Clinical Psychology: Beyond Psychopathology and Clinical Interventions

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As clinical psychology addresses an increasingly wide spectrum of problems, the discipline's dominant emphasis on psychopathology must be integrated with an equivalent understanding of psychosocial problems. Such a balance is viewed as improving work done in relation to all problems addressed by clinical psychology and the mental health field. In support of these views, this article explores the importance of going beyond psychopathology with respect to (a) classifying behavioral, emotional, and learning problems and (b) conceiving intervention models.

Key words: psychosocial problems, transactional view, psychopathology, diagnostic taxonomies, intervention models, school-based interventions, School-Based Health Centers. *[Clin Psychol Sci Prac 2:28–44, 1995]*

The range of human problems addressed by clinical psychologists continues to increase, but the emphasis on psychopathology continues to dominate the discipline and the field of mental health in general. This domination is seen in the relatively superficial way psychosocial problems are attended to by many clinical psychologists in their roles as academicians, researchers, practitioners, and policy shapers. For example, the extensive activity devoted to developing formal schemes for classifying psychopathology has not been paralleled for psychosocial problems. Thus, it is common for persons manifesting emotional upset, misbehavior, and learning problems of a nonpathological nature

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to be assigned pathological diagnostic labels—such as depression, ADHD (attention-deficit/hyperactivity disorder), and LD (learning disabled). Invalid differential diagnoses, of course, contaminate research samples and may lead to inappropriate interventions. When this occurs, the dominant emphasis on pathology negatively affects work done in relation to both psychopathology and psychosocial problems.

This article aims at encouraging the field to adopt a policy of parity so that the topic of psychosocial problems is allotted the same status given to psychopathology. In pursuing this aim, the article has two underlying themes: One is that the understanding and amelioration of psychosocial problems require the same quality of conceptual and empirical attention from the discipline that currently is given to psychopathology; the other is that clinical psychology and the field of mental health can benefit from viewing psychopathology within a framework that encompasses psychosocial problems. These themes are aired through brief discussions of (a) classifying behavioral, emotional, and learning problems from a perspective that goes beyond psychopathology and (b) moving beyond clinical intervention models.

The audience I most want to address are those who shape thinking about clinical psychology and mental health research and training. Psychology departments, in particular, need to examine their curriculum with respect to course offerings, practicum placements, and research opportunities to determine the degree to which psychosocial problems are a focus. Those that primarily emphasize psychopathology may wish to maintain this stance; if they do, they should formalize their rationale for doing so and advise prospective undergraduate majors and graduate applicants accordingly. Some, however, may wish to consider moving toward a formal commitment

and systematic focus on both psychopathology and psychosocial problems.

CLASSIFYING BEHAVIORAL, EMOTIONAL, AND LEARNING PROBLEMS

Classification tends to determine the nature and scope of what is studied and what is done to correct problems. Even more fundamentally, disciplines and applied fields profoundly shape their very essence as they adopt classification schemes. For example, in psychology, psychiatry, and education, the schemes adopted have far-reaching effects. They determine the ways individuals are described, studied, and served; they shape prevailing practices related to intervention, professional training, and certification; and they influence decisions about funding. It is not surprising, therefore, that debates about classification schemes, specific diagnostic procedures, and the very act of labeling are so heated.

As occurs with all abstract constructs, operationalizing categories is difficult and fraught with complex problems and issues. Consequently, any particular scheme is an easy target for criticism and controversy. And, the critiques cut two ways. For one, they can hurt a field's image by laying out its deficiencies. At the same time, the criticism can be a stimulus for improving the unsatisfactory status quo.

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by causal and corrective models stressing personal pathology. This dominance is evident in causal hypotheses, classification schemes, and intervention strategies. One result has been a failure to develop classification schemes in ways that effectively differentiate psychosocial problems from personal pathology; more generally, there has been a relative lack of attention to the need for systematic categorization of psychosocial problems (e.g., Adelman & Taylor, 1994; Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990; Kazdin, 1993). The failure to place personal pathology within a perspective that adequately accounts for psychosocial problems is well illustrated by the widely used classification scheme published as the *Diagnostic and Statistical Manual of Mental Disorders* (hereafter DSM-IV; American Psychiatric Association, 1994). This problem is evident even with schemes that are highly empirical and dimensionally oriented—such as the MMPI (Minnesota Multiphasic Personality Inventory) categories and those that Achenbach and others have formulated based on behavior rating scales.

Because they do not adequately differentiate psychopathology from other related problems, comprehensive *formal* schemes used to classify problems in human functioning generally convey the impression that behavioral, emotional, or learning problems are instigated by internal *pathology* (e.g., often attributed primarily to *nature*—using the term broadly). Efforts to temper this impression usually suggest that the pathology is a vulnerability that manifests as a problem only under stress. At the same time, however, bias toward personal pathology in classifying problems may be bolstered by the tendency (outlined in attribution theory) for observers to perceive the problems of others as rooted in stable personal dispositions (Bradley, 1978; Deci & Ryan, 1985; Miller & Porter, 1988). This tendency may be further promoted by societal and professional interests (e.g., economic and political) that favor a view of such problems in terms of personal rather than social causation (Becker, 1963; Chase, 1977; Hobbs, 1975; Lopez, 1989; Schact, 1985; Wakefield, 1992).

The way in which DSM-IV presents the differential diagnosis of children's behavior problems provides a commonplace example of a pathological bias in classifying such problems. For instance, in making a judgment about whether to assign a diagnosis of conduct disorder, the manual primarily stresses differentiation in terms of other disorders (e.g., oppositional defiant disorder, attention-deficit/hyperactivity disorder, adjustment disorder). That is, the emphasis is on choosing from among disorders. Thus, the bias is toward diagnosing one or more disorders, rather than framing the classification problem in terms of the question, Is there a disorder?

An overemphasis on classifying problems in terms of personal pathology skews theory, research, and practice. One example is seen in the fact that comprehensive classification schemes do not exist for environmentally caused problems (i.e., those attributable primarily to improper *nurture*) or for psychosocial problems (e.g., instigated by both *nature and nurture*). There is considerable irony in all this because it is likely that on a theoretical level many who use prevailing diagnostic schemes think in terms of the interplay of person and environment in viewing the etiology of most problems in human functioning—with differences in view concentrating on the amount of variance hypothetically attributed to each.

To counter nature-*versus*-nurture biases in thinking about problems, it is beneficial to approach all classification and intervention guided by a broad model that incorporates both views in thinking about human behav-

ior (including problems). In psychology, such a model is the currently prevailing transactional view.

A Broad View of Human Functioning

Before the 1920s, psychology was dominated by models of human behavior that viewed the determinants of behavior primarily as a function of personal variables, especially inborn characteristics. With the rise of behaviorism, a strong competing model stressed that behavior was primarily a function of the environment, for example, the stimuli and reinforcers one encounters.

The contemporary model for understanding human functioning is a transactional view that emphasizes the reciprocal interplay of person and environment (see Bandura, 1978). However, in clinical psychology, current approaches to classifying and ameliorating human problems continue to create an impression that such problems are attributable primarily to either person or environment variables. This is both unfortunate and unnecessary. It is unfortunate because it limits efforts to advance knowledge. It is unnecessary because a transactional view encompasses functioning determined by person, environment, or both and encourages a comprehensive perspective of cause and correction.

To illustrate the nature of transactional thinking, I draw on my research group's work related to learning problems (cf. Adelman, 1994a; Adelman & Taylor, 1993a). In teaching a lesson, a classroom teacher will find that some students learn easily and some do not; some misbehave, some do not. Even a good student may appear distracted on a given day. Why the differences?

A commonsense answer suggests that each student brings something different to the situation and therefore experiences it differently. And that's a pretty good answer—as far as it goes. What gets lost in this simple explanation is the essence of the differences and the reciprocal impact student and situation have on each other—resulting in continuous change in both.

For purposes of the present discussion, any student can be viewed as bringing to each situation *capacities and attitudes* accumulated over time, as well as *current states of being and behaving*. These "person" variables transact with each other and also with the environment. At the same time, the situation in which students are expected to function not only consists of *instructional processes and content*, but also the *physical and social context* in which instruction takes place. Each part of the environment also transacts with

the others. Obviously, the transactions can vary considerably and can lead to a variety of outcomes with respect to changes in the students. At any given time, observers noting student outcomes may judge them as positive, negative, or some combination of both. For example, as outlined in Figure 1, the types of functioning and potential changes in accumulated capacities and attitudes can be described as

1. Desired functioning (with possible changes and expansion of capacities and attitudes in "approved" ways)

2. Deviant functioning (with possible changes and expansion of capacities and attitudes but not in "approved" ways)

3. Disrupted functioning (interference with ability to function, including distorted attitudes and possibly a decrease in capacities)

4. Delayed and arrested functioning (with little change in capacities and perhaps in attitudes)

Such outcomes, of course, are accompanied by concomitant shifts in current states of being and behaving. Any specific outcome (e.g., deviant functioning) may *primarily* reflect the contribution of personal variables, environmental variables, or both. Similarly, subsequent changes in functioning (e.g., amelioration of problems) may require interventions that focus primarily on person, environment, or both.

From the above perspective, a critical need exists for taxonomic categories that differentiate positive and negative functioning with respect to internal causes, environmental determinants, or the transaction of both. While such a scheme cannot be generated solely from existing research findings, the theoretical foundation for proceeding clearly is available. The absence of such categories limits understanding of human behavior and thus unduly restricts theory, research, and practice related to human problems. (Note: Although the term *psychosocial problems* connotes problems that arise because of the way specific person and environmental factors transact, for convenience in the present discussion the label also is used to encompass problems instigated primarily by environmental variables.)

Toward Broadening the Classification of Problems

Conceptually, defining and differentiating problems in human functioning is tantamount to the general task of
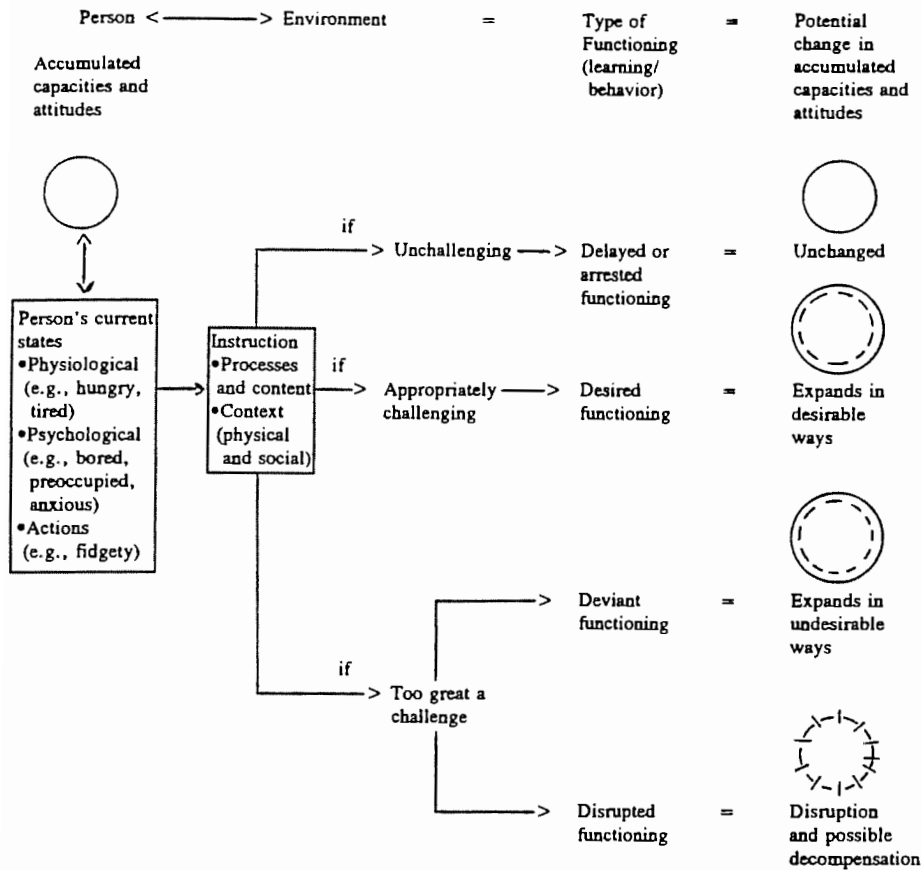
Person $<\longrightarrow>$ Environment $\quad = \quad$ Type of Functioning (learning/ behavior) $\quad = \quad$ Potential change in accumulated capacities and attitudes

Accumulated capacities and attitudes

Person's current states
• Physiological (e.g., hungry, tired)
• Psychological (e.g., bored, preoccupied, anxious)
• Actions (e.g., fidgety)

Instruction
• Processes and content
• Context (physical and social)

if > Unchallenging ⟶> Delayed or arrested functioning $\quad = \quad$ Unchanged

if > Appropriately challenging ⟶> Desired functioning $\quad = \quad$ Expands in desirable ways

> Deviant functioning $\quad = \quad$ Expands in undesirable ways

if > Too great a challenge

> Disrupted functioning $\quad = \quad$ Disruption and possible decompensation

Figure 1. Learning and behavior as a function of person-and-environment transactions. (See Table 1 for examples of personal and environmental factors—and their transactions—that lead to problems. From Adelman & Taylor, 1993a, p. 162. Copyright 1993 Wadsworth, Inc. Reprinted by permission of Brooks/Cole Publishing Company.)

classification or taxonomic sorting. Classification begins with creation of categories into which phenomena will be ordered. The process of constructing categories may be inductive, deductive, or both. How many class categories are created depends essentially on one's ability to abstract from one's experience (including statistical analyses). The categories may range in level of abstraction from highly descriptive to extremely abstract. Principles used in constructing such classes usually are closely related to the purposes for which the classification scheme is developed. In this regard, researchers may adopt different principles than practitioners, and both may prefer to classify phenomena differently from policy makers and administrators.

The task of classification, of course, involves more than development of a conceptual scheme; it requires procedures for differentially measuring (i.e., operationally identifying) phenomena of interest. A great deal of criticism aimed at psychiatric and special education classification stems from the fact that current identification procedures result in heterogeneous groupings. For

example, individuals assigned the same diagnostic label may differ with reference to symptoms, causes, current performance, and prognosis. At the simplest level, this criticism raises the point that a group assigned a particular label encompasses important subgroups. At a more complex level, this criticism suggests the diagnostic label does not capture the essence of an important class of phenomena.

Present efforts to classify psychological and educational problems use taxonomies and typologies defined in terms of current dysfunctioning, causal factors, intervention implications, or some combination of all these (American Psychiatric Association, 1994; Cromwell, Blashfield, & Strauss, 1975; McReynolds, 1989; Rutter & Gould, 1985; Rutter & Tuma, 1988; Zigler & Phillips, 1961). The approach to taxonomy building generally is based on observation or multivariate statistical techniques, and the specific variables and criteria used in defining a category usually are chosen because they have immediate relevance for research, intervention, administrative, or policy matters. For many labels, however, the

difficulty in validly identifying cause precludes doing more than grouping by symptoms and handicapping condition. Psychiatric and special education classifications, for example, use a polythetic approach, whereby those persons who share a number of attributes usually are assigned the same label. It should be noted, however, that designated symptoms have constituted a relatively limited range of the potentially important correlates, and the classification schemes have not adequately dealt with the dimensions of severity and pervasiveness or with causality. As greater attention is given to classifying psychosocial problems, these factors will reemerge as essential concerns for differential categorization. (It is relevant to note that DSM-IV includes an enhanced emphasis on severity.)

Severity and Pervasiveness. The dimensions of severity (mild to profound) and pervasiveness (narrow to broad) have fundamental significance for planning, implementing, and evaluating intervention. As graphically presented in Figure 2, treating the combination of pervasiveness and severity as discrete categories rather than continuous variables yields 9 classification groups. When *paradigmatic* causes of dysfunction are added as a third dimension, the schema jumps to 27 groups. If duration is added, another large leap in categories results.

The relatively straightforward nine-group classification of severity and pervasiveness underscores a rather simple fact: it is *minimally* essential for intervention planning, implementation, and evaluation to differentiate with regard to such basic dimensions. For example, in making prognoses and evaluating intervention efficacy, one must account for severity given comparably pervasive problems. That is, realistic intervention requires recognition that comprehensive improvements are more easily accomplished with those whose problem severity is mild (X''') as contrasted to profound (X')—given equal pervasiveness.

Issues do arise, however, because of lack of agreement about how to define severity and pervasiveness. For example, in assessing individuals, severity might be defined in terms of intensity and frequency of specified deviant and devious behavior and/or nonoccurrence of adaptive skills and behavior. Pervasiveness might be defined with respect to the range of developmental areas and/or situations affected. Satisfactorily operationalizing these dimensions remains a major task confronting classi-
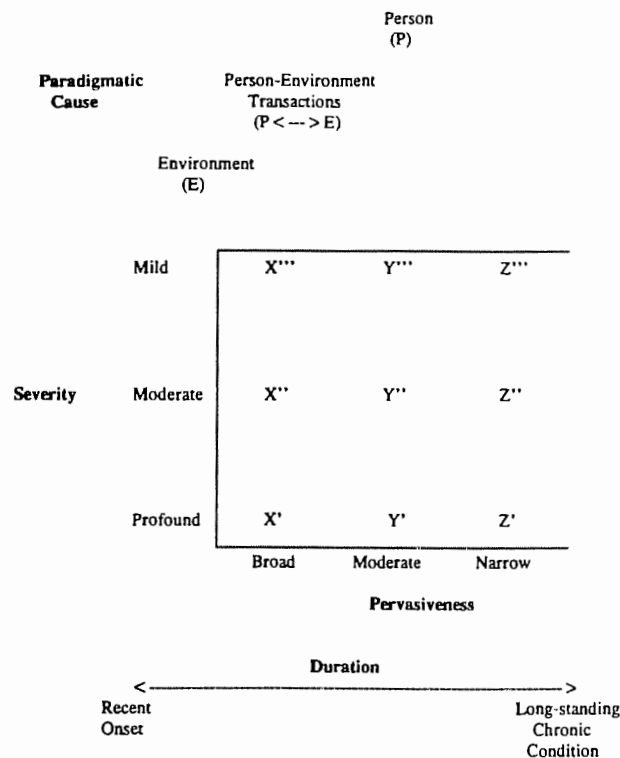

Figure 2. Four key dimensions of concern in classifying psychosocial and education problems.

fication researchers. The problem, of course, is that specific criteria for judging severity and pervasiveness depend on prevailing contextual norms and standards, such as expectations related to age, sex, subculture, and social status. Deviance (e.g., psychopathology, psychosocial problems), after all, is defined by social groups.

Causal Classification. Classification by cause may be done with reference to paradigmatic cause or in terms of specific instigators (primary/secondary contributing factors). The number of possible specific instigating factors is immense; indeed, a list of such factors related to psychological and educational problems would fill a book. For purposes of the present discussion, the broad, reciprocal, deterministic paradigm of cause has been used to generate an outline of general factors hypothesized as causing behavioral, emotional, and learning problems (see Table 1).

A critical look at Table 1 suggests some of the empirical and conceptual problems associated with using cause to classify problems. For example, many variables may be

Table 1. Factors instigating emotional, behavioral, and learning problems

Environment (E) (Type I Problems)	Person (P) (Type III Problems)	Interactions and Transactions Between E and P* (Type II Problems)
1. Insufficient stimuli (e.g., prolonged periods in impoverished environments; deprivation of learning opportunities at home or school, such as lack of play and practice situations and poor instruction; inadequate diet)	1. Physiological insult (e.g., cerebral trauma, such as accident or stroke, endocrine dysfunctions and chemical imbalances; illness affecting brain or sensory functioning)	1. Severe to moderate personal vulnerabilities and environmental defects and differences (e.g., person with extremely slow development in a highly demanding environment, all of which simultaneously and equally instigate the problem)
2. Excessive stimuli (e.g., overly demanding home, school, or work experiences, such as overwhelming pressure to achieve and contradictory expectations; overcrowding)	2. Genetic anomaly (e.g., genes that limit, slow down, or lead to any atypical development)	2. Minor personal vulnerabilities not accommodated by the situation (e.g., person with minimal CNS disorders resulting in auditory perceptual disability trying to do auditory-loaded tasks; very active person forced into situations at home, school, or work that do not tolerate this level of activity)
3. Intrusive and hostile stimuli (e.g., medical practices, especially at birth, leading to physiological impairment; contaminated environments; conflict in home, school, workplace; faulty child-rearing practices, such as long-standing abuse and rejection; dysfunctional family; migratory family; language used is a second language; social prejudices related to race, sex, age, physical characteristics and behavior)	3. Cognitive activity and affective states experienced by self as deviant (e.g., lack of knowledge or skills such as basic cognitive strategies; lack of ability to cope effectively with emotions, such as low self-esteem)	3. Minor environmental defects and differences not accommodated by the individual (e.g., person is in the minority racially or culturally and is not participating in many social activities because he or she thinks others may be unreceptive)
	4. Physical characteristics shaping contact with environment and/or experienced by self as deviant (e.g., visual, auditory, or motoric deficits; excessive or reduced sensitivity to stimuli; easily fatigued; factors such as race, sex, age, or unusual appearance that produce stereotypical responses)	
	5. Deviant actions of the individual (e.g., performance problems, such as excessive errors in performing; high or low levels of activity)	

Note: From Adelman & Taylor, 1993a, p. 64. Copyright 1993 Wadsworth, Inc. Reprinted by permission of Brooks/Cole Publishing Company.
*May involve only one (P) and one (E) variable or may involve multiple combinations.

primary or secondary instigating factors. And, of course, secondary causal factors interact with primary instigators. In general, the degree to which secondary factors exacerbate problems is determined by type of primary instigator and the degree of dysfunction produced by it. This is exemplified when a genetic anomaly or physiological "insult" causes a major central nervous system (CNS) disorder and the effect on behavior is so severe and pervasive that resultant dysfunctioning cannot be significantly worsened. In contrast, when CNS disorders are minor, a great many secondary variables can aggravate existing dysfunctions and create other problems.

As the above analysis suggests, sometimes causal factors and their effects are logical indicators for intervention decisions and are potential predictors of outcome. That is, outcomes should differ for groups who differ in the degree to which the negative impact of causal factors can be compensated for or reversed.

From the above perspective, classification by causal factors and their immediate effects and current manifesta-

tions could be of great significance in intervention planning, implementation, and evaluation. The problem, of course, is that available methods for assessing causes (e.g., testing causal hypotheses) have major limitations.

A Working Example. Efforts to improve classification of problems in psychology, psychiatry, and education involve an interplay of conceptual and empirical activity. Progress has accelerated with advances in methodology, especially improved measurement, sequential decision making, and use of multiple approaches. However, the consensus among reviewers in this area is that considerable work remains to be done. For example, in reviewing classification of childhood problems, Quay, Routh, and Shapiro (1987) conclude that current classification schemes are seriously deficient. They stress the need for categories or dimensions that are distinguishable from other syndromes (to facilitate reliable diagnosis) and that also are associated with different causes, outcomes, or interventions.

A clear indication of the need to address a wider range of variables in labeling problems is seen in efforts to develop multifaceted classification schemes. The multiaxial classification system developed by the American Psychiatric Association in its DSM-IV represents the dominant approach (American Psychiatric Association, 1994). Although the system includes a dimension acknowledging "psychosocial stressors," this dimension is used mostly to deal with the environment as a contributing factor (i.e., such stressors are not usually specified as primary causes).

The following conceptual example is offered to illustrate the type of broad scheme that might provide a useful *starting* place in classifying behavioral, emotional, and learning problems with a view to differentiating psychopathology and psychosocial problems. From the perspective of a transactional view of the determinants of behavior, it is useful conceptually to differentiate along a continuum that separates problems caused by internal factors, environmental variables, or a combination of both. As can be seen in Figure 3, problems caused by the environment can be placed at one end of such a continuum and referred to as Type I problems. At the other end are problems caused primarily by pathology within the person and designated as Type III problems. In the middle are problems stemming from a relatively equal contribution of environmental and person sources, labeled Type II problems.

To be more specific: In this scheme, diagnostic labels connoting *extremely* dysfunctional problems caused by pathological conditions within a person are most appropriate for individuals whose problems fit the cluster designated as Type III problems. Obviously, some problems caused by pathological conditions within a person are not manifested in severe, pervasive ways, and there are persons without such pathology whose problems do become severe and pervasive. The intent is not to ignore these individuals; as a first categorization step, however, it is essential they not be confused with those seen as having Type III problems.

At the other end of the continuum are individuals with problems arising from outside the person (i.e., Type I problems). For example, many persons grow up in impoverished and hostile environmental circumstances; based on the best evidence available, such environmental conditions should be considered first in hypothesizing the primary instigating causes of the behavioral, emotional, and learning problems these individuals manifest. (Once such conditions are ruled out as the basis for observed problems, hypotheses about within-person causality become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of personal characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, personal variables account for more of the problem (thus e<--->P).

Clearly, a simple continuum cannot do justice to the complexities associated with classifying and differentiating psychopathology and psychosocial problems. Furthermore, some problems are not easily assessed or do not fall readily into a group due to data limitations and comorbidity (two of the frustrating realities confronting classifiers). However, as an example, the above conceptual scheme serves to suggest the value of initially using a broad, paradigmatic conception of causality. Specifically, the approach minimizes the presumptive tendency toward viewing problems as caused by deficiencies or pathology within the individual. In doing so, it helps avoid tendencies toward "blaming the victim" (Ryan, 1971). It also helps broaden the focus of intervention by highlighting the fact that a prerequisite and sometimes sufficient approach to ameliorating some problems involves improving the environment's accommodation of individual differences.

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each domain and major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, and learning problems arising from serious internal pathology

Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

E	(E < ---> p)	E < --- > P	(e < ---> P)	P

|---|---|
| Type I problems | Type II problems | Type III problems |

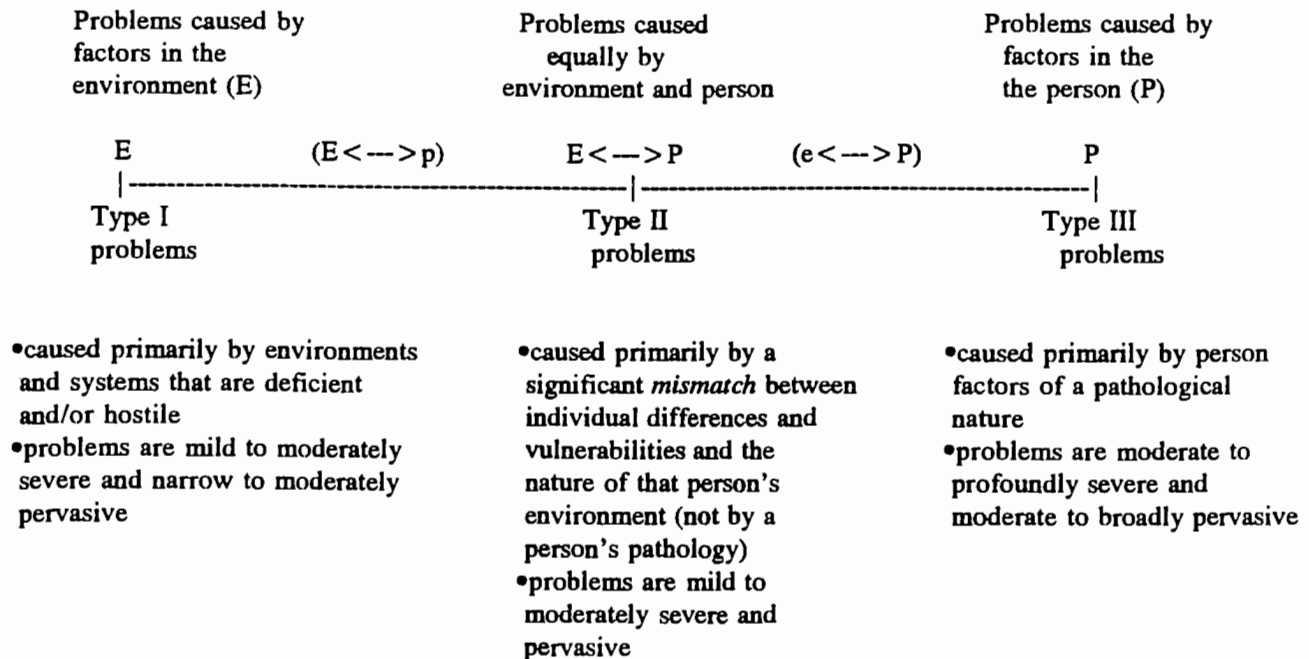| •caused primarily by environments and systems that are deficient and/or hostile •problems are mild to moderately severe and narrow to moderately pervasive	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology) •problems are mild to moderately severe and pervasive	•caused primarily by person factors of a pathological nature •problems are moderate to profoundly severe and moderate to broadly pervasive

Figure 3. A continuum of problems reflecting a transactional view of the locus of primary instigating factors. In this conceptual scheme, the emphasis in each case is on problems that are beyond the early stage of onset.

(e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). In doing so, it is evident there also is a need for a category to cover problems that pervade all three domains. Then, subtypes might be differentiated within each of these categories. For illustrative purposes, Figure 4 presents some ideas for subgrouping Type I and III problems; Figure 5 presents ideas for further subtyping misbehavior within the Type I category. In formulating subtypes, basic dimensions such as problem severity, pervasiveness, and chronicity continue to play a key role, as do considerations about development, gender, culture, and social class.

My point in offering specific examples is not to argue for their adoption but to emphasize that discussion of classification raises theoretical, practical, legal, and ethical matters of profound concern to researchers, practitioners, and policy makers. As the above discussion underscores, efforts to improve classification are essential to improving differential diagnoses related to psychopathology and psychosocial problems. The clearer the image of phenomena that are of interest, the sharper the focus of discussion

related to cause and correction and the greater the chances for advancing knowledge.

BROADENING INTERVENTION MODELS

Besides fostering new classification schemes, an equitable focus on psychosocial problems seems essential to efforts to broaden the nature and scope of models for intervention and to stimulate new directions for research and practice. Clinical psychology attempts to address a wide range of behavioral, emotional, and learning problems (e.g., psychoses, depression, suicide, attention deficit, substance abuse, unwanted pregnancy, spread of sexually transmitted diseases, illiteracy, school and societal dropouts, and violence in neighborhoods, homes, and schools). As long as psychopathology is the primary interest in the discipline of clinical psychology and the field of mental health, severe and pervasive problems are likely to be overemphasized in research, practice, and training. The focus on ameliorating such problems usually takes the form of specific clinical interventions. And, these clinical interventions tend to be pursued in isolation from other forms of intervention. That is, clinical interventions
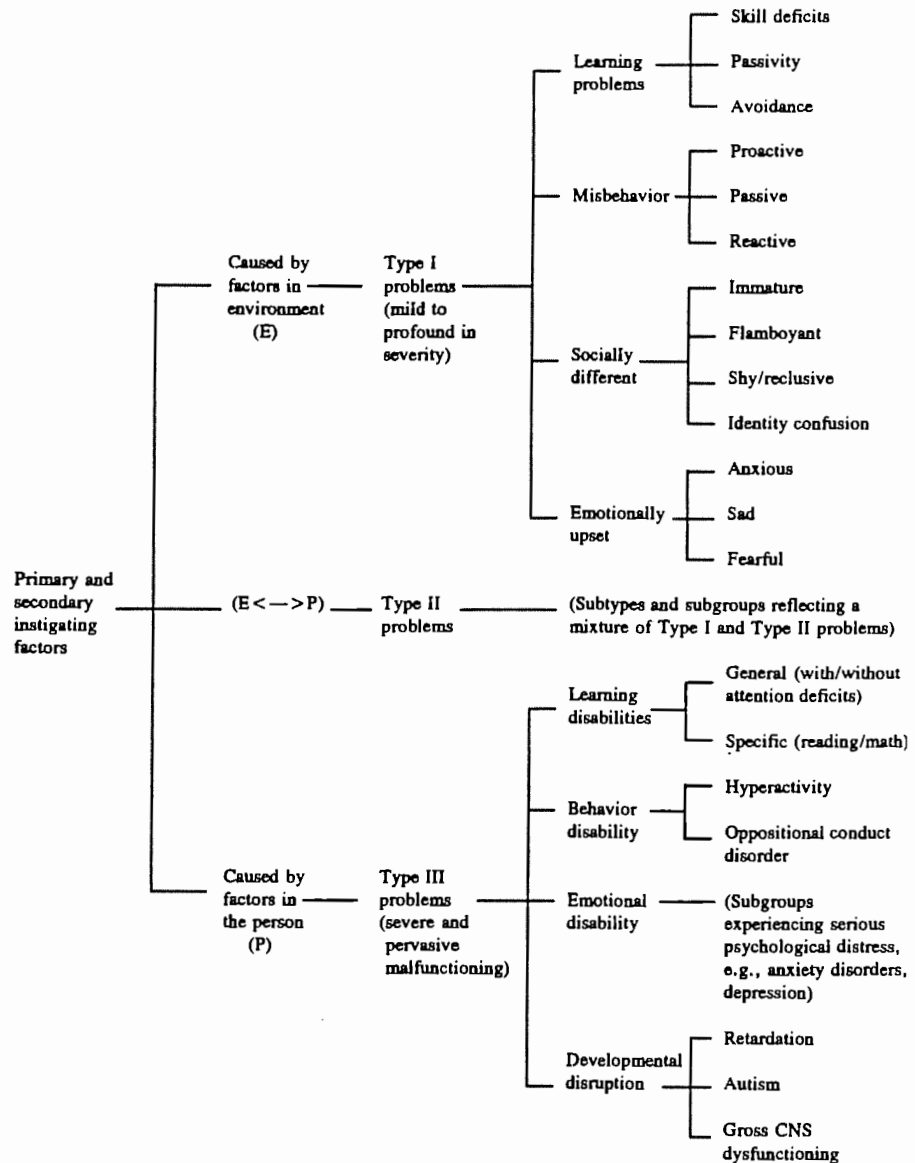
Figure 4. A categorization of Type I, II, and III problems. (From Adelman & Taylor, 1993a, p. 274. Copyright 1993 Wadsworth, Inc. Reprinted with permission of Brooks/Cole Publishing Company.)

Primary and secondary instigating factors

Caused by factors in environment (E) — Type I problems (mild to profound in severity)
- Learning problems — Skill deficits / Passivity / Avoidance
- Misbehavior — Proactive / Passive / Reactive
- Socially different — Immature / Flamboyant / Shy/reclusive / Identity confusion
- Emotionally upset — Anxious / Sad / Fearful

(E <—> P) — Type II problems — (Subtypes and subgroups reflecting a mixture of Type I and Type II problems)

Caused by factors in the person (P) — Type III problems (severe and pervasive malfunctioning)
- Learning disabilities — General (with/without attention deficits) / Specific (reading/math)
- Behavior disability — Hyperactivity / Oppositional conduct disorder
- Emotional disability — (Subgroups experiencing serious psychological distress, e.g., anxiety disorders, depression)
- Developmental disruption — Retardation / Autism / Gross CNS dysfunctioning

often are not conceived programmatically or carried out as part of a comprehensive, integrated system. When this is the case, they represent another example of the use of piecemeal strategies and fragmentation in addressing problems (see Adler & Gardner, 1994; Chaudry, Maurer, Oshinsky, & Mackie, 1993; also see Adelman, 1993; Dryfoos, 1993, 1994).

An increased focus on psychosocial problems can provide a correction to the above trends by underscoring the necessity of moving beyond current clinical intervention models to address the full range of behavioral, emotional, and learning problems with which the discipline is confronted. Two areas of intervention activity that illustrate the point are efforts (a) to address the problem of piecemeal and fragmented interventions and (b) to incorporate "mental health" programs into school settings.

Comprehensive and Integrated Intervention

Amelioration of the full continuum of problems illustrated above (e.g., Type I, II, and III problems) generally requires a comprehensive and integrated programmatic approach (e.g., mental health, physical health, social services). That is, any one of the problems may require

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                          │   Intentional Misbehavior │
                          │  (devious & deviant behavior) │
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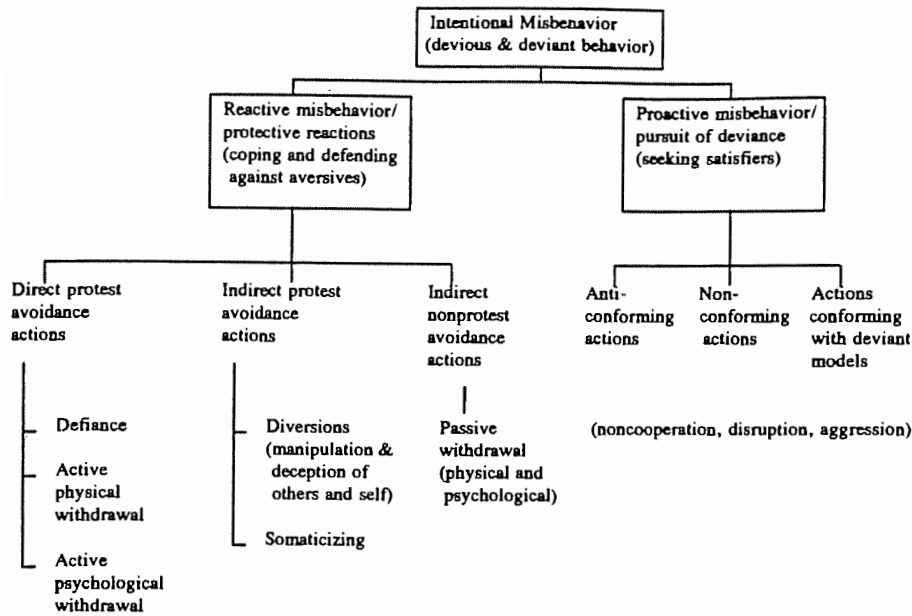
Figure 5. Subtyping intentional misbehavior (a Type I problem).

the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that interventions should be at least coordinated and, if feasible, integrated.

For the most part, however, interventions are developed and function in relative isolation of each other. One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other (sometimes within the same agency). Similarly, a youngster identified and treated in special infant and preschool programs who still requires special support may cease to receive appropriate help upon entering school. And so forth.

To illustrate the type of comprehensive model that emerges from a focus on both psychopathology and psychosocial problems, a continuum of interventions for addressing behavioral, learning, and emotional problems is outlined in Figure 6. The continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention, through those for addressing problems soon after onset, on to treatments for severe and chronic problems. With respect to *comprehensiveness*, the continuum highlights that many problems must be addressed developmentally and with a range of programs—some focused on individuals and some on environmental systems, some focused on mental health and some focused on physical health, education, and social services. With respect to concerns about *integrating* programs (e.g., to avoid piecemeal approaches), the model underscores the need for concurrent interprogram linkages and for linkages over extended periods of time.

It is relatively easy to conceptualize a comprehensive package of interventions. It is excruciatingly hard to (a) establish such a range of programs, (b) integrate those that are in operation, and (c) conduct the type of research that advances understanding. The picture that emerges from the literature on psychological, educational, health, and social interventions illustrates the difficulty (see Adler & Gardner, 1994; Hodgkinson, 1989; Kagan, Rivera, & Parker, 1990). Poor interface is characteristic of most intervention activity related to behavioral, emotional, and learning problems. Programs to address physical, mental health, and psychosocial problems rarely are coordinated with each other or with educational programs, and thus are widespread examples of the problem of piecemeal and fragmented intervention. Carefully designed and implemented research on comprehensive, integrated, programmatic efforts is almost nonexistent.

Deficiencies related to comprehensiveness and interface are attributable in significant measure to the way interventions are conceived and organized and the way professionals understand their roles and functions. Con-
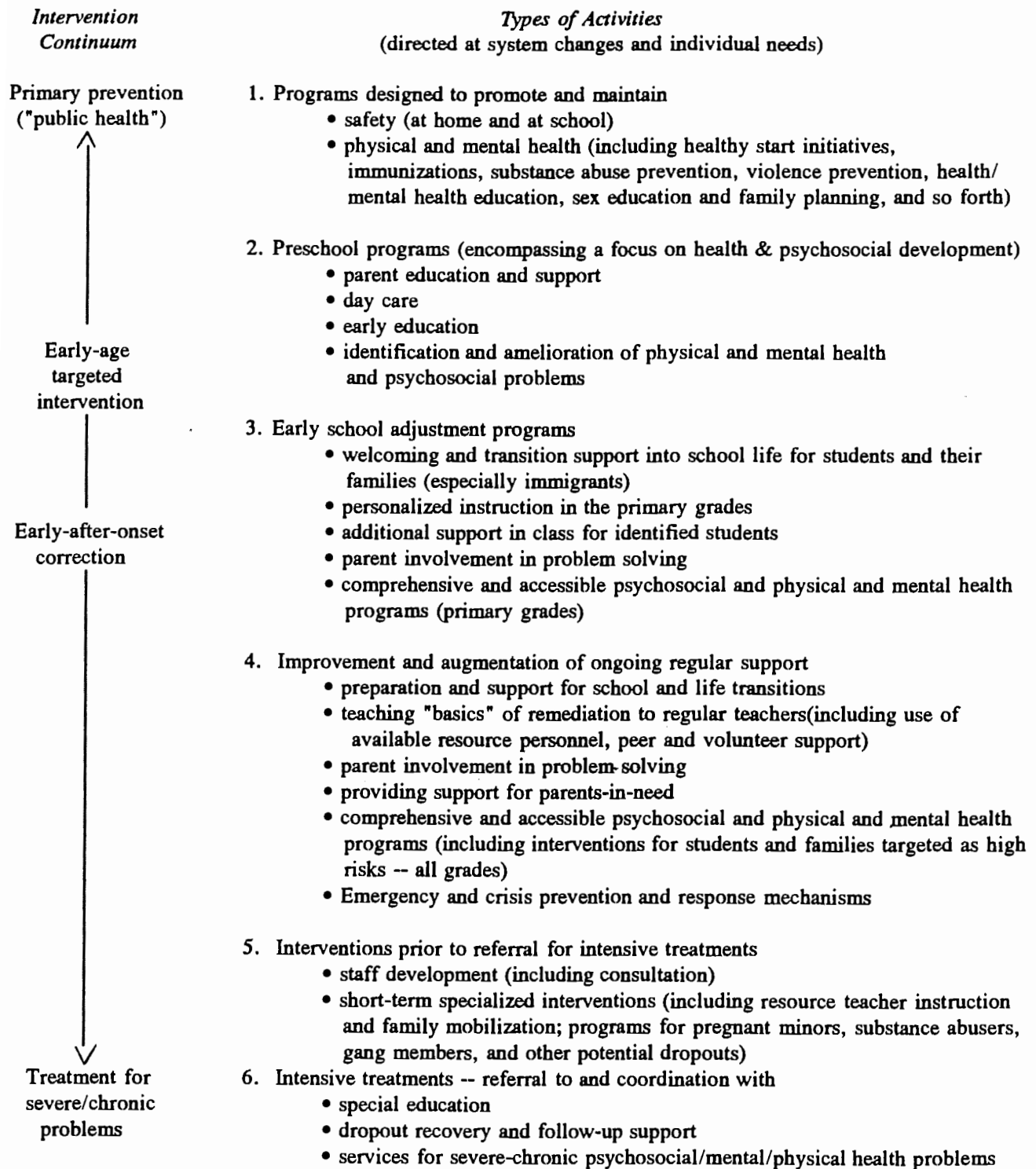
Intervention Continuum	Types of Activities (directed at system changes and individual needs)

Intervention Continuum

Types of Activities
(directed at system changes and individual needs)

**Primary prevention
("public health")**

⋀
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|
|

1. Programs designed to promote and maintain
   - safety (at home and at school)
   - physical and mental health (including healthy start initiatives, immunizations, substance abuse prevention, violence prevention, health/ mental health education, sex education and family planning, and so forth)

2. Preschool programs (encompassing a focus on health & psychosocial development)
   - parent education and support
   - day care
   - early education
   - identification and amelioration of physical and mental health and psychosocial problems

**Early-age
targeted
intervention**

3. Early school adjustment programs
   - welcoming and transition support into school life for students and their families (especially immigrants)
   - personalized instruction in the primary grades
   - additional support in class for identified students
   - parent involvement in problem solving
   - comprehensive and accessible psychosocial and physical and mental health programs (primary grades)

**Early-after-onset
correction**

4. Improvement and augmentation of ongoing regular support
   - preparation and support for school and life transitions
   - teaching "basics" of remediation to regular teachers(including use of available resource personnel, peer and volunteer support)
   - parent involvement in problem-solving
   - providing support for parents-in-need
   - comprehensive and accessible psychosocial and physical and mental health programs (including interventions for students and families targeted as high risks -- all grades)
   - Emergency and crisis prevention and response mechanisms

5. Interventions prior to referral for intensive treatments
   - staff development (including consultation)
   - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for pregnant minors, substance abusers, gang members, and other potential dropouts)

⋁

**Treatment for
severe/chronic
problems**

6. Intensive treatments -- referral to and coordination with
   - special education
   - dropout recovery and follow-up support
   - services for severe-chronic psychosocial/mental/physical health problems

Figure 6. From prevention to treatment: a continuum of programs for amelioration of learning, behavior, and socioemotional problems. (From Adelman & Taylor, 1993a, p. 279. Copyright 1993 Wadsworth, Inc. Reprinted by permission of Brooks/Cole Publishing Company.)

ceptually, intervention rarely is presented comprehensively. Organizationally, the tendency is for policy makers to mandate and planners and developers to focus on specific programs. Functionally, most practitioners and intervention researchers spend the majority of their time working directly with specific interventions and samples and give little thought or time to comprehensive models or mechanisms for program development and collaboration.

In response to continuous criticism about piecemeal and fragmented programs for addressing mental and physical health and social and educational problems, major initiatives have been undertaken for system restructuring. Some of the most ambitious efforts are seen in statewide policy initiatives (e.g., in New Jersey, Kentucky, California) designed to integrate community-based services and link them to school sites (Adler & Gardner, 1994; Center for the Study of School Policy, 1991; Gardner, 1989; Kean, 1989; Kusserow, 1991; Morrill, Marks, Reisner, & Chimerine, 1991). The flourishing of these initiatives reflects the growing recognition among policy makers regarding the critical importance of improving coordination and eventually integrating health (physical and mental), social, and human service programs.

Concern about the current state of affairs naturally stems from awareness that noncomprehensive and piecemeal approaches limit efficacy and work against cost-efficiency. Limited efficacy seems inevitable as long as a reasonably full continuum of necessary programs are unavailable; limited cost-effectiveness seems inevitable as long as related interventions are carried out in isolation of each other. From this perspective, many doubt that major intervention breakthroughs can occur without a comprehensive and integrated programmatic thrust (Adelman, 1989; Anthony, Cohen, & Kennard, 1990; Center for the Future of Children Staff, 1992; Hodgkinson, 1989; Kagan, Rivera, & Parker, 1990). To redress concern over piecemeal and fragmented approaches, greater understanding is needed with respect to the broad nature and scope of (a) the problems that must be addressed, (b) the programs needed to ameliorate the problems, and (c) the mechanisms necessary to ensure that programs remain mobilized and function cohesively. One step toward increasing such understanding involves moving beyond a narrow focus on psychopathology and clinical interventions with a view to enhancing interest in broad-based intervention theory and research.

Schools and Clinical Psychology

Another illustration of the need for clinical psychology to increase its emphasis on psychosocial problems is found in recent "mental health" research and practice conducted in schools. Some of this activity is an effort to outreach to those with mental and physical health problems who do not come to clinics (i.e., those described as underserved and hard-to-reach). The majority of the work, however, is aimed at the growing number of students and families for whom psychosocial problems are major barriers to society's ability to accomplish its educational mission. It has long been recognized that such problems must be addressed if schools are to function satisfactorily and if students are to learn and perform effectively (Tyack, 1979, 1992).

In recent years, there has been renewed interest in school-based and school-linked mental health and psychosocial programs emphasizing early intervention, treatment, crisis intervention, problem prevention, and promotion of healthy development (e.g., Adelman & Taylor, 1991, 1993b; Bond & Compas, 1989; Carnegie Council on Adolescent Development, 1988; Christopher, Kurtz, & Howing, 1989; Conoley & Conoley, 1991; Dryfoos, 1990, 1994; Haynes, Comer, & Hamilton-Lee, 1988; Hickey, Lockwood, Payzant, & Wenrich, 1990; Holtzman, 1992; Price, Cowen, Lorion, et al., 1988; Schorr, 1988; Sitwell, DeMers, & Niguette, 1985; Tharp, 1991; Weissberg, Caplan, & Harwood, 1991). In specific relation to initiatives to integrate community-based services and link them to school sites, projects are underway to demonstrate the concept of "one-stop shopping"—whereby a center (e.g., a Family Service Center) is established at or near a school site to house as many medical, mental health, and social services as feasible (Center for the Future of Children staff, 1992; Dryfoos, 1994; Hodgkinson, 1989; Holtzman, 1992; Kagan, 1990; Kagan, Rivera, & Parker, 1990; Kirst, 1991; Melaville & Blank, 1991).

The various school-linked programs aim at addressing a wide variety of problems of concern to clinical psychology; however, relatively few clinical psychologists are involved in developing and studying the interventions. Those who are involved have found that school settings

provide not only access to underserved and hard-to-reach populations, but also opportunities to advance conceptualizations and research related to a range of important problems. Inevitably, they also have found it essential to expand their focus beyond psychopathology and clinical interventions.

As a specific example, it is useful to look at the movement toward comprehensive School-Based Health Centers (SBHCs). Over the last decade, there has been a rapid (and controversial) proliferation of SBHCs (e.g., see Adelman & Taylor, 1991; Dryfoos, 1994). Rising from about 10 in 1984, there are currently are at least 500 in operation (mostly in high schools) throughout the United States (Dryfoos, 1994). As a result, most major urban centers and some rural areas already have in place an important demonstration program of interest to scholars and policy makers.

The movement toward creating SBHCs stems from increasing concern about teen pregnancy and the recognition that school-based programs allow large and underserved segments of child and adolescent populations access to physical and mental health care. In pursuing their agenda, SBHCs have found it essential also to address mental health concerns as a primary focus for intervention. The need to do so arises from the confluence of several factors. One is the recognition that efforts to stem the tide of teen pregnancy require a comprehensive approach that includes psychosocial interventions. This recognition is bolstered by the awareness that students' physical complaints often are psychogenic and that treatment of various medical problems is aided by psychological intervention. Added to these considerations is the fact that in a large number of cases students come to SBHCs primarily for help with nonmedical problems (e.g., personal adjustment and relationship problems, emotional distress, problems related to physical and sexual abuse, concerns stemming from use of alcohol and other drugs). Indeed, up to 50% of those seen at the centers are treated for nonmedical concerns (Center for Reproductive Health Policy Research, 1989; Robert Wood Johnson Foundation, 1989).

In addressing nonmedical problems, the initial response at SBHCs was to hire a part-time mental health professional who offered individual or group psychological intervention to some and provided referrals to others. Not surprisingly, the demand for psychological treatment quickly outstripped the resources available.

It did not take long for those involved with SBHCs to realize that too few students received the type of help needed. Individual and small-group psychological treatment was not the most effective intervention approach for many of the problems encountered, and there were many barriers to follow-through on referrals (including impoverished local resources). In effect, they had adopted a clinical approach, which proved to be a weak intervention model. The model is weak because it is grossly inadequate for addressing the nature and magnitude of psychosocial problems, and it fails to capitalize appropriately on other resources available in and around school settings. Thus, the burgeoning SBHC movement has provided another example of the need for broader intervention models built around (a) an understanding of psychosocial problems as well as psychopathology and (b) the role of school-linked interventions in ameliorating a wide range of problems.

A demonstration of first efforts to develop a more comprehensive and integrated mental health intervention model for SBHCs is seen in the work of the School Mental Health Project at UCLA (see Adelman & Taylor, 1991; also described in Dryfoos, 1993, 1994). This work has significant implications for understanding how schools, with or without SBHCs, can improve their response to mental health and psychosocial problems (Adelman, 1993; Adelman & Taylor, 1991, 1993b). In addition, SBHCs provide an important opportunity for increasing understanding of the mental health status and help-seeking attitudes and behavior of understudied populations (Adelman, Barker, & Nelson, 1993; Barker & Adelman, 1994).

Of course, even the best SBHCs cannot be expected to provide the range of interventions needed to assist students in overcoming the many barriers that interfere with effective learning at school. Therefore, schools and their surrounding communities continue to require help in conceptualizing, developing, implementing, and evaluating more comprehensive ways to offer essential aid. The need has become even more pressing now that policy makers have codified into law specific educational goals aimed at ensuring that schools are free of drugs, alcohol, and violence and that all students are ready to learn. Clearly these are desirable goals. However, in the absence of comprehensive models for restructuring education support activities and integrating them with community resources, efforts to achieve such goals are likely to

produce additional piecemeal approaches—thereby exacerbating what already is an overly fragmented enterprise.

Another example from the work of the School Mental Health Project at UCLA illustrates the type of comprehensive approach that appears necessary. A new and hopefully unifying concept called the *enabling component* has been formulated and is generating new avenues for psychologically-oriented intervention research (Adelman, in press; Adelman, 1994b; Adelman & Taylor, 1994). The aim is to provide a general framework for (a) restructuring school support services and programs and (b) promoting appropriate integration of community health and human services. In doing so, the intent is to move from fragmented and categorically oriented services toward a comprehensive and cohesive programmatic approach. Pilot research currently is underway as part of the Los Angeles Unified School District's restructuring reforms (with support from the U.S. Department of Education) and as a major feature of one of the nine "break the mold" models funded by the New American Schools Development Corporation.

The enabling component represents a fundamental reconception of school-based and -linked activity to promote healthy development and address barriers that interfere with teaching and learning. For schools, it is conceived as one of three primary and complementary components that must be addressed in restructuring education. (The other two are the instructional and management components.) This moves "enabling" activity from the position of being viewed as supplementary ("added on") to that of a full-fledged, integrated, and essential component.

Operationalization of the enabling component has generated six interrelated, school-based programmatic areas. These are designated as encompassing a focus on (a) enhancing classroom-based efforts to enable learning, (b) providing special services to assist students and families in need, (c) responding to and preventing crises, (d) providing support for transitions, (e) enhancing home involvement in schooling, and (f) outreaching to the community (including volunteer recruitment) to develop greater involvement in schooling and support for efforts to enable learning. In practice, the component emerges from what is available at a school site, expands what is available by working to integrate school and community resources, and enhances access to community programs

and services by linking as many as feasible to programs at the site. Through integration with the instructional component, a strong emphasis is given to promoting healthy development and facilitating positive functioning as the best way to prevent many problems and as an essential adjunct to corrective interventions.

Clearly, schools represent an area of need and a rich opportunity for clinical psychology to pursue model building, research, training, and practice. Unfortunately, few in the field are responding, either to the need or the opportunity.

CONCLUDING COMMENTS

Increasingly, clinical psychologists are called upon to address problems for which valid classification schemes are lacking and for which clinical interventions are either insufficient or inappropriate. For lack of a better term, many of these problems are referred to as psychosocial problems. Clinical psychology (and the mental health field as a whole) has a great deal to contribute to the study and amelioration of such problems. And, as the above discussion suggests, an important place to begin is with the refinement of existing classification systems and the development of new ones. Appropriate classification is essential to enhancing intervention planning, implementation, and evaluation and is fundamental to efforts to advance knowledge.

Many of the difficulties involved in devising classification schemes are not amenable to easy solution. They are rooted in complex problems of an epistemological, philosophical, theoretical, and methodological nature. Despite this, some emerging directions have promise for improving classification schemes related to psychopathology and psychosocial problems. One is the continued refinement of the multiaxial approach to diagnosing pathology, paired with efforts to place pathology in perspective using a reciprocal determinist view of behavior. In turn, this should lead to improved schemes for multidimensional classifications of psychosocial, environmental/organizational, and transactional problems. Another promising direction focuses on ways to move beyond the emphasis on deviance, weaknesses, and limitations to classify non-problem functioning and strengths. Methodologically, the path to improvement remains one of enhancing reliability and demonstrating the differential validity of each category in a scheme. This involves not only development of precise criteria and readily applied operations but

also effective training procedures for those who do the labeling (including error-reduction strategies).

With respect to intervention, the discipline should be a major force in expanding prevailing models and shaping current policy reforms. Particularly needed are efforts that focus on improving intervention efficacy through integrating physical and mental health and social services and restructuring that component of school programs designed to address psychosocial problems. For this to happen, however, as much scholarly attention must be devoted to psychosocial problems as is given to psychopathology—especially efforts focused on conceptualizing, developing, implementing, and evaluating comprehensive, integrated models of intervention.

One place to begin addressing the imbalance related to scholarly activity is with analyses of psychology curricula at both the undergraduate and graduate levels with a view to making modifications when the emphasis is lopsided. Ultimately, the field must develop a cadre of leaders who have a broader perspective than currently prevails if the next generation is to make significant breakthroughs in understanding and ameliorating psychopathology and psychosocial problems and in facilitating psychosocial development.

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