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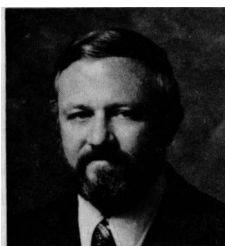
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What is This?

A REAPPRAISAL OF
MENTAL HEALTH EDUCATION:
A HUMANISTIC APPROACH

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SUMMARY

This article presents arguments in favor of a humanistic approach to the "mental health" education of the general public. Within the context of a "demythologizing" approach, I propose that conceptual paradigms other than the medical model would be of greater benefit to the public in construing their psychological problems. Research evidence is reviewed which attests to the utility of a more humanistic, psychosocial approach.

Humanistically-oriented professionals (e.g., Adams, 1964; Szasz, 1961, 1970a, 1970b, 1974; Winthrop, 1964) have deplored the medical paradigm of mental illness without, however, finding effective methods to alter the public's general acceptance of that paradigm. Kelly (1972) asserts that, as "bad as the [medical] model is, it is difficult to abandon because it is institutionalized, established, built into the fabric of our society in legislation, practice, and traditional education [p. 71]."

The four basic postulates of the medical model according to Blaney (1975) are: (*a*) mental disorders are organic diseases; (*b*) the visible evidences of the disorder are but manifestations of an underlying substructure; (*c*) the individual has no responsibility for his or her behavior; and (*d*) the best way to understand psychiatric symptoms is through diagnostic procedures. These stand in clear contrast to the five basic postulates of humanistic psychology set down by Bugental (1964): (*a*)

human beings supercede the sum of their parts; (*b*) people have being in a human context; (*c*) we are aware; (*d*) we have choice; (*e*) we are intentional.

The public has generally accepted the basic tenets of the medical model and is convinced that mental illness is an illness like any other, it can strike anyone, its victims are entitled to the care of physicians, and this illness can be cured (Bentz & Edgerton, 1970; Crocetti & Lemkau, 1963; Crocetti, Spiro, & Siassi, 1971; Lemkau & Crocetti, 1962; Meyer, 1964; Rabkin, 1974; Ring & Schein, 1970). Without attempting to detail the cogent arguments made by critics of the medical model (e.g., Sarbin & Mancuso, 1970, 1972; Szasz, 1961, 1970a, 1970b, 1974; Torrey, 1974), I will briefly outline some of the principle disadvantages of the public's acceptance of the medical paradigm.

First of all, the medical model's emphasis on organic dysfunctioning has at least indirectly led to dehumanizing experimentation on mental patients, such as the early use of electroshock treatment and psychosurgery. We are also now aware of patients who were involuntarily committed to mental hospitals for treatment, but who languished in confinement for many years without receiving anything akin to treatment. Furthermore, at least until recently, it was not uncommon for patients to take large doses of major tranquilizers for many years. Such dosages of tranquilizers in combination with other medications caused serious negative side-effects (e.g., brain damage). It seems likely that if the public had not allowed medical practitioners such unwarranted legal and moral power (Ennis, 1972; Ennis & Siegel, 1973; Holdrige-Crane, Morrison, & Morrison, in press; Szasz, 1965, 1970a), and if they had more alternative conceptual models to consider, such abuses would have been fewer.

Second, acceptance of a medical paradigm may frequently influence the public to assume less direct responsibility for resolving personal problems. To view one's problems as a "mental illness," and to seek out a psychiatrist to treat this "illness," implies that lay people can do little or nothing by themselves to change their condition. Such a perspective may lead to increased dependence on psychiatric professionals and a diminished sense of personal responsibility. One study (Morrison, Bushell, Hanson, & Fentiman, 1977) indicates that psychiatric clients' medically oriented attitudes toward mental illness are significantly correlated ($r = .60$) with attitudes of dependence on psychiatric staff. Thus, the more oriented a person is toward the medical paradigm, the more inclined is that person toward seeing others (e.g., psychiatric professionals) as being responsible

for one's happiness or unhappiness. Such attitudes may often lead persons seeking psychiatric help to have unrealistic expectations about the effectiveness of the services offered. Frequently, clinicians encounter clients who are angry because the "treatment" is not producing the "cure" advertised in mental health publicity. Proponents of the medical model, by emphasizing organic and unconscious causes, necessarily deemphasize free choice, intentionality and ultimately a person's responsibility for behavior.

Third, the equation of "mental illness" with "physical illness" circumscribes the delivery of services as the rightful and legitimate prerogative of medical professionals. This state of affairs communicates to the public that other professional specialists (clinical and community psychologists, psychiatric social workers, vocational-rehabilitation counselors) can provide only second-class services. Witness the current debate over third party insurance reimbursement for "mental health" services which appears to place clinical psychologists in the position of either endorsing the validity of the medical model, or of being penalized financially (Albee, 1975). It is perhaps not surprising that a substantial number of nonmedical professionals (e.g., clinical psychologists and psychiatric social workers) currently reject many of the major tenets of the medical model (Morrison & Nevid, 1976c; Morrison & Hanson, 1978).

Of course, some psychiatrists (e.g., Osmond, 1973; Siegler & Osmond, 1974a, 1974b) claim the medical paradigm has some distinct advantages over nonmedical models. Certainly, for those patients who cannot, or do not want to, accept any responsibility for their own behavior, construing their personal problems as a "mental illness" or "disease" might reduce guilt among those clients and their families. However, such clients and families may still be the eventual losers since family systems are then likely to remain as dysfunctional as before, but now, unfortunately, with one member clearly in the role of scapegoat.

ADVANTAGES OF A NON-MEDICAL, HUMANISTIC APPROACH

The advantages for the public of humanistically oriented nonmedical paradigms are best understood in relationship to the corresponding disadvantages of the medical model mentioned above. Thus, the possible abuses resulting from psychological problem-solving strategies are less life-threatening than those which can result from medical treatments. Misuse of nonmedical techniques (e.g., fixed-role therapy, psychodrama,

or encounter groups) by unscrupulous or incompetent professionals is less risky than the misuse of radical medical procedures (e.g., ECT, psychosurgery, or drugs).

An advantage of nonmedical, humanistically oriented models which emphasize some personal responsibility for the development and maintenance of personal problems is that such conceptual approaches induce more realistic expectations of psychological services and less dependence on mental health professionals. Evidence from Morrison, Bushell, Hanson, and Fentiman (1977) indicates that psychosocial attitudes congruent with humanistic psychology are significantly related to attitudes which reflect a sense of personal responsibility. That one has "problems" instead of an "illness" conveys to the public the message that since problematic behavior is primarily learned, it can be unlearned.

In addition, psychosocial paradigms allow important roles for *all* professional specialists. Thus, if one has various psychological/medical/ legal/financial/moral/educational "problems" one should consult psychologists, psychiatrists, physicians, lawyers, budgetary experts, clergymen, and teachers, all of whom have their own special approaches to problem solving.

A HUMANISTIC APPROACH TO PSYCHOSOCIAL EDUCATION

In the past few years, several colleagues and I have undertaken to present a nonmedical model to persons in one geographic area. Our humanistic approach focuses first on the "myths of mental illness" (Morrison, in press) and second, on a psychosocial approach to personal problems, with heavy emphasis on personal construct theory (Kelly, 1955). The demythologizing approach derives from Szasz and others who emphasize that mental illness is only a "metaphorical disease" (e.g., Szasz, 1974); that diagnostic procedures and projective tests are of questionable reliability and validity (e.g., Mischel, 1968; Rosenhan, 1973); that mental patients are not strange, bizarre, unpredictable and dangerous persons (e.g., Braginsky, Braginsky, & Ring, 1969; Ennis, 1972; Steadman, 1973); and that many of our current psychiatric interventions (e.g., involuntary hospitalizations, ECT, psychosurgery), as currently used, are of questionable utility. In small seminars, each of the myths of mental illness is considered with ample opportunity for discussion and disagreement. We point out that many medical model proponents would be vigorously opposed to the views presented, and that each person should decide for himself or herself which paradigm is of greatest utility.

After the myths are outlined, the seminar participants offered an alternative approach. Borrowing heavily from Maslow, Perls, Rogers, and especially George Kelly, my associates and I present seminar participants with theories and research evidence (in simplified language) that psychological problems are primarily caused by inter- and intrapersonal factors, that an inability to define and express a wide range of feelings can cause psychological problems, that people develop problems as they are unable to predict events within presently existing construct systems, that persons have some responsibility for resolving their problems, and that people are capable of tremendous personal growth.

The response of the public to this approach has been instructive. Frequently, we receive feedback that it is refreshing to hear such professional honesty from mental health professionals. Perhaps much of the ridicule of "shrinks" in the media is justified simply because we have taken ourselves and our role all too seriously. An adult education course which reveals our mistakes, our prejudices, and our limitations can actually do much to restore integrity to our profession. The public has always known that we cannot deliver on some of our more grandiose promises of curing the world's ills. But, people want to hear *us* admit as much.

REVIEW OF RESEARCH

Research studies convincingly demonstrate that "demythologizing" seminars are effective in changing the attitudes toward mental illness of psychiatric staff (Morrison & Becker, 1975), psychiatric clients (Morrison, 1976; Morrison & Nevid, 1976b), family caretakers (Morrison & Nevid, 1976a), college students (Morrison, Cocozza, & Vanderwyst, 1978), general hospital personnel (Morrison & Brown, 1976), and the general public (Morrison & Teta, 1977; Morrison & Teta, in press). Following a presentation of data in direct opposition to the basic assumptions of a medical paradigm, the participants in those studies responded on a very reliable and predictive attitude measure (Client Attitude Questionnaire, Morrison, 1976) in such a way as to reflect a rejection of a medical approach and an acceptance of a psychosocial, humanistic approach. That such an acceptance of an alternative model was a meaningful and stable one is indicated by evidence that participants could explain why they changed their attitudes (Morrison & Nevid, 1976b) and that such attitudes remained virtually unchanged in follow-up administrations from three to nine months after the seminars (Morrison, 1976; Morrison & Becker, 1975; Morrison & Teta, 1977; Morrison, Cocozza & Vanderwyst, 1978).

Of most importance to our argument is evidence that these seminars appear to produce a number of positive changes in seminar participants. One study suggests that demythologized psychiatric clients experience fewer hospitalizations than do a matched group of similar clients who do not receive "demythologizing" (Morrison, 1976). Another study (Morrison, 1977) demonstrates that such seminars can reduce the negative attributions to "the typical mental patient" made by psychiatric clients. A study by Morrison & Teta (1977) indicated that seminars for the public induce an increase of positive self-attributions among participants.

The implications of these studies are important. If changing the public's attitudes in the direction of a humanistic approach leads to positive effects (decreased psychiatric hospitalizations, more positive self-attributions) then perhaps one can tentatively conclude that the public finds "psychological relief" in construing themselves and their problems in humanistic as opposed to medical terms. Thus, if one does not have to fear that "mental illness" might strike at any time, one's self-confidence and feelings of self-reliance should increase. Furthermore, if mental illness is a myth, and if in reality unacceptable behavior is for the most part learned and therefore comprehensible, then one can also learn to change that behavior. One does not have to depend exclusively on physicians or psychiatrists and their corresponding medical interventions; one only needs to seek assistance in *learning* how to resolve one's problems.

Crampton (1969) argues that there is really no difference between what we call "psychotherapy" and what we call "education." Psychotherapy is a word which too often connotes a mystical, medical intervention, instead of what really is a process of self-education and personal growth. By changing some of our common terminology, we might begin to dissolve some of the mysticism which still surrounds "therapy." Changing the terminology will, of course, only be a cosmetic change unless we begin to offer seminars and courses which will enable more of the public to gain knowledge of recent theoretical and operational approaches to human behavior.

CONCLUSIONS

Although the public has substantially accepted the basic propositions of the medical paradigm, the time has come to present alternative paradigms. Evidence indicates that there is some utility in offering the public nonmedical, humanistic paradigms. Only when people are made aware of a number of different paradigms can they be said to have free choice in selecting the approach of maximum utility for them.

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