow for better transfer to the real world of the classroom because of the similarities in the perceived functioning of self-in-interaction between the classroom and the therapy space.

3. There is an effect upon the duration of therapist-pupil relationship. Depending upon the situation, the relationship may be lengthened or shortened under the direct influence of the school. In other words, the school staff's observations and evaluations of the pupil's behavior and/or learning may influence the time and decision regarding termination. The school may encourage longer stay in therapy where it sees the pupil as not having made enough overt progress to terminate, whereas alone the psychologist might have terminated on the basis of a measure of internal change. The school might compare the current improved behavior of those in therapy with the behavior of others not in therapy and suggest termination, unaware that the gains may not be sufficiently established to be lasting. Nevertheless, the psychologist can and does make some use of what the school people say about the adjustment of the pupil(s) in therapy to gauge the tapering off process or the phasing out of the therapeutic relationship.

4. The influence of the school setting upon intended outcomes is perhaps most obvious. Expected outcomes are usually stated in terms of the realities of school life and are thought to be helpful to the pupil in becoming a better learner. Such objectives as acquisition of specific cognitive skills, positive peer interaction, improved attendance, and the like may be said to be secondary to the underlying process of therapy; they are stated to express the outcomes of therapy in terms of the school's criteria for successful learning and behavior.

5. The communication pattern between therapist and pupil client is also shaped by school factors. The psychologist providing the therapy encourages the teacher or others to provide a relationship that is supportive of the therapy. In order to communicate and to maintain cooperation, to allay fear and distrust, there is need for the psychologist—with the knowledge and agreement of the child—to remain in touch with teachers and others regarding what is happening with the pupil client (without violating confidences).

WAYS IN WHICH PSYCHOEDUCATIONAL THERAPY IS INFLUENCED BY FACTORS OTHER THAN SCHOOL STRUCTURE AND FUNCTION

There are factors other than those relating to school structure and function that have important effects upon the therapy. Some of these are pupil age, SES, and ethnic identity. Where focus is upon the younger child, prekindergarten through grade three, emphasis is placed upon *activities* in

association with the talking therapies, and groups are small, comprising two or three pupils. Ambivalence and suspiciousness as functions of SES and ethnic identity retard the therapy relationship but do not prevent it from getting established or from being maintained once established.

"RESPONSIBILITY" OF THE MODEL DEFINED

We see this as a responsibility model of psychological services for three reasons. First, it provides follow-through from diagnosis into therapeutic intervention. Second, its intent is to make therapeutic intervention have an effect upon the child's learning and behavior in the classroom. The therapist has the responsibility to see that the result of the therapy is better pupil functioning in the classroom and school. Third, it makes the psychologist share in accountability for achieving the goals of the school system, especially in developing the attributes of positive self-concept and social interaction skills.

Psychoeducational therapy, at this point in its evaluation, is projected as a flexible, school-oriented type of intervention (Zucker, 1971) that responds to the call to follow diagnosis with treatment and that holds promise for children who have the potential for being in the school at all.

ELEMENTS OF THE MODEL THAT RESPOND TO THE PROBLEMATIC SCHOOL ENVIRONMENT

There are numerous system elements or aspects of this responsibility model that back up and support psychoeducational therapy in that they are calculated to ameliorate school environmental conditions which might be generating the very behavior for which the pupils might otherwise be referred for psychoeducational therapy. These elements include programs of human relations leadership training for school staffs, parent counseling and therapy, teacher therapy (Jackson, 1969), and in-service training for staffs through organized courses and workshops. The balance that the system elements introduce into the model serve to insure that forces, factors, and persons in the environment can be modified generally in a positive direction and specifically when the problem resides with the school rather than with the pupil.

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