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PATHOLOGY

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Table of Contents

	Page
Abstract	1
Introduction	2
The Medical Model	2
The Behavioral Model	4
The Deficit Model	5
Elaborations	15
1. The presence of pathology and explanations of it	16
2. The social dimension of pathology	23
3. The ideal of universality and the problem of relativity	24
4. Norm and judgment in pathology descriptions	26
5. The logic of explanations for pathology	30
6. Legitimate and illegitimate explanation	41
7. Pathology and needs	51
8. Pathology and problems	55
The Noncommittal Model: DSM III	59
The Deficit Model and DSM III	72
Taxonomies for Psychopathology	80
References	83

Abstract

The Deficit Model of pathology is presented in contrast to the traditional Medical Model and Behavioral Model. The structure of the Deficit Model as a Descriptive-Psychology formulation is given in some detail. Explanations of pathology are contrasted with the concept of pathology itself. The social, normative, judgmental, and relativistic aspects of pathology and pathology attributions are discussed. The conceptual structure of explanations of pathology is explicated and the relation of pathology to personal problems is discussed. The current psychiatric taxonomy, DSM III, is critically analyzed and the relation of the Deficit Model to the DSM III approach is analyzed. The value of classificatory schemes is discussed.

Pathology

The purpose of this paper is to sketch the Descriptive-Psychology (DP) concept of pathology, which is arrived at by articulating the primary concepts of Person and Behavior. The DP formulation is conventionally designated as the Deficit Model of pathology. It contrasts in a variety of ways with the more familiar models of pathology found in most current forms of treatment theory and practice. These latter can be assimilated to two generic models, which are readily identifiable as the Medical Model and the Behavioral Model. For convenience in making comparisons, these two generic models are summarized briefly below.

The Medical Model

The logical schema upon which the Medical Model depends is that underlying conditions cause overt manifestations. Within this framework, certain underlying conditions are normatively identified as pathologies, and their causal consequences as either symptoms or signs of the pathology.

The use of the Medical Model is, of course, not restricted to the fields of physiology and medical practice. The model also finds considerable use in clinical psychology and psychological practice.

Most often, and particularly in the case of psychopathology, the underlying condition is conceptualized as an "inner" condition; correspondingly, its causal consequences are "outer" manifestations. A number of different conceptual systems may be used in identifying an inner pathological condition. For example, a physiological conceptual system can

be used to identify pathological conditions such as a brain lesion, a sodium ion imbalance, etc. Similarly, a phenomenological conceptual system can be used to identify such "inner" conditions as an emotional conflict, a strong feeling of helplessness, etc. Likewise, various psychodynamic theories can be used to identify such "inner" conditions as the repression of an emotional conflict, an animus-anima imbalance, etc.

A central feature of underlying or inner conditions is that they are not open to direct inspection (except for certain conditions identified in physiological terms), since they depend on theoretical/hypothetical conceptual systems whose grounding in reality is itself uncertain or even suspect. To be sure, clinicians often arrive at such conclusions (e.g., "feeling of helplessness", "need to demonstrate superiority", "repressed anger") on the basis of observation. However, far from implying that such inner conditions are observable, these clinical practices raise serious methodological questions about the relation between what is observed and what is concluded. Most practitioners who use the Medical Model say that they are <u>inferring</u> the presence of the inner cause, but no way of justifying such inferences has been discovered, and it seems unlikely that such conclusions are in fact warrantable on the basis of inference.

Given that pathology consists of an underlying, usually inner, condition, treatment in the Medical Model naturally consists of efforts to eliminate the pathological inner cause and produce a corresponding non-pathological inner condition. In this connection, we may recall the famous slogan, "Where Id was, there Ego shall be." Derivatively, treatment may be directed merely at ameliorating the effects (symptoms) rather than

(or independently of) removing the causes. In the case of psychopathology, such merely symptomatic treatment would, by itself, assimilate more readily to the Behavioral Model than to the Medical Model.

The Behavioral Model

The logical schema upon which the Behavioral Model of pathology depends is that outward events cause observable behavior. In this model it is behaviors themselves--in a social, normative context--which are identified as constituting pathology or normality.

In the Behavioral Model, assessment takes the form of surveying the person's behaviors within a normative framework and evaluating them as normal ("adaptive") or pathological ("maladaptive"). It consists further of gathering evidence as to what the external causes of the pathological behaviors are (e.g., being scolded by the father causes the child to wet the bed).

In recent years, many experimental and clinical practitioners who use the Behavioral Model have extended the class of causes of behavior to include inner events such as having certain thoughts or certain imagery. The inclusion of inner causes results in a greater resemblance to the Medical Model, but an essential difference is preserved, namely that the pathology lies in the effect (the behavior), not in the cause of that effect.

Accordingly, treatment takes the form of efforts to prevent the recurrence of the maladaptive behavior. These efforts, in turn, may take various forms. The most obvious is to prevent the occurrence of the causal

event or episode (e.g., get the father not to scold the child, or, in the case of an inner cause, get the child not to have thoughts of the father scolding him). Another major possibility is to reduce or change the causal efficacy of the causal event (e.g., get the child to react differently to the father's scolding by giving him practice at reacting differently, by extinguishing the response, by counterconditioning, or by other means). The common factor is to try to prevent the recurrence of the maladaptive behavior in the context where it is maladaptive.

The Deficit Model

Since the Descriptive Psychology concept of a pathological state is simply a special case under the more general concept of a state, and this, in turn, presupposes certain other concepts, some conceptual groundwork must be laid. The concepts of person, personal characteristic, Deliberate Action, and social practice are substantively central in this respect, and the methodological concepts of parametric analysis and paradigm case formulation (Ossorio, 1981) are directly relevant.

1. As a preliminary move, it should be noted that the DP formulation of persons, behavior, and pathology makes no use of the traditional "inner-outer" model. Traditionally "inner" things such as thoughts, feelings, desires, experiences, motivations, attitudes, states, knowledge, and so on are classified as "personal," i.e., they belong to the person. Thus, my inner feelings are simply my feelings; my inner states and inner experience are simply my states and my experiences, and so on.

Traditionally "outer" phenomena such as the presence of a table, a

tree, an automobile, other persons, etc., and happenings and states of affairs such as the drawer being opened, being asked a question, the traffic light failing for the first time in two years, the TV program ending or continuing, etc., are classified as being included in the person's circumstances. (There is no spatiotemporal limit to a person's possible circumstances.)

A person's behavior is both personal and public. It is personal because it belongs to him as its author. It is public because doing it is a participation in a social pattern of behavior (see below).

2. In Deliberate Action a person engages in a given behavior, B; further, he knows that he is doing B rather than other behaviors which he distinguishes and he has chosen B as B from among a set of distinguished behavioral alternatives as being the thing to do. In the vernacular, we might say, "He knows what he's doing and is doing it on purpose." Deliberate Action does not imply deliberation or prior thought about what to do, and, in fact, almost all Deliberate Action is spontaneous, unrehearsed, and unreflective.

Deliberate Action is archetypal for persons. If persons did not normally have the ability to distinguish what they were doing and to do it on purpose, we would not have the concept of person that we in fact do. The capability for Deliberate Action is not merely an expectation; it is a social and legal requirement. Few people would argue with the principle that a person who either doesn't know what he is doing or can't control what he does is a danger to himself and others and needs some form of custody.

3. A social practice is a learnable, teachable, do-able, public (social)

pattern of behavior. The standard DP form for representing social practices is the process description (Ossorio, 1971/1978), in which the gross structure is given by specifying a sequence of behavioral Stages and, for each stage, a set of behavioral Options, each of which is a way of accomplishing that stage of the process.

The DP formulation of social practice is such that all behavior which is intelligible as human behavior (including, importantly, emotional behavior) qualifies as a participation in one or more social practices. In particular, any case of engaging in Deliberate Action is, ipso facto, a case of participating in a social practice; the set of behaviors from which the Deliberate Action, B, is chosen is, in the simplest case, just the set of behavioral Options in the social practice being engaged in (more accurately, the behavioral Options in the Stage which corresponds to B).

4. A person is an individual whose history is, paradigmatically, a history of Deliberate Action.

This definition reflects several facts. The first is that engaging in Deliberate Action is conceptually the essential characteristic of a person. The second is that persons do not literally spend their entire lives engaging in Deliberate Action. The third is that, since it is conceptually essential, some form of explanation is called for and is available for those cases and those times when a person is not enacting a Deliberate Action. (Most commonly, the explanation refers to a particular state such as being asleep, being unconscious, being delirious, and so on.)

This way of understanding persons involves an implicit paradigm case formulation (Ossorio, 1981), as indicated by the term "paradigmatically" in the definition. In a paradigm case formulation (PCF) the task is to

introduce a range or set of cases and to distinguish those cases from everything else. We perform this task in two stages. In the first stage we specify a paradigm case, and that specification directly picks out some of the cases in question. In the second stage we introduce some number of transformations of the paradigm case, and each transformation picks out some additional cases. Each transformation has the force of saying, "Start with the paradigm case. Change it in this way (the transformation) and you'll still have a case." The eventual result is that we pick out all the cases we want and distinguish them from everything else.

The relevant contrast here is between a PCF and a definition. A definition accomplishes the same result as a PCF insofar as it, too, picks out a set of cases and distinguishes them from everything else. However, a definition is possible only when there is a set of necessary and sufficient conditions which are literally common to all the cases. Where the cases do not all have something necessary and sufficient in common (other than being cases of the kind in question) a definition is not possible, but a PCF may accomplish the task, since a PCF does not require that there be anything common to all the cases other than their being cases.

The PCF which is implicit in the definition of a person may be made more explicit in the following way. In stage one we specify as the paradigm case the case of Deliberate Action, which is archetypal for persons. In stage two, we introduce transformations dealing with the various exceptions. For example, in the vernacular, "Start with a person who is engaging in Deliberate Action and participating thereby in some social practices. Change that person by making him asleep rather than

awake (and therefore not engaging in Deliberate Action at that time) and you'll still have a person."

This way of understanding persons separates what is conceptually or categorically necessary from what is historically universal. Deliberate Action is conceptually necessary for the logical category of "person," but it need not thereby hold for all persons at all times. (Compare: It is essential to the concept of an airplane that an airplane moves through the air. It does not follow that every airplane must at all times be moving through the air, or even that each individual airplane must at some time move through the air.)

In contrast, had we taken the traditional approach and offered a simple definition of "person," we would have been forced to accept a "lowest common denominator" concept of persons, since what is necessary and sufficient will be historically universal among the cases, and what is historically universal could only be some sort of lowest common denominator. The traditional equation, "person = a kind of organism," which assumes, blindly, that a person must <u>at least</u> be an organism is a case in point (note that our definition does not require a person to be an organism). Even worse, what is historically universal may not be a necessary or sufficient condition at all. (Imagine saying, on a spring day in 1917, "Well, an airplane is <u>at least</u> a machine with a propeller in front." And perhaps then, "So an airplane is a kind of propeller.") The Aristotelian separation of essence and accident is still sound, but we need to be able to apply it to conceptual domains and not merely to individual cases.

5. To give a parametric analysis of the domain of persons is to specify

the ways in which one person can be the same as another person or different from another person as such. Using the definition of person given above, a parametric analysis allows us to derive conceptually the traditional kinds of "personality variables" and more besides. The general term for all of these is "person characteristic" or "personal characteristic"; originally, they were called "individual difference concepts".

The primary derivation is of types of personal characteristic which are defined directly as a result of the parametric analysis and involve direct reference to behavior. These include (a) abilities, knowledge, and values; and (b) traits, attitudes, interests, and styles. The first set is designated as powers because these concepts deal with what behaviors are or are not possible for a person. The second set is designated as dispositions because they deal with what behaviors are to be expected from a person.

The secondary derivation is of types of personal characteristic which are conceptually one step further removed from behavior. These are capacities, embodiments, and states. The latter is of particular interest here.

The defining formula for the general concept of "state" is as follows. "When a person is in a particular state there is a systematic difference in his powers and/or dispositions." States come about, or are caused, rather than being chosen as behaviors are chosen.

Among the states which we commonly distinguish are being asleep, unconscious, tired, drunk, depressed, euphoric, ecstatic, apprehensive, excited, intoxicated, hypervigilant, expectant, sick, angry, and so on. Paradigmatically, states are temporary and reversible, but since the

concept of being in a particular state is a systematic concept rather than a name for a peculiar sort of 'referent' we may use this notion whenever there is a point in doing so, including some cases where the state is not taken to be temporary or reversible, e.g., being blind.

6. A person's behavior reflects both his personal characteristics and his circumstances. Both personal characteristics and circumstances make a difference in what a given person does at a given time, but the relation is not a causal one.

A heuristic example of the non-causal influence of individual characteristics is the following. Take a ball and put it on the table. Tap the ball. The ball rolls across the table. If we now ask, "Why did the ball roll across the table?," the obvious answer is "Because I tapped it," and that may be taken as a causal explanation. However, if we ask, "Why did the ball roll across the table when you tapped it?," the answer will be "Because it's round," and that is a non-causal explanation. Note that if it had been a cube on the table it would not have rolled, no matter how much I tapped it.

Explaining that a person gave money to a charitable cause because she is generous is exactly the same form of explanation as saying that the ball rolled because it's round. In both cases we appeal to the non-causal influence of an individual characteristic; the difference is that in the one case the individual is specifically a human individual and, correspondingly, the individual characteristic is specifically a personal characteristic. In a similar vein, we can say that just as the cube will not roll when we tap it, a person who lacks the ability to multiply numbers will not engage in the Deliberate Action of multiplying numbers no matter

what kind of incentives and opportunities we offer him. (He may, of course, try and then get the right answer by chance. The various forms of behavior description [Ossorio, 1969/1981] and the PCF allow us to deal with such derivative cases.)

With these preliminaries, we are in a position to proceed to a brief presentation of the Deficit Model and then to some elaborations. We begin with a defining formula for the concept of a pathological state: When a person is in a pathological state there is a significant restriction on his ability (a) to engage in Deliberate Action and, equivalently, (b) to participate in the social practices of the community.

The practical force of this definition is perhaps best indicated by some vernacular paraphrases. One is, "A person is sick when he is sufficiently limited in his ability to do what is essential to being a person, i.e., act on purpose in ways that make sense, knowing what he is doing." Another is, "A person is sick when he is sufficiently limited in his ability to do what, as a real person in a real life setting, he ought to be able to do."

We will develop the significance of the formulation in various contexts below. From the outset, it is important to note that the definitional formula does not apply to cases where the significant restriction in a person's behavior potential is the result of lacking the opportunity. A person who is locked in a jail cell and a person who has the status of a slave will both be strongly limited in what they are able to do, because there are many behaviors which they lack the opportunity to

engage in, but neither is necessarily limited in his abilities, and so neither of them is ipso facto in a pathological state. To be sure, a person who has been locked up in a jail cell all his life or who has been a slave all his life may be extremely limited in what abilities he acquires, and he may thereby be in a pathological state (but see below on children and refugees). Similarly, a person who merely refuses to act in many of the conventional ways, but has the ability to do so, is not thereby in a pathological state.

It is because the formulation of the concept of a pathological state depends in an essential way on the concept of a disability that the designation "Deficit Model" seems appropriate. The limitation in a person's abilities in the case of pathology may apply to which social practices he is able to participate in or to the ways in which he can participate in given social practices. (Compare (a) not being able to do arithmetic with (b) being able to do arithmetic, but only with a hand calculator. Both reflect limited abilities, from a normative standpoint.)

Correspondingly, the assessment of pathology takes the logical form of drawing conclusions about a person's abilities and disabilities in regard to engaging in Deliberate Action or in regard to participating in the social practices of the community. This is done on the basis of observation (e.g., of how well a person orients or answers questions), conversation (e.g., a survey of the person's history, accomplishments, relationships, etc.), testing, or any other available means.

A pathological state is a type of state, and a state is a type of person characteristic, so that to say that a person is in a pathological state is formally to give a perfectly straightforward person description.

However, that is seldom enough for our purposes, and so we need to be able to go beyond that. In a clinical assessment we generally try to do more than decide whether the person is in a pathological state.

One way of going beyond the simple attribution of pathology is to specify which one out of a set of already distinguished pathological-state categories applies in the case in question. And one way of doing that is to employ the traditional sorts of diagnostic taxonomies (see below on DSM III).

A different way of going beyond the simple attribution of pathology is to provide an explanation of why this person has the limitations he has and is in the pathological state he is in. The usual way of doing that in the pragmatic clinical practice associated with Descriptive Psychology is to provide an individual case formulation. The individual case formulation deals with the particulars of a person's life and history as well as his characteristics, preferred modes of interacting with others, actual relationships with significant others, and so on. Because of this, no separate formulation of which pathological state he is in is needed, e.g., for the purpose of devising and conducting treatment.

Treatment in accordance with the Deficit Model consists of efforts designed to increase the person's relevant abilities to the point where he is no longer in a pathological state. In this connection we may note that if a person is in a pathological state then not only does he have that person characteristic, but also, by virtue of that, he has other personal characteristics. The significant limitation in the ability to participate in the social practices of the community is a complex disability. It will therefore be possible, analytically if not functionally, to redescribe

being in the pathological state as a case of having a variety of more specific disabilities with respect to particular social practices or classes of social practices. These may reflect particular cognitive, motivational, or competence limitations. It is toward the more specific disabilities that, in general, treatment efforts are selectively directed.

Elaborations

It is by now a truism that, if I am watching a game of bridge, I can point to a card and truthfully say "That's trumps," but I will never discover anything about trumps by examining that card very closely and subjecting it to various sorts of analyses. This is because "trumps" is not a name for an extralinguistic 'referent' that I can point to; rather, it designates a concept which is defined by the conceptual system in which it occurs. If it is the name of anything at all, it is the name of a position or substructure within a structure of concepts. So also is "left front tire," "dollar bill," "plumber," "mountain," "up," and almost every other locution in a natural language, with proper names being possibly the major exception.

These considerations hold equally for the concept of pathology. We have seen its dependence on other concepts and connections to other concepts. In order to delineate some of its broader connections and relationships, it will be of interest to place the concept of pathology in a variety of broader contexts, though in a less systematic fashion than in the primary presentation above.

1. The presence of pathology and the explanations of it

The definition of "pathological state" tells us what it is for a person to be in a pathological state. It does not preempt the question of how we explain or account for a person's being in the pathological state he is in. Since we do in fact offer various sorts of explanation, the definition underlines the necessity for maintaining the distinction between the presence of pathology and any putative explanation of it.

For example, certain kinds of condition, e.g., ulcers, arthritis, blindness, etc., are commonly called "physical illness". And certain other kinds of condition, e.g., phobias, obsessive thoughts, schizophrenia, "hysterical" blindness, etc., are commonly called "mental illness". The distinction between the two, however, is the distinction between explanations of pathology, not between kinds of pathology per se. In this connection, a simple thought experiment will be helpful.

Thought Experiment A

Imagine that I have a broken leg or an extreme case of gout or arthritis affecting my legs. Imagine also that, nevertheless, I am able to do all of the things I used to be able to do before I had this condition. That is, I can walk, run, hop, kick various objects, climb ladders, dance (and enjoy it), and so on. Moreover, this state of affairs can be expected to continue indefinitely. And finally, imagine that I am not exceptional in these respects, but rather that I am typical of people who have broken legs, gout, or arthritis.

Under these conditions, would I or anyone else claim that I was "sick"? Obviously not--it would be nonsensical. Yet such physiological conditions are what we routinely and unreflectively refer to as the illness. What the thought experiment brings out clearly is that it is the restriction in behavioral capabilities which is essential to the notion of illness, because without that there is nothing to be explained by reference to a physiological, psychological, or other "condition," and there is nothing that calls for treatment by reference to physiological, psychological, or other theories.

Indeed, physiologists themselves not infrequently remind us that normal human beings often exhibit physiological anomalies which are more extreme and dramatic to the physiologist (e.g., a heart on the right side of the body and having three chambers instead of two) than those involved in many serious illnesses. If these anomalies have no serious behavioral consequences, they often pass completely unnoticed, and certainly no one would dream of calling them illnesses. Likewise, we often detect psychological anomalies which occur in the absence of a significant restriction on the person's ability to participate in the social practices of the community. In these cases we identify them as quirks, foibles, crotchets, eccentricities, harmless addictions, etc., and do not thereby impute pathology.

Here again is an occasion to keep in mind the difference between what is conceptually necessary and what is historically universal. For example, if we discover that a friend has a breast tumor that she never noticed because it made no discernible difference in her life, we are not unlikely to say that she is sick and urge immediate treatment, even though there is

no corresponding restriction in her abilities. However, note that in the thought experiment we stipulated that "this state of affairs will continue into the indefinite future". Clearly, the grounds for saying that our friend is sick now are that we believe that we have detected an earlier stage of a process which in its later stages would have the relevant disability as its consequences. For if we were firmly convinced that the current tumor would never, even if untreated, result in any disability, it would again be nonsensical to say that she is sick now. Similarly, we may discover that a four-year-old boy has recently acquired an alcoholic stepfather who punishes and degrades him. Even if we detect no relevant disability now, we say, "He's in trouble," in large part because of what we can readily foresee.

Again, physicians are inclined to define some illnesses, e.g., headaches, by reference to pain. But the considerations here are essentially the same as for the broken bone, etc., in the thought experiment. First, note that pain which goes beyond the level of minor discomfort will essentially inevitably reduce various abilities, e.g., to concentrate, to pay attention, to calculate accurately, to make sensible judgments, to perform certain movements or performances, and so on. In the absence of any such limitations, we are reminded of the classic statement attributed to a lobotomized patient--"I still have my pain, but it doesn't bother me," and we are back to the point of saying, "Why would anyone call that illness?"

Second, there is a difference between participating in a social practice with a normal degree of appreciation (enjoyment, excitement, pleasure, satisfaction, etc.) and participating without that degree of

appreciation. For technical reasons having to do with the formulation of Deliberate Action, this kind of difference would be represented as different behavioral Options in the social practice. Thus, a person who could participate, but only with pain and not appreciation, would be significantly limited in the ways in which he could participate, and this is one of the two forms of limitation already allowed for above in connection with pathological states.

Note that with systematic concepts we have some range of choice in how we talk because we have some range of choice in which portions of the conceptual structure we operate with on a given occasion. For example, in the case of the breast tumor, we might equally well say that she was not sick but that she had better go see a physician in order to avoid being sick later. Or we might show our understanding of the difference between a paradigmatic illness and this derivative sort by saying, "You'd better go see a specialist before you really get sick."

Once we recognize that the conceptually essential feature of an illness is a significant limitation on a person's ability to act and participate in social forms, we are in a position to take two further steps. First, we recognize that such a limitation calls for an explanation. And, second, we recognize that, in general, different sorts of explanation are possible.

Different sorts of explanation are possible because we can map human lives into many different conceptual structures. Where we can do this, we can also map differences between normality and pathology into these conceptual structures. And where we can do that, we can look for useful correspondences (whether we interpret them as causal or not) between the

descriptions of pathology/normality which we give in the real-world context and the "technical" descriptions we give in other conceptual systems, e.g., those provided by physiological or psychological or spiritual, sociological, economic, evolutionary, etc., theories. Thus, we might offer many explanations, and many kinds of explanation, for a person's being in the pathological state he is in.

As it happens, we do not have a guarantee from Heaven that one such conceptual system is superior to all others or that any single one is sufficient for all our needs--or anything else, for that matter. Thus, in many cases, our choice of explanation is likely to be as much an expression of our own quirks and crotchets and ideology and social affiliations as it is a reflection of our competence and the nature of the phenomena. To describe a pathological state as a "physical illness" is, clearly, to signal that one endorses a physical or physiological explanation of it. To describe the pathological state as <u>really</u> a physical illness is, likewise, to signal that one <u>insists</u> on a physical or physiological explanation of it. Clearly, controversies about whether particular sorts of pathology are <u>really</u> physical or <u>really</u> psychological are really political controversies, not scientific ones. Such controversies are a regular feature of our current communities of academic and clinical practitioners.

Corresponding to the multiplicity of explanations, treatments may be of various sorts. Most often, the explanations given of the pathological state and the treatment undertaken for it are formulated in the same conceptual system. However, this need not be the case. The treatment and the explanation may be conceptualized in different conceptual systems. For

example, we may conceptualize arthritis in physiological terms and yet address it psychologically for treatment purposes. Or we may conceptualize a depression as essentially a psychological phenomenon and still use medication as the primary treatment. Or we may regard a headache as being either physiologically caused or psychologically caused and then select a treatment, biofeedback, in which both physiological and psychological aspects are prominent.

One example of this sort provides a kind of reductio ad absurdum argument with respect to the thesis that the illness lies in the physiological anomaly. Imagine that Wil has an irreversible brain lesion which produces aphasia of sufficient extent to qualify as a pathological state, and we accept that it is the brain lesion which caused the aphasia. For treatment purposes, however, we adopt a psychosocial framework and set about to re-educate him in the ways of speech. We succeed completely, so that by the end of treatment he has no trace of aphasia or any other functional effect of the brain lesion. The brain lesion, however, remains. If the illness consisted in having the brain lesion, we would now have to say that he is still in a pathological state and that he still has the same pathology, namely aphasia. But this is absurd.

In one sense, the definition of pathological state amounts to saying that all pathology is psychopathology. This is correct, but only if one interprets the "psycho" as a reference to the existential, real-world context of persons and their behavior in contrast to limited conceptual systems such as those found in physiological or psychological theories. The definition is not a way of favoring technical psychological explanations over other kinds. A second thought experiment may help to bring this out.

Thought Experiment B

Imagine that we are developing behavioral criteria for various illnesses. Accordingly, either we look for groups of behavioral symptoms which empirically go together and identify some of these groups as criteria, or else we start with groups of people whom we have already identified as being in a given pathological state and ask, "What common set of behaviors do they exhibit?" Now, imagine that we use this approach to the phenomenon of blindness. Blindness is one of those archetypal cases where we can say, "If ever there was a case of being in a pathological state, this is it!" What we discover, however, is that there are no impressive regularities in the behaviors of blind persons. For one thing, the behaviors of blind persons show an extensive overlap, in both kind and variety, with those of people who are not blind. And certainly, doing such things as feeling doors and walls, or occasionally stopping and listening, or reading Braille inscriptions, or carrying a white cane, or being accompanied by a dog in a distinctive harness are nowhere near universal among blind people. Such behaviors are not <u>what blindness is</u>. They are not maladaptive, either. And so we are left in a quandary.

In short, behavioral criteria do not give us access to the phenomenon, and they do not provide any understanding of it, either. The reason for this result is obvious. The pathology of blindness consists of being unable to see. <u>The behavioral commonality among blind persons lies not</u>

in what blind persons do, but in what they do not and cannot do, namely any behavior that requires that they be able to see. What they do do is as various as it is because it depends on their circumstances and on all their traits, values, abilities, and other personal characteristics other than being blind, and these are just as various for blind persons as for sighted persons.

Conversely, if we look for causes, we find that they, too, are various. Some are corneal, some are retinal, some are occipital, some are psychological, and some are unknown. Of course we can and do subdivide blindness for diagnostic purposes into categories corresponding to these different explanations. But what is it that we are subdividing? Why, the illness itself, the blindness. The diagnosis of blindness is already the diagnosis of the illness itself--we do not wait to establish a cause of blindness in order to decide whether it is a case of pathology. Deciding on a cause is useful in deciding what to do about it, but it does not help us understand what it is for a person not to be able to see or why that makes the difference it does.

2. The social dimension of pathology

The definition of a pathological state indicates why pathology is a matter for social concern. A viable society requires that its members have and exercise a variety of basic capabilities in engaging in social patterns of behavior in normative ways. In general, normal social interactions and collective social participation require that a member of a community be able to take for granted that other members have and exercise that basic level of capability. Such mundane things as speaking the language, driving on the correct side of the street, looking after the safety of others,

counting and calculating of this or that sort, respecting the rights of others, and so on, are among these essentials. There are many others.

When a person is clearly incapable of meeting the basic requirements for social participation, he is unacceptable as a member in good standing (and it would be fruitless to go through the motions of accepting him as a member in good standing, even if one were so inclined). In such cases it is normative for the community to expel the person, put him in protective custody of some kind, or otherwise radically insulate him and other community members from normal interdependence and opportunities of interaction.

But there are also intermediate cases, where the person exhibits incapacities which are not serious or extensive enough for Draconian measures, but are too serious to ignore with impunity. Such incapacities are of legitimate interest to other people for the same reason that any salient personal characteristics are important to other people; namely, so that they can suitably adjust their expectations, their requirements, and their actions, strategies, and policies in dealing with him. Among such actions, of course, may be attempts to help him.

The definition of a pathological state refers to "a significant restriction on his ability to participate in the social practices of the community". This is a way of bringing out the way in which the social character of human pathology is an essential ingredient of the concept of pathology itself. This holds for both the radical incapacities mentioned above and for the intermediate cases.

3. The ideal of universality and the problem of relativity

In the study of psychopathology we have aspired to a definition of psychopathology which would have universal applicability across times and

places. On ideological grounds, we have also tried to define psychopathology in terms of what we can readily observe, i.e., behaviors, visible symptoms, or, to a lesser extent, certain personal characteristics. The effort has been fruitless and frustrating. The fact is that many a person who would be correctly classified as being in a pathological state in Boulder, Colorado, in 1950 would, given the same characteristics and behaviors, not be correctly classified as being in a pathological state in Boulder, Colorado, in 1983, or in Culiacan, Mexico, in either 1950 or 1983, and conversely.

Consequently, a definition of psychopathology in terms of behaviors or simple observables is not a suitable vehicle for scientific theory or research. At best, such definitions have a local and temporary practical value. The temporary character can be mitigated from a practical standpoint by frequent updating (it is not a mere happenstance that the APA Diagnostic and Statistical Manual has just gone into a third edition, involving a substantial revision from the second edition). However, the parochial character remains, and it is not merely an academic issue, but rather a clear and present danger (Ossorio, 1983; Aylesworth and Ossorio, 1983).

The error involved in trying to define psychopathology in concrete terms is the same as the error involved in trying to define trumps by pointing to the queen of hearts. The moral that systematic concepts might be illustrated by pointing but cannot be defined that way should be now be clear. In this connection, it is often helpful to think of "pathological state" not primarily as a phenomenon or condition, but rather as a form of description which we can use when there is a point in doing so. Our

freedom to do so will in general be limited to some extent by the norms of our own community.

Our definition of "pathological state", by making essential reference to a cultural context, shows the relativity of pathology not as an unfortunate dilemma or artifact, but rather as an essential element in the concept of pathology, so that only a definition which incorporated this relativity could be illuminating or truly universal. What is implied by the relativity in the definition is that judgments of pathology are essentially context-dependent; that such judgments must, paradigmatically, be made by a member of a given community in the light of the norms, practices, and requirements of that community; and that, in so doing, that person is also operating within the norms and practices of the community. What the definition tells us is what it is, essentially, that is being decided by a person who makes that judgment competently.

4. Norm and judgment in pathology description

In pursuing the implications of the concept of a pathological state, we may note that the definition refers to "a significant restriction on his ability to . . . ". This phrasing directs us toward the essential normative component of the concept of pathology. In this connection, recall the paraphrase, "A person is sick when he is sufficiently limited in his ability to do what, as a real person in a real life setting, he ought to be able to do." Thus, if we ask, in regard to the definition, "significantly restricted compared to what?", the answer will be "significantly restricted in comparison to what he ought to be able to do".

What ought he to be able to do? Note that although a given community may discriminate against children, elderly people, or refugees in

this respect, the definition does not, for it is non-committal on this point. To repeat, what the definition tells us is what it is, essentially, that is being decided by a person who gives a pathology description. And one of the things that is being decided is whether the person's ability to act and to participate socially is significantly less than it ought to be.

Judgments about what a person ought to be able to do can be rigorously made only in a full historical real-world context. However, some informative general statements can be made in this regard. For example, the norms and requirements in regard to the ability to participate socially are different for children and for elderly persons, as contrasted with young and middle-aged adults. We do not, for example, regard a child of four as showing a significant limitation if he is unable to calculate or vote or say what day of the week it is, but we do regard it as a significant limitation if he has difficulty accepting food that is offered or if he cannot walk from one place to another. In general, the social practices of a community evolve in ways that reflect the abilities of the members of the community, and the age of the person in question is one of the contextual factors routinely taken into account in setting social requirements and making judgments of pathology.

To be sure, adult norms are primary. However, once we have those, it is child's play, conceptually, to develop corresponding developmental norms. For all we have to do is to examine the sequences of personal characteristics exhibited by children at different ages and note which sequences terminate in normal adult characteristics without any special effort's being made to achieve the result on an individual basis. Such sequences and their alternatives thus provide our paradigm cases of

normality and non-normality at any age. Scientific techniques may extend our observational base and elaborate our calculations, but the logic of such adjustments, we may presume, has been familiar to human beings since there have been young human beings and old human beings. This does not, of course, prevent particular parents from being poor judges of what their children ought to be able to do.

Refugees are not as ubiquitous as children, and so they are likely to be in a different case. Consider the example of a displaced person who at age 60 comes to live in the United States. He comes from a society in which in ordinary conversation you stand face-to-face at a distance of six inches and poke the other person in the chest periodically as you talk. He has tried various ways of breaking this habit, but he finds it extremely difficult, even though it creates enormous social difficulties for him and he knows it. Is he in a pathological state?

The clinician's notorious answer to questions posed in the abstract is, "Well, it all depends." In the present case we can say that the answer depends on what our refugee ought to be able to do. Consider some possibilities. First, suppose that all the refugees from his country have that problem and that this fact is well known, and that the general tack taken by us natives is (a) avoid and exclude them whenever possible, which creates difficulties for them; and (b) in conversation, hold your hand against the refugee's shoulder or chest and hold him at arm's length, so as to help him learn our norms. Under these conditions, we probably would not judge that our refugee ought to be able to do much differently from what he in fact does, and there would be little point in describing him (or them) as being in a pathological state. In contrast, suppose that other refugees

from his country did have the same problem, but usually only for a few weeks, and our refugee is still doing the same thing five years after arriving here. Under these conditions we might well suspect that he didn't really want to change, but if we accepted that he simply couldn't, then there would be a point in saying that he was in a pathological state. (Since other refugees do adapt, he ought to be able to do so also; his being a refugee doesn't account for his difficulty.) To be sure, we would regard it as a peculiar affliction, because we are not familiar with such phenomena, but we might assimilate it to such other peculiar afflictions as amnesias or aphasias. Finally, suppose that, being extremely ethnocentric and already being familiar with an American affliction called "poke-itis", whose symptoms are pretty much as we have described the refugee's behavior, we judged that any normal adult, no matter what his color, ought to know enough to behave properly. Under these conditions we would probably find that there was a good deal of point in saying, "He's sick. It's an obvious case of poke-itis." Even if we were not ethnocentric but were familiar with the illness, we might well judge our refugee to be suffering from poke-itis. In this regard, it is of some interest to note that in a mental health facility providing services to Indochinese refugees (Aylesworth and Ossorio, 1983), five of the first six referrals received by the facility had been misdiagnosed as cases of mental retardation or schizophrenia.

The point is that there are various possibilities, and they depend on a variety of immediate considerations, e.g., what ought he to be able to do, which in turn reflect some further considerations, e.g., have we made a viable place in our community for refugees with their limitations just as we have made a viable place for four-year-olds with their limitations? In

each case, we could ask, "Is the refugee really in a pathological state?" But we might rather ask, "What is the point of saying that he is (or is not) in a pathological state?"

5. The logic of explanation for pathology

We have noted that the concept of a pathological state is grounded in the more general and basic conceptual structure which includes the concepts of Person, Behavior, Reality, and Language (Ossorio, 1969/1978). Beyond this, however, the logic of explanation for pathological states is also grounded in that conceptual structure. To show how this is so, even schematically, requires a brief technical sketch of the concepts of "social practice" and "Behavior".

The definition of a pathological state refers to a significant restriction on a person's ability to participate in the social practices of the community. Since a social practice is a pattern of behavior, we can say that a social practice is a type of process, i.e., a behavioral process. ("Process" is one of the Reality concepts.) In turn, the conventional DP form for representing processes, including social practices, is the Process Description (Ossorio, 1971/1978), which reflects a parametric analysis of the domain of processes. The Process Description is characterized as follows:

1. Since a process has duration, the Process Description involves the specification of some number of Stages. (For a social practice, the stages will generally correspond to individual behaviors.)
2. Since a given type of process can occur differently on different occasions, the Process Description involves the specification of

some number of Options for each Stage. (For a social practice, the Options will generally be behavioral options, i.e., Deliberate Actions.)

3. The "ingredients" of a process are given by specifying formal Elements (comparable to characters in a play or positions on a team) and formal Individuals, each corresponding to one or more Elements. Formal Individuals must be embodied by historical (actual) individuals if the process actually takes place.
4. Each Option is itself a process and can be so represented.
5. The occurrence of the process on a given occasion is the same thing as the occurrence of one of the Options for Stage 1 followed by one of the Options for Stage 2 and so on. In general, for a given process, there will be some restrictions on the conditions under which a given Option for a given Stage would be the one which occurred.
6. Such restrictions are given by contingency statements, which specify what the occurrence of that Option is contingent on. Contingencies may be any of four kinds:
   (a) In a co-occurrence contingency, the occurrence of the Option is contingent on the occurrence of certain other Options in certain other stages of the process.
   (b) In an attributional contingency, the Option is available only if a given Element involved in that Option has certain attributes. The attributes, if the Element is a person, will be personal characteristics such as traits, knowledge, values, abilities, and so on. (Attributional contingencies

are also used in specifying the kind of Formal Individuals who are eligible to be a given Element. For example, a given Formal Individual may be specified as being a person.)

(c) In a relational contingency, the Option is available only if a given Element involved in that Option has a particular relationship with other Elements involved in that process.

(d) In a factual contingency, the Option is available only if a given state of affairs holds. (In principle, this type of contingency is redundant with respect to the preceding three, but it is a technical convenience.)

We noted above that there are two ways in which a person might be restricted in his ability to participate in the social practices of the community. That is, he might be restricted in regard to which practices he could participate in at all, and he might be restricted in regard to the ways in which he could participate. In technical terms, both of these restrictions can be directly represented by reference to attributional contingencies. In the first type of case, we could say that the person lacks the attributes which are required for a Formal Individual to be eligible to be any of the relevant Elements in a given social practice. Less formally, the person lacks the characteristics required to participate in the practice at all. In the second type of case, we could say that the person lacks the attributes which are required in order for certain Options in the social practice to be available.

Relational contingencies may be used in ways parallel to the attributional contingencies in regard to specifying restrictions or a person's ability to participate in social practices. Because participation

in social practices generally involves persons interacting with each other, and because the ways that people interact depend on the relationships between them, relational contingencies have a near-universal applicability. However, because we have almost no terminology for characterizing relationships perspicuously, in practice it is usually difficult to specify which relationships among participants must hold in order for various Options in the social practice to be available. We are often inclined to say, "Well--normal relationships".

The key contribution of the Process Representation of social practices is that it provides a systematic way of representing what there is to do in a given community, and it provides it in such a way that the basic units, the Options, are themselves individual behaviors. Because of this, the significant restriction in a person's abilities to engage in Deliberate Action and to participate in social practices becomes conceptually a straightforward matter of which behavioral Options (Deliberate Actions) are available or unavailable to the person on the basis of ability (an attributional contingency). Thus, we move to the next stage of the analysis, which depends on the technical articulation of the concept of Behavior.

The formal explanation of limited behavioral possibilities (limited behavior potential) can be derived systematically from the basic formula (corresponding to a parametric analysis) for behavior:

$$\langle B \rangle = \langle I , W , K , KH , P , A , PC , S \rangle$$

where

B = Behavior

I = Identity: the identity of the person whose behavior it is

W = Want: the state of affairs which is to be brought about and which serves as a logical criterion for the success or failure of the behavior

K = Know: the distinction which is being made and acted on; the concept being acted on

KH = Know How: the competence that is being employed

P = Performance: the process, or procedural aspects of the behavior, including all bodily postures, movements, and processes which are involved in the behavior

A = Achievement: the outcome of the behavior; the difference that the behavior makes

PC = Personal Characteristics: the personal characteristics of which the behavior in question is an expression

S = Significance: the more inclusive patterns of behavior enacted by virtue of enacting the behavior in question

In this formula, we may focus first on the Personal Characteristic (PC) parameter. Any given behavior (Deliberate Action) on a person's part is, archetypally, one of the Options in the social practice(s) he is enacting, or participating in. A behavior which reflects the PC of a "significant restriction on the ability to participate in the social practices of the community" will also thereby reflect a variety of other

PCs--namely, those that make available the Option chosen and those that make unavailable certain other Options. The latter may be expressed as disabilities. It is such disabilities as these which explain the presence of the pathological state.

Moreover, major categories of disability can be distinguished by reference to the behavior formula above; this is because the formula represents a parametric analysis of behavior. If we ask how it could be the case that a given Deliberate Action is not available to a given person, the general answer will be "because the behavior in question requires something the person doesn't have, hence the behavior is not one he can engage in." If we ask, further, what could a Deliberate Action require which the person might not have, then (excluding opportunity, which has to do with the circumstances rather than the person) the answer will be, "The behavior requires certain concepts or facts to be discriminated and acted upon in order to be the behavior it is; hence, if the person lacks those concepts or facts he can't engage in that behavior." Similarly, the behavior requires certain motivations and motivational priorities, and it requires certain competences and certain performances, and so if the person doesn't have those motivations and priorities or doesn't have those competences or can't make the right movements, gestures, or other performances, then he can't engage in that behavior. In short, the Know, Want, Know How, and Performance parameters of a behavior must have the requisite values, or else the behavior is some other behavior, not the one we are concerned with.

But there are several categories of personal characteristics which are conceptually coordinated to these parameters of behavior. They are

primarily the Powers concepts, i.e., Abilities, Values, and Knowledge. Because they are all Powers, Values and Knowledge can be considered abilities:

(a) A person's Knowledge is the set of facts (states of affairs) and concepts which he has the ability to act on.

(b) A person's Values are the set of priorities among motivations that he has the ability to act on.

Thus, we can say that a given Deliberate Action will not be available to a person if he is lacking the relevant personal characteristics, i.e., the requisite knowledge, concepts, motivations, motivational priorities, and competences. All of these deficits correspond to ability deficits.

With respect to Performance (movements, postures, facial expressions, etc.), the situation is a little more complex. Ordinarily, we would say simply that the question of whether a person could make the required movements, postures, facial expressions, etc., was simply a matter of his abilities. In a broader context, it is necessary to make explicit that performances depend on embodiment also. A person's embodiment (the kind of bodily apparatus he has) sets some limits to what performances can be accomplished (without a face, you can't smile), and so also to what abilities can be acquired or exercised. (Note the importance of this fact to the concept of a "physical illness". It is what allows us to say, e.g., that a person has aphasia <u>because</u> he has a brain lesion or that he can't walk <u>because</u> he has a broken leg.)

Given the foregoing reconstruction, we can see not merely why being in a pathological state is a matter of having a certain disability, but also why the direct explanation of pathology is a set of more specific

disabilities and why the further explanation of those is given by reference to deficiencies or anomalies in knowledge, values, abilities, or embodiments.

Nor does explanation end there. Each of these kinds of deficiency is formally capable of further explanation. For example, the person's history and capacities might be such that the requisite knowledge, value structure, abilities, or embodiment were simply never acquired (Ossorio, 1971/1981). Or they may be temporarily lacking by virtue of his being in a particular state. But now we are in the conceptual region of development and personal change, which are entirely general and not distinctively associated with pathology.

A special case of this kind of historical explanation, and one that has its own persuasive logic, is to explain that the reason the person does not have the requisite knowledge, value structure, etc., is that these are incompatible with characteristics he does have. (If the characteristics are incompatible, the historical processes of acquiring them would be also. With respect to knowledge, for example, the absence of certain types of knowledge might be explained by reference to one of the "distortion-of-reality" (traditionally, "unconscious motivation") paradigms. For example, "He is lacking knowledge of certain facts about his behavior and its significance because seeing things that way would leave him in an impossible position, and so he sees things in another way and acts accordingly." Or, again, with respect to values, we may give such explanations as, "Here's a person who is so narcissistic and self-involved that he <u>can't</u> give other people's interests proper weight, and so is pretty well bound to treat people in manipulative and selfish ways and have

only fairly superficial relationships with them."

A kind of explanation which is closely related to the example of a narcissistic character and which is of special interest to clinicians is one in which we say that a high-priority ulterior motivation results in preempting certain behavioral options at the expense of others. This kind of explanation is possible because (a) a person may enact more than one social practice simultaneously, and (b) if a person enacts practice W and practice Z simultaneously, he is restricted to those behaviors which are options in both W and Z; in general, this is a considerable restriction relative to the full range of Options in W as such and in Z as such. Thus, a person who places a high value on having certain relationships or types of interaction or on enacting particular human dramas jointly with other people (in DP, technically, "scenarios") will be restricted to the Options in the existing social practices which fit these specifications.

In this connection, the standard heuristic example of "Dinner at 8:30" may be helpful.

Dinner at 8:30

Suppose I tell you that I got home from work at 6:30 last evening and that we had dinner at 8:30, and it was steak well done. Probably your reaction would be, "OK, so what? Probably half the people in town could say the same thing."

Now suppose I add several facts. First, I tell you that yesterday morning I had a particularly acrimonious disagreement with my wife, and we did not resolve it. Second, I usually get home at 6:30 but we usually have dinner at 7:30, not 8:30.

Third, I like steak, but I like it rare, and I hate it well done.

About this time you have a very different picture of what was going on last night, don't you?

When "Dinner at 8:30" is presented to undergraduate classes, it is usual for half the class to begin smiling as soon as they are told that "we usually have dinner at 7:30". By the time the last piece of information is given, ninety percent of the class is smiling broadly, because by then it is obvious that what was going on was not merely the one social practice of "having dinner", but also the second social practice of "provocation elicits hostility, unless . . . ". The point is not that the latter is necessarily true (it doesn't actually follow from the statements), but rather that it is obvious. A behavior description which brings out the hostility is, "She made me wait an hour and then served something she knows I hate."

Ulterior motivation does not differ from non-ulterior motivation in this respect, namely that when it is expressed in a person's behavior, that expression can be represented as the participation in a corresponding social practice. In the case of ulterior motivation, that social practice is in addition to the ones that are openly or avowedly being engaged in. The restriction imposed by the ulterior motivation typically results in a non-standard choice of Options (8:30; steak well done) in the social practice which is openly engaged in (having dinner). Much of clinical interpretation reflects a sensitivity to this phenomenon.

Note that in the simple episode of "Dinner at 8:30" we would ordinarily say "angry", "hostile", or "vengeful", rather than "sick". But

now, suppose that revenge was an obsession with her and that episodes like the dinner at 8:30 occurred constantly even though we had talked things over and made peace. And suppose that these episodes involved a variety of other men at different times, not merely myself. Or suppose that, although the hostility episodes were restricted to me, she spent so much time and effort brooding over her wrongs and our latest interactions and what she was going to do, etc., that her relationships with everyone else were seriously degraded. Somewhere in this series of developments we would entertain the notion of a pathological state, and we would see her in a way comparable to the narcissistic character described above.

Our endorsement of a pathology description in this case would correspond closely to our judgment that the hostility was preemptive and not merely strong. We would say that she was "carried away by her anger" or that she was "obsessed with the need for revenge". In contrast, if we did not judge the hostility to be preemptive, we would say, "She places such importance on revenge that she's willing to sacrifice all of these other values and relationships."

These are different kinds of explanation and they have different social implications. In a case of ordinary choice it is simply a case of the relative weight which different considerations have for the person making the choice. In the case of preemptive motivation, and what we may designate correspondingly as preemptive choice, the person makes a choice on the basis of the preemptive consideration, without regard to other considerations (or at least without due regard). Thus, in this case, from a functional standpoint, the person is more or less radically out of touch with the relevant considerations which reflect his genuine interests. Our

major option in such a case is to consider the deficiency in judgment to be the direct expression of a temporary disability associated with the operation of the preemptive motivation. Such a conclusion is even more plausible when the person shows a due regard for those neglected considerations in other contexts before and after the episodes involving the preemptive choices. In sum, a preemptive-motivation explanation is essentially a disability motivation, and that is why it can provide the basis both for saying that the person in question is in a pathological state, and for explaining how it is that he is in that state.

6. Legitimate and illegitimate explanation

In general, motivational explanations contrast with ability or disability explanations. If we want to explain why a given person didn't engage in a certain behavior, and we eliminate opportunity as a factor, we are left, directly or ultimately, with two options. The first is motivational, i.e., "He didn't want to (enough)." In this case, he turned it down in favor of some other alternative. The second is modal, i.e., "He couldn't." In this case he lacked some requisite knowledge, sensitivity, skill, or embodiment. Since a person's abilities and disabilities determine which behaviors are possible for him and which are not, whereas his motivations merely select from what is possible, the ability/disability form of account has a certain priority.

Since the judgment that someone is in a pathological state is intrinsically a judgment about his abilities, it is important to be clear about the place of motivational explanations in explanations of pathology. We will begin with the primary, non-problematic case as follows:

Paradigm Case

In this case, there is a behavior pattern (e.g., revenge, as in the example above) which is preemptive. The motivational preemptiveness of that pattern accounts for certain disabilities with respect to various Options in certain social practices. These disabilities, in turn, are merely part of a larger set of disabilities with respect to social practice Options. It is the collective force of the larger set of disabilities which corresponds to (and accounts for) the single general disability which is conceptually connected to pathology, i.e., the significantly restricted ability to participate in the social practices of the community.

This case is non-problematical because the essential contribution of the disabilities is not clouded or confused by the subsidiary motivational explanation. However, this primary case contains within it the seeds of some serious problems, each of which comes about with only minor formal changes in the primary case. Consider the following three kinds of cases:

A. There is a special case of the pattern described above where, instead of a whole set of disabilities contributing independently to the pathological state, there is essentially only one, and that one with a motivational explanation (e.g., something like the "revenge" example, above).

In such a case, we may opt for the motivational explanation overall, and then, instead of saying, "He didn't because he couldn't because he's sick," we say, "He didn't because he didn't want to enough, and so he chose

otherwise." A major difference between the two cases is that in the latter case we will hold him responsible, whereas in the former case we often do not.

One of the conditions under which we are inclined to say "He didn't want to" rather than "He couldn't" is when we reject the preemptiveness of the motivation, and thereby treat the phenomenon as one of ordinary choice. If we do this, we are left with the tautology that a person will do what, as he understands things to be, he has most reason to do; so, of course, we conclude, "He didn't want to (enough)." Having chosen this description, we will deny that he couldn't do it, and, accordingly, we will deny that it is a matter of illness. From such an approach, it is a short step to making a universal judgment to the effect that, really, no motivation is preemptive, and so, "There's no such thing as mental illness; there's only [character defects, problems in living, misconceptions, etc.]."

Sometimes this kind of slogan is merely a way of denying that psychopathology is a <u>disease</u>. The Disease Model is a special case of the Medical Model in which the "inner cause" is a specific microorganism which is active at specific places in the body. Disease contrasts with, e.g., a systemic illness, such as a vitamin deficiency, which is not caused by a microorganism at all and which is usually only diffusely localized in the body. Most practitioners who use the Medical Model of <u>psycho</u>pathology (i.e., those for whom the inner cause is psychological) reject the Disease Model. More often, however, such slogans are adopted as a rationale for holding "mentally ill" persons responsible for their behavior. There are reasons why that is an attractive option. However, the denial that there is any such thing as psychopathology is a heavy and unnecessary price to pay.

We do commonly hold people responsible for the expressions of certain deficiencies, particularly characterological ones, even though we may agree that, given the deficit, the person really couldn't be expected to do otherwise (which is not the same as flatly saying he couldn't). For example, our selfish, narcissistic person would no doubt encounter a good deal of social sanctions for his proclivities insofar as they were known, even though everyone might agree that "He can't help acting that way, given his selfish, narcissistic character." For most persons, to understand all is not to forgive all.

A rationale for the unforgiving stance is that the rational corollary of discovering that a person has a given incapacity is to bar that person from participation in social practices which require that capability, if the welfare of other persons would be jeopardized. For example, it is generally illegal for a person to drive an automobile if he is blind or if he is subject to epileptic seizures, and so on. Given the limitation on participation, we are then free to treat the person as being responsible for what he does. For example, we hold a blind person responsible for the behavior he does engage in, and we hold him responsible for recognizing his limitations and acting accordingly.

However, for our narcissistic individual (and for our vengeful person and for most other forms of psychopathology) it is not clear how we might effectively restrict his participation in our common social practices. The difficulty arises because expressions of the pathological state could occur in just about any context imaginable. Thus, where the person is not grossly incapacitated and does not voluntarily take effective steps to protect others from the results of his disabilities, those others are left

with a caveat emptor situation. It is appropriate then for others to disqualify the person in regard to situations and judgments in which the preemptive motivation and associated disability are involved. Such a policy is an appropriate expression of the recognition of his disability, but, even so, it is not always possible to keep from being victimized by it. Because we do often enough find ourselves being victimized, we also find ourselves wanting to hold him responsible for what he does on these occasions. This gives "There's no such thing as mental illness" a perennial attractiveness.

The one place where we often do segregate the expression of pathology from an otherwise normal capability for participation is in treatment. The client's capability for responsibly entering into a contract for treatment is one of the presuppositions of most private practice in psychological treatment. Moreover, most of the techniques, strategies, procedures, and interactions in psychological treatment presuppose something more than a minimal capability for responsible participation on the client's part.

B. The second problematic variation on the primary case described above is where we, either literally or in effect, treat all of a person's operative motivation as preemptive. We do this, for example, when we say that whatever behavior a person engages in is the only behavior he could have engaged in under the conditions that obtained. This amounts to saying that only one behavioral option was in fact available to the person on that occasion. From this, it follows that no choice was, in fact, made. (Note that any "choice" which is an inevitable outcome of a prior condition is not a choice, but at most something having the appearance of a choice.)

A technical note is in order here. Any ability, e.g., the ability to

do arithmetic, has at least three sorts of specifications or restrictions associated with it. The first is the specification of some distinguishable achievement (e.g., "arithmetic") which is what identifies qualitatively which ability it is. The second is the period of time during which a given person has the ability. (It is sometimes argued that determinism is compatible with our ordinary understanding of people because the deterministic thesis does not imply that a person loses his abilities to "do otherwise" when he is not using those abilities, so that in that sense the person does "have the ability to do otherwise".) The third is the set of circumstances in which the ability can be exercised with the expectation of success. Where these circumstances are not explicitly mentioned, we assume "under normal circumstances". (I may have the ability to do arithmetic but I cannot thereby be expected to succeed at arithmetic tasks if I am hanging upside down ten feet over a flaming pit.) Most of the abilities which are required for normal and reponsible participation in our social practices are of the latter sort, i.e., they can be exercised with the expectation of success under normal circumstances. An ability which could be exercised only in a very restricted set of circumstances, e.g., those in which it is in fact exercised, would be very limited relative to normal abilities. Thus, any general ideology of the "He couldn't have done otherwise" variety is not merely a metaphysical position in the scientifically objectionable sense that no evidence could possibly support or falsify it; but also, if the 'thesis' were not incoherent (see Ossorio, 1971/1978, for a critical examination of "determinism") it would amount to saying that every one of us is in a radically pathological state.

There is, of course, a strong tradition of adopting a metaphysical

position of this sort in psychology and other social sciences and of superimposing this metaphysics on particular substantive theories or building it into such theories. Most academic and clinical practitioners who use the Medical Model or the Behavioral Model also insist on the metaphysics of "determinism". Presumably, this insistence reflects the radically mistaken (Ossorio, 1971/1978) notion that the effort to establish lawfulness in the world requires the assumption of this paradoxical sort of "lawfulness". This tradition brings these disciplines (or at least these theories) into direct conflict with legal, political, and other social institutions, including the institution of scientific methodology, which presupposes that persons, including scientists, are routinely capable of making reasonable choices on a rational basis.

It is not merely that traditional psychological theories suffer from a multitude of substantive and methodological inadequacies. Rather, these inadequacies make them actively pathogenic when they are accepted, as they commonly are, as providing the real picture of human nature and human behavior. They are not pathogenic if we accept them as humanly-invented verbal technologies which have a proper place in the human activities for which they were devised and a very limited range of additional activities. These considerations give rise to a slogan: "For every methodological error there is a corresponding form of psychopathology."

The explication of the slogan is simple. Any error which is sufficiently basic and general to be called a methodological error constitutes an equally basic and general distortion of reality. A person who makes this error and acts on it is blind to certain facts; like our literally blind person, those behavioral options which are contingent on

having any of the facts in question will not be open to him and his behavior potential will be restricted. If it is a basic and general sort of error, the restriction on his behavior potential is very likely to be significant enough to correspond to his being in a pathological state. This conclusion is based on observation and not merely on argumentation. In point of fact, the slogan was initially developed on the basis of clinical experience with clients who, in their attempts to understand themselves and other people and live their lives accordingly, were depending on behavioral, psychodynamic, or other traditional psychological or philosophical theories. The slogan is a useful reminder that serious hazards to public health are by no means restricted to such familiar cases as ambient radiation, carcinogens in foods, leakage of polyvinyl chlorides, and so on.

C. The third problematic variation on the primary case described above is the case where we use overly broad and self-serving standards for what constitutes a disability; our corresponding judgments concerning pathology will also be overly broad and self-serving. All that is required is that we adopt two crucial policies. The first is to define as normal, acceptable, or intelligible only those social practice Options which conform to a given political or ideological orthodoxy which we endorse. The second is to explain any contrary choices as expressions of disability, rather than as expressions of dissent or of the employment of coherent alternative frameworks. There would then be a more or less complete equivalence between a person's violating our orthodoxy and our judging him to be in a pathological state.

In turn, these two policies would set the stage for a third. For,

given the rationale set forth earlier, we could adopt the policy of (c) barring the deviant individual from those social practices for which his "disabilities" make him "incompetent". In practice, this would amount to incarceration and/or removal of social and political rights. Although tendencies toward overt political oppression have been prominent in political régimes from earliest historical times to the present, the use of the concept of psychopathology as a basis for political oppression appears to be a relatively recent development. Presumably this development reflects (a) the notion that insofar as a person is sick he is not responsible for what he does, (b) the principle that a person who is not rational or responsible for what he does is not fit to participate in the political process, and (c) the rise of "scientific" theories which ~~(1)~~ imply (1) either that no one is responsible for what he does or else that insofar as people are responsible, they are also irrational; and (2) that any moral, religious, or political beliefs which might dissuade us from being oppressors are mere superstitions or rationalizations.

The specter of political oppression is one of the things that makes us willing to live with our selfish, narcissistic individual instead of insisting that he be locked up and cured, for there, but for the grace of God, goes us. If it could happen to him, it could happen to us, for who among us has no character flaws? It is also one of the things that leads us to ask, "Where do you draw the line between illness and political incompetence? Or between normality and pathology? And where do you draw the line between mental health treatment and political coercion?"

There are no such lines to be drawn. It is a radical misconception and a methodological error to suppose that there are.

As we noted above, the concept of psychopathology is a systematic concept, not the name of something one points at. Accordingly, there are no visible criteria, and judgments concerning psychopathology depend on the cultural, historical, and situational context. Not only is it impossible in principle (and absurd to try) to define psychopathology by reference to specific behaviors or other specific personal characteristics (other than the pathological state itself), but experience shows us ineluctably that our efforts to do so have at best a very local and very temporary and very approximate validity. This feature of the concept is not a peculiar one--it probably holds for ninety percent of our concepts. (Where do you draw the line between dangerous and not dangerous, between convenient and not convenient, between near and not near, between thoughtful and not thoughtful?) Any specification of concepts must directly or ultimately appeal to judgments that people are able to make and to abilities and sensitivities they are able to exercise.

Rather than "Where do you draw the line?" we should want to ask "What point is there in saying that?" Descriptions and judgments are not in general mutually exclusive in the way that taxonomic classifications generally are. There may well be a point in saying <u>both</u> "That's mental health treatment" and "That's political oppression". Then it is a case of priorities. Do we abstain from treatment or resist it on the grounds that it would be political oppression? Or do we press ahead and violate a person's political rights because something should be done about his pathology? For most persons, political rights take priority, since they serve, as much as anything can, as a guarantee of other rights and other opportunities, including rights to mental health treatment or opportunities for it.

The methodological safeguards against errors in clinical and ethical judgments are not very different from our familiar safeguards against political oppression, i.e., (a) institutions which are presumed to inculcate the relevant competence and sensitivity for making the judgment; (b) the existence of, and the appeal to, a framework for negotiating apparent differences (Ossorio, 1977); and (c) placing the burden of proof on any thesis which denies the validity of a person's judgment.

7. Pathology and needs

In most of the psychological literature, "need" is used as a technical term designating a motivational concept. For example, in such ways of talking as "He has a strong need to demonstrate his masculinity", "They have a high need for achievement", "I have a strong need to express my anger", the term "need" is a motivational one. The Descriptive Psychology concept of need is a non-motivational one which corresponds closely to ordinary English usage.

The paradigmatic concept of "need" is given by the following definition: A need is a condition or requirement which, if not satisfied, results in a pathological state.

This definition provides a simple conceptual schema for giving causal explanations for a person's being in a pathological state: He's in a pathological state because his need for [Vitamin A, emotional support, social acceptance, water, sleep, etc.] was not met.

The convenience of the schema conceals some potential difficulties having to do with precision and accuracy in identifying the need. For example, my need for Vitamin A is not a need for Vitamin A in general or in the abstract, nor is it even the need to ingest Vitamin A (since there are

other ways of getting enough). Rather, we take it that the need (the condition the absence of which causes the pathological state) is for the vitamin to be present at certain functional sites in my body. As long as that condition is met, we believe, it will not matter whether I have ingested Vitamin A or whether I "have" it in some other sense. However, we don't know what these sites are (and even the reference to sites is an oversimplification). Thus, we are in the dilemma that we don't know what the need is, literally, and that insofar as we can say at all what it is, we are being inaccurate or very imprecise. The dilemma is present for other needs, such as emotional support (what kind, from whom, when, under what conditions?), social acceptance, etc. Nevertheless, we do say, "He needs emotional support [etc.]", and it is generally informative.

One of the common points of simplification in our common talk about needs is the quantitative aspects. For example, he doesn't merely need emotional support; rather, he needs <u>enough</u> of it. (And he needs <u>enough</u> sleep, <u>enough</u> social acceptance, <u>enough</u> Vitamin A, etc.) Thus, we have introduced the notion of relative deprivation. And then we can consider questions concerning what happens when a person doesn't merely not get enough, but rather gets none, or almost none, of what he needs. And we can ask, what happens when a person gets enough so as not to be pathological, but gets less than is normal, typical, etc.?

Although the concept of need is non-motivational, it is easy to see why it would have motivational implications. The general connection between needs and motivations is cognitive, not causal or merely coincidental. Since the consequence of failing to meet a given need is that I will be in a pathological state, if I take it (<u>rightly or wrongly</u>)

that I have a given need, I will thereby (unless I am in an unusual state of mind) be strongly (prudentially) motivated to satisfy that need. If I take it that the satisfaction of the need is essential for my survival, the motivation may well be preemptive. The technical use of "need" as a motivational term carries strong connotations of preemptiveness or lack of awareness or both. Consider, for example, the differential impact of saying "He wants to demonstrate his autonomy" as against saying "He has a need to demonstrate his autonomy".

From the paradigmatic concept of need given by the definition above, we can derive two other need concepts:

In the first case, we note that to enter into a pathological state is to suffer a loss of behavior potential, and, accordingly, it is to be worse off. If we retain this feature of the paradigmatic concept of need we can derive the concept of "trivial" needs. "I need a quick drink right now." "I need to get an A in this class." "I need a ride to the store."

This sort of reference to "need" clearly is not to the paradigmatic notion of "need". Obviously, I would not enter into a pathological state if I had to do without the quick drink, or the ride downtown, or the A in the class. But I would be worse off, other things being equal. And because I would, it makes <u>that</u> sense to say "I need . . .". To be sure, in ordinary discourse, "I need" is often a euphemism for "I want".

In the second case we consider what lies beyond pathological states and restricted behavior potential, and that leads us to the notion of a <u>Basic Human Need</u> (BHN), which is defined as follows:

<u>A Basic Human Need is a condition or requirement which, if not satisfied at all, makes human behavior impossible</u>.

As this rule-of-thumb definition indicates, any Basic Human Need reflects something fundamental and universal about persons and their behavior as such. Because of these two features, the framework of Basic Human Needs is one which can be used without prejudice across cultural boundaries (Ossorio, 1983), and serves as a basis for multicultural mental health service delivery and research programs (Aylesworth and Ossorio, 1983).

Traditionally, social scientists who have presented us with lists of basic human needs have presented them as both universal and fundamental, but have said little about the concept of "need" itself. If the general character of needs is uncertain, the uncertainty will be heightened, not reduced, by stipulating that they are universal or fundamental.

Note that the definition does not imply that there is any single definitive set of Basic Human Needs. And, in fact, different authors present different sets of Basic Human Needs. The items on the different lists show many strong family resemblances, but there is very little exact duplication. Typical of items on these lists are "Order and Meaning", "Adequacy", "Autonomy", "Self Esteem", "Safety and Security", "Physical Health", and "Love and Affection".

An examination of the Basic Human Needs referred to in the literature shows that almost all of them clearly fit the definition above. For example, Adequacy, Competence, Order and Meaning, Safety and Security, and Self Esteem appear to provide a clean fit. A few are dubious or borderline (e.g., Physical Health and Love and Affection), and their fit to the definition depends on how broadly we construe them. For example, if the need for Love and Affection is interpreted as the need to have <u>some</u>

positive standing in some community of persons, then it fits the definition.

In contrast, it may be more illuminating to consider that a need like Love and Affection may be analogous to a "trivial" need in relation to those BHN which clearly fit the definition. That is, we would be inclined to say "Yes, I would be worse off, but . . . "

However, there is no need to underwrite the validity of every item on every list of BHN in the literature. It is enough that the systematic concepts introduced above make it easy to understand why the traditional lists have the kind of contents they do and why different people present different lists. Beyond that, it is better not to assume more responsibility for making those lists sensible and non-arbitrary than their authors have.

8. Pathology and problems

To be in a pathological state is to have significantly restricted behavior potential, but one can have significantly restricted behavior potential without being in a pathological state. The latter case is found where the restriction is a matter of opportunity constraints rather than ability deficits. For example, being locked in a cell or being a slave are likely to represent seriously restricted behavior potential but do not per se constitute pathology.

Of course, not all cases of opportunity constraints are as clear-cut as these examples might suggest. Consider the following two examples: (a) Jil is a 40-year-old woman who lives with her mother in the home where she grew up. Her place in the family, and her relationship with her mother, is to be the obedient conscientious daughter. Jil is a successful

professional woman who has a normal complement of friends, is financially self-supporting, and manages the household. She finds it unthinkable to get married and leave her mother and the family home.

(b) Family X consists of a father, mother, and three sons and daughters, the youngest being ten years old. The family system operates on the principle that it is overwhelmingly important to be right: if you are right, then you get to have your way, and your existence is validated; but if you are wrong, then you are a helpless nonentity. Both the interactions of family members and the interactions of the family with other individuals and agencies consist of do-or-die struggles to be right. Any family member who comments on this way of operating is immediately put in the wrong. Nobody in the family is happy. Individually, family members interact more or less normally with people outside the family, though they have a tendency to be righteous.

In such cases as these two, we would often judge that some or all of these family members were significantly restricted in their actual participation in the social practices of the community. One of our options then would be to say that these individuals were in a pathological state and that the crucial ability deficit was their inability to break out of the family pattern.

Another option would be to say that these individuals were lacking in the normal opportunities to break out of the family pattern because, in each case, to do so in this family would be a heinous undertaking--and since that is so, these persons don't really have a chance to break out of the family pattern. This is comparable to saying that the slave doesn't really have the opportunity to do many of the things he has the ability

to do, not because the occasions and implements are unavailable, but because he would be put to death if he did.

Note that this latter kind of formulation does not entail that the motivation is preemptive; the very fact that the motivation is as strong as it is makes it quite capable of being entirely decisive without being preemptive at all. At the same time, there is nothing about such a formulation that precludes preemptiveness of the motivation. Thus, we might expect a good deal of disagreement and less than optimal certainty in people's judgments in such cases. Characteristically, we say that the individuals in question "have problems" or "have difficulties", rather than that they "are sick".

Of course, family problems are not the only kind which might concern us in this way. Interpersonal relationships and system functioning in social, occupational, educational, political, and religious settings may also be major ingredients in personal problems.

What is it for a person to have a problem? Ordinarily, we say that a person has a problem when (a) there is a state of affairs which it is important for the person to achieve and (b) as matters stand, that achievement is either unlikely or quite uncertain. Note that the state of affairs in question may encompass any set of requirements (to succeed and not get anyone angry; to succeed in a given period of time or without paying an unacceptable cost, etc.).

It follows that when a person, P, has a problem, P's behavior potential is significantly restricted relative to a given standard. This formulation holds no matter whether it is P or someone else who judges that P has a problem (whoever makes the judgment supplies the standard). Given

the definition of a pathological state, it also follows that being in a pathological state is a special case of having a problem. (And having a problem is a special case of "being worse off", i.e., worse off than if the problem had been solved.) Presumably this is part of the basis for the slogan, "There's no such thing as mental illness--there's only problems in living." Correspondingly, a significant number of clinicians who would not actively deny that there is such a thing as mental illness prefer not to operate with the concept of pathology (which they often equate to the Medical Model) at all. Rather, they deal with problems in living, and often operate in an educational or consultative model.

Methods, techniques, and approaches which are effective in dealing with psychopathology are sometimes effective in dealing with other life problems. This extended range of applicability is least surprising when the techniques are based on general psychological principles. In Descriptive psychotherapy, for example, methods and techniques are explicitly designed to increase behavior potential and are based on universal status dynamic principles. Not surprisingly, not merely the general principles but many of the therapeutic techniques and concepts are readily applicable in family, organizational, and other social settings. Thus, at least for Descriptive Psychology practitioners, working with problems rather than pathology is in principle a viable way to proceed.

There are two important limitations and potential problems in such an approach. The first is that problem solving is a substantive enterprise and not merely a formal or procedural one. Having expertise with respect to one class of problems in no way creates a corresponding expertise with

respect to other classes of problems, even when the same principles apply and even when some of the same techniques are effective in the latter cases. For example, training in theories, techniques, and application in psychotherapy does not automatically create a corresponding competence at working with problems of families, organizations, etc.

The second limitation of the "I deal with problems" approach is that it glosses over a very important distinction, i.e., the distinction between pathology and other classes of problems. Pathology is distinctive, though perhaps not unique, in that it is the occasion of legitimate social concern and social action. We all have a significant stake in the fate of persons who lack the ability to function as normal members of society. We do not have the same stake in an organization which is not making a profit or an employee whose career is progressing too slowly, or in family members who are unhappy with each other.

The Noncommittal Model: DSM III

Various professional groups and government agencies employ standard classification schemes for categorizing "mental disorders". One of these schemes, adopted by the Americal Psychiatric Association, is codified in the APA Diagnostic and Statistical Manual, and is commonly used by mental health professionals such as clinical psychologists, counseling psychologists, and psychiatric social workers, as well as by insurance companies and a number of government agencies. A recent revision (DSM III) was accomplished by a committee in which various practitioner viewpoints were represented.

Among the practitioner viewpoints to which DSM III appears to be responsive are (a) the Medical Model, represented by psychoanalytic, physiological, and "psychodynamic" viewpoints; (b) the Behavioral Model, represented by operant conditioning, social learning, and classical conditioning viewpoints; and, to some extent, (c) the overtly atheoretical existential/humanistic viewpoint. As might be expected, the task of being responsive to this variety of viewpoints was formidable. In the absence of an appropriate multi-perspective framework (Ossorio, 1983), the accommodation to disparate viewpoints inevitably led to a lowest-common-denominator formulation, since only a formulation of this kind would be noncommittal with respect to the differences in viewpoint.

In this situation, there are two forms of lowest common denominator which are obvious possibilities. The first is simple disjunctive expansion. That is, since each of the viewpoints leads to pathology categories which reflect that viewpoint, it would be possible to give a simple disjunctive definition and classificatory system, i.e., "A mental disorder is either one of these [categories] or one of these, or . . . or one of these."

The second form of lowest-common-denominator formulation is to retain only what is common to the different pathology categories generated from the several viewpoints. Probably the most obvious ways of doing this are (a) to encompass what is common by using very noncommittal or abstract characterizations and (b) to focus on symptomatology, or, more generally, to focus on what is readily established on the basis of observation. Both the disjunctive technique and the common-element technique are evident in the taxonomic system which was arrived at and in the corresponding

formulation of psychopathology.

DSM III does not have an acknowledged definition of psychopathology (one of the ways in which it is noncommittal), but it does have the following explication (p. 6) which functions as a definition (see, e.g., the reference to this paragraph on p. 92):

> In DSM III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is limited to a conflict between the individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.)

It requires little reflection to recognize in this definition a heroic effort not to violate any of the various points of view on psychopathology represented on the committee. Closer attention reveals it as a tour de force of noncommittal verbalization. This high order of achievement has at least three major ingredients.

A. Shifting references

A review of the definition shows that it contains a variety of pathology-like concepts, i.e., disorder, syndrome, impairment, disability, dysfunction, and disturbance. None of these is ever repeated (except for

the parenthetical reference to "disturbance"). Further, none of these concepts is explicated, nor are the similarities, differences, or relationships among them explained. As a result, it would be extremely difficult, if not impossible, to understand from the definition (a) what is being said, (b) what is being talked about, (c) what a mental disorder is, or (d) what would qualify as an example of a mental disorder (see below).

B. Disjunction and amorphousness

In part, the noncommittal character of the definition reflects the use of multiple and indefinite alternatives without anywhere an indication of a unifying genus or an explanation of why those are the alternatives. In this genre, we have "behavioral or psychological", "syndrome or pattern", "painful symptom . . . or impairment", "one or more areas", and "behavioral, psychological, or biological dysfunction".

This usage leaves us with a number of questions. Why, for example, count distress and disability as alternatives? What are they alternatives of, for, or to? Why these? We might merely conclude that politics makes strange bedfellows.

A different sort of question is "What comes under the heading of 'psychological', of 'behavioral', of 'syndrome', of 'pattern'?" These are tremendously inclusive terms; with a little stretching, any one of them might be claimed to include everything whatever. Their use here is, therefore, highly uninformative and not merely noncommittal.

C. Uncertain connections

In part, the noncommittal character of the definition reflects the use of grammar and terminology which connects logical elements or ingredients in a purely formal way without specifying or indicating what the actual

relationships are intended or assumed to be. In this vein we have the following:

1. "a syndrome or pattern which occurs in an individual . . . "

   One hardly dares ask, does this really mean something which occurs inside an individual as contrasted with something that occurs on or outside an individual? (Recall that the "inner-outer" idiom is endemic to the Medical Model.) If so, this would exclude behaviors and behavior patterns, since the behaviors and behavior patterns which are presumably in question are observable ones (e.g., wetting the bed) of which it would be nonsensical to say either that they occur inside a person or that they occur outside the person. Yet the definition refers to "a behavioral or psychological syndrome or pattern" (emphasis added). We are left without any intelligible candidate for the relation between the syndrome or pattern and the individual. We could, of course, import the Deficit-Model notion of possession or ownership, and say that the relationship in question is that the person has the pattern or syndrome, in the sense that it is his or her pattern or syndrome.

2. ". . . pattern or syndrome . . . that is typically associated with [distress or disability]"

   (a) In one sense the connection is relatively intelligible but also unbelievable, since it implies that a given syndrome or patterns which is typically associated with distress or disability is a mental disorder even in those cases where it is present but no distress or disability is present. But this is absurd (recall the thought experiments above). Also, if we accept this part of the definition at

face value, we give up the requirement of any reality constraints on what we take to be a case of psychopathology. This is because we then have the option of specifying the syndrome or pattern in purely theoretical/hypothetical terms, such as "impaired early object relations" or "defective conditionability" or "basic inauthenticity", which we are free to define as being typically associated with distress or disability.

Given the earlier discussion, the political implications of such license are obvious. The dangers are not merely hypothetical. For example, judicial and bureaucratic decisions as to child custody not uncommonly hinge on the fact that a parent is described in such terms as "weak ego boundaries" or "unable to form positive object relations" or "Borderline Personality", in the absence of a direct evaluation of parental competence.

(b) Although "typically associated with" is intelligible, it is also highly indefinite. There are many different ways for one thing to be associated with another, and in most cases it makes all the difference in the world which way is in fact the case. For example, it generally makes a difference whether or not the association is based on a causal relation, and it makes a difference which is the cause and which is the effect. (Recall that the Medical Model and Behavioral Model involve causal relations, whereas the Deficit Model involves expression or manifestation.)

If we take this part of the definition literally and seriously we will conclude that taking an aspirin and consulting a physician are mental disorders, since they are clinically significant behavioral patterns

which are typically associated with having a headache (distress). Similarly, we will count being a rodeo cowboy as a mental disorder, since it is a behavioral pattern which is typically associated with pain and disability. Finally, merely being alive would also count as a mental disorder, since it is a clinically significant psychological syndrome which, on a global scale, is typically associated with pain and/or disability.

3. "In addition, there is an inference that there is a . . . dysfunction . . . "

(a) Here we would want to ask, "In addition to what?" Is it that there is an inference (or the inferred dysfunction) in addition to the "syndrome or pattern"? Or is it in addition to the disability or distress? Or is this simply an additional fact about mental disorders, or an additional fact about the association of "syndrome or pattern" with "distress or disability"? There does not seem to be any informative way to relate this sentence to the preceding one.

(b) Also incredible is the notion that the presence of an inference is essential to the phenomenon of a mental disorder. If no dysfunction is inferred by anyone, is it then the case that, e.g., a headache or a phobia is not a mental disorder? And then, do they become mental disorders as soon as anyone infers a dysfunction (and presumably from any premises whatever, since no grounds for the inference are either specified or excluded). One might suppose that what the committee really wanted to say was flatly "there is a dysfunction . . ." and incorporated the reference to an inference merely to meet some objections. In that case, we would only be left

with complete uncertainty as to the relation of the "dysfunction" to the "mental disorder", the "pattern" or "syndrome", and the "distress" or "disability" referred to in the first sentence.

4. ". . . the disturbance is not only in the relationship between the individual and society . . . "

Here, we begin by asking "What disturbance?", since no disturbance has been mentioned previously (recall the issue of shifting reference, noted above), and move quickly on to "What relationship?" This connection could be disambiguated by paraphrasing the parenthetical explanation as follows: "When what is wrong is only that there is a conflict between an individual and a society, the individual may well be socially deviant, but he is not thereby in a pathological state."

Perhaps enough has been said about the definition. The shifting reference, disjunctive constructions, indefinite terminology, and uncertain connections make this formulation simply inadequate as a vehicle for distinguishing "mental disorders" from other phenomena, or for explaining why the categories and criteria for the "mental disorders" are what they are.

The set of categories fares little better.

1. Inconsistent classification principles

One reason for describing the mental disorder categories as a set rather than as a system is that there are no consistent principles for generating the categories. Sometimes etiology is a defining characteristic (e.g., organic mental disorders) and sometimes it is not (e.g., organic brain syndrome). Sometimes behavioral criteria predominate (e.g.,

stuttering; Oppositional Disorder) and at other times they do not (e.g., Identity Disorder). Sometimes categories are relatively theory-dependent (e.g., Identity Disorder), and at other times they are not.

2. Intralevel and interlevel inconsistency

Specific mental disorders are grouped together under general categories (e.g., Substance Use Disorder, Anxiety Disorders, Schizophrenic Disorders). Inconsistencies may be found (a) in the characterizations of the general categories, (b) between particular disorders and their generic categories, and (c) between particular disorders and the definition of mental disorder.

(a) An example of within-category inconsistency is provided by the Substance Abuse Disorders. These are characterized as needing only "tolerance" and "withdrawal" as criteria, except for alcohol and cannabis use, where consequent impairment of social functioning is also required. No rationale for these exceptions is given. Moreover, caffeine dependency, where tolerance and withdrawal can be demonstrated, is not classified as a disorder at all, on the grounds that no social impairment is demonstrated.

(b) An example of inconsistency between particular disorders and their general category is found in the classification of Obsessive Compulsive Disorder as a member of the group of Anxiety Disorders. Since anxiety is not a defining feature of Obsessive-Compulsive Disorder and is not typically found in this connection, one can only suspect that this placement of Obsessive-Compulsive Disorder reflects a return of the repressed psychoanalytic explanation, which does lean heavily on the notion of anxiety.

(c) Examples of inconsistency with the definition of mental disorder are provided by Pica and Enuresis. Here, there is no evidence of distress or impairment, which are called for by the definition. In these, as in a number of other developmental problems, the primary symptom is distress on the part of parents or other family members. Yet the definition clearly excludes from the category of "mental disorder" cases in which "the disturbance is only in the relationship of the individual to society".

3. Unimpressive reliability

A reliability study is reported for the final version of the Manual, using the Kappa index as the relevant statistic (a Kappa of .70 represents "high agreement"). From the table of results (pp. 470, 471) we can calculate the following: For adults, the average Kappa was .59 for seventeen major categories and .52 for thirteen subcategories. For children, the average Kappa was .42 for eleven major categories and .51 for thirteen subcategories.

The average Kappas are somewhat lower than the overall Kappas which are reported on pp. 470 and 471, reflecting the fact that some of the categories with larger percentages of the cases were also used with a greater level of agreement. Since our interest here is in the classification scheme as such, the average Kappa appears to be the more relevant statistic. Given that the Kappas ranged from -.02 to 1.0, and that the averages do not represent high agreement, the degree of objectivity, in the sense of inter-observer agreement, of the scheme is hardly impressive, though it is perhaps not flatly disreputable, either.

4. Low "external validity"

The two major sorts of justification which might be offered for a classification scheme for psychopathology are (a) that the distinctions involved in the sceme enter into interesting empirical regularities; or (b) that the scheme is useful in structuring treatment efforts in that, paradigmatically, cases which are classified in the same way can be effectively treated in the same way. There is not a strong case to be made for DSM III on either basis.

It may seem premature to comment at all on the scientific or clinical usefulness of a recently-introduced classification schema, for we cannot foretell what results the future will bring forth. However, the categories in question are not, after all, very different from the categories of DSM II, ICD9, and so on. They are of a familiar kind.

The history of research in which official categories of psychopathology are employed has not been impressive in contributing to a fuller or deeper understanding of the phenomenon of psychopathology. Given the degree of inconsistency, the conceptual heterogeneity, and the degree of arbitrariness we have seen in the newer, "improved" edition, and given the near-universal failure among experimental practitioners to give explicit conceptual recognition to the most basic features of the phenomenon, i.e., its evaluational, contextual, social, and nonbehavioral features, and its absolute conceptual distinctness from <u>any</u> explanation, the minimal contribution of past research efforts is understandable, and expectations in regard to future research results should be correspondingly modest.

With respect to treatment, we are told, following the definition on

p.6., that it is a mistake to suppose that persons who have the same disorder are alike in all important respects, including those which may make an important difference in treatment. But matters are worse than this. It is not the familiar phenomenon exemplified in medical practice by the fact that although there is a more or less standard approach to the treatment of pneumonia, the treatment may be modified considerably for a patient who also has asthma or is prone to cardiac arrest.

Rather, there are in general no standard treatments for the various categories of mental disorder (except for some categories and some schools of thought or some organizations), and, although doubtless there are modal differences among mental health professions in this respect, it appears that very few, if any, clinicians routinely plan or implement treatment of psychopathology primarily on the basis of a DSM type of diagnosis, and there is no presumption that everyone with the same diagnosis should receive the same treatment. Rather, treatment is routinely based on some sort of individual formulation which is more or less colored by classificatory concepts ("psychotic", "character disorder", "Borderline", etc.) and more or less dependent on a particular conceptual orientation.

5. Imperialism

The classification scheme has a subset of categories, commonly referred to as "V codes", which are admittedly not mental disorders but which may, nevertheless, "appropriately be the focus of attention or treatment". (Note the continued use of the kind of noncommittal language discussed above in connection with the "definition" of mental disorder.) Among these categories are "malingering", "marital problem", "academic

problem", "occupational problem", "other interpersonal problem", and "phase of life problem or other life circumstance problem".

No rationale is given as to why such phenomena are appropriately the focus of treatment, or why a mental health professional would have any claim to professional competence in dealing with them. (Or, conversely, no explanation is given as to why focussing on such matters by a psychiatrist would constitute treatment.) In point of fact, it seems highly likely that most family therapists and organizational consultants or vocational consultants would take a strong position to the contrary.

Further, given the nonspecific character of such categories as "other interpersonal problem" and "other life circumstance problem", it appears that literally anything may "appropriately be the focus of attention or treatment". Not merely academic and occupational problems, but financial, artistic, political, spiritual, ethical, scientific, legal, mathematical, engineering, and any other problems are "appropriate" targets for treatment. The general position appears to be that "These are not mental disorders, but it is appropriate to treat them as if they were." In the case of "malingering", the "treat it as if it were a mental disorder" position runs directly contrary to the definitional disclaimer ("When the disturbance is limited to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but it is not by itself a mental disorder"). It also puts the medical profession in the unsavory position of being the enforcer of political, social, or other orthodoxy.

The formalization of the difference between mental disorders and the "V code" phenomena appears to reflect a recognition that not all problems

involve psychopathology. The difficulties created by the handling of the non-disorders appear to reflect a grandiose refusal to recognize reality constraints on the validity of medical practice. This position provides a direct basis for employing mental health treatment as a form of political action.

The Deficit Model and DSM III

In spite of the manifold and decisive difficulties which make DSM III conceptually and practically inadequate as a classification system for psychopathology, the DSM III approach is more compatible with the Deficit Model than may be apparent. In large part, this is because DSM III attempts as a practical necessity what the Deficit Model accomplishes as a conceptual and methodological necessity, namely to separate the notion of pathology (and psychopathology) as such from the various alternative explanations of particular cases of pathology and of pathology in general. In part, too, it appears that the logic of the Deficit Model is sufficiently compelling intuitively for the DSM III system to be visibly responsive to it in a significant degree. Points of similarity and compatibility may be found both in the definition on page 6 of DSM III and in the criteria for particular disorders or categories of disorder.

With respect to the definition of a "mental disorder", it is illuminating to consider the kind of change in the definition which would bring it into line with the Deficit Model. These changes are shown as follows:

1. For "impairment in one or more important areas of functioning (disability)", read "a normatively significant (serious) disability". There is no way to judge that there is a disorder or dysfunction without reference to a normative standard (note "important" areas of functioning). However, it is the impairment or disability which must be significant, not the area of functioning per se--a very minor impairment in an important area of functioning would surely not count as pathology.
2. Drop the reference to pain and distress, recognizing that in order to be evaluated as pathology, pain or distress must result in a normatively significant disability (recall that we only count a headache as an illness when it interferes with what we can do, including, e.g., whether we can enjoy or appreciate a concert or a conversation). Thus, the force of the reference to pain and distress is already included in the reference to a normatively significant (serious) disability.
3. For "clinically significant", read "pathological" and then drop it as redundant. It does not appear that there is any sensible criterion for what is "clinically significant" except what we judge to be pathological or pathogenic, hence the introduction of the phrase appears to beg the question.
4. For "a . . . behavioral or psychological pattern or syndrome", read "a psychological phenomenon". This reference appears to be a way of specifying the logical category to which "mental disorder" belongs, and, brand-name recognition considerations aside, surely "behavioral" is included in "psychological", and surely a <u>mental</u> disorder is a psychological phenomenon.

5. For "is typically associated with", read "consists of" or "is the same thing as". (See the critique, above, of "is typically associated with".)

6. For "In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction", read "In addition, there is an explanation for the disability, and the explanation refers to a behavioral, psychological, or biological dysfunction." (See the critique, above, of "there is an inference".)

7. For "the disturbance is not only in the relationship between the individual and society", read "the disorder is <u>essentially</u> a matter of a person's abilities and disabilities, rather than his motivations, opportunities, or relationships; hence, social deviance (which is likely to reflect motivations and opportunities primarily) is not per se pathology and does not imply pathology."

The result of these changes is the following revised definition: "A mental disorder (psychopathology) is a psychological phenomenon which consists of a normatively significant disability for which there is an explanation which refers to a behavioral, psychological, or biological dysfunction; the disorder is essentially a matter of a person's abilities and disabilities, rather than his motivations, opportunities, or relationships; hence, social deviance (which is likely to reflect a person's motivations and opportunities primarily) is not per se pathology and does not imply pathology."

A more compressed version would begin:

"A mental disorder is a normatively significant psychological disability for which there is a behavioral, psychological, or biological explanation . . . "

In effect, when the most outstanding redundancies, ambiguities, and technical flaws are removed, the DSM III definition comes very close to the Deficit Model definition.

With respect to the specific and generic mental disorders detailed in the Manual, it is important to lay to rest some current misconceptions. It has become a cliché to comment that, in contrast to DSM II, the current Manual has "objective, behavioral criteria" for the various disorders. In fact, however, more often than not the criteria are disability criteria rather than behavioral criteria, and their objectivity, whether in the sense of being readily established by observation or in the sense that there is agreement among observers, is open to serious question.

With respect to behavioral vs. disability criteria, consider the following:

A. Attention Deficit Disorder with Hyperactivity

For this disorder there are three clinical criterion categories (Inattention, Impulsivity, Hyperactivity) and three arbitrary, or merely limiting, categories (Onset before age 7, Duration at least 6 months, Not due to Schizophrenia, etc.). Under the three clinical categories, there are 16 specific criteria. Of these, 9 are clearly disability or failure criteria (e.g., Often fails to finish things he or she starts; has difficulty awaiting turn in games): Five are clearly behavioral (e.g.,

shifts excessively from one activity to another; moves about excessively during sleep). Two are ambiguous (easily distracted; often acts before thinking), but are more suggestive of disabilities than of behaviors.

B. Alcohol Dependence

For this disorder, there are two clinical criterion categories. The first is either Pattern of pathological alcohol use or Impairment in social or occupational functioning due to alcohol use. The second is either Tolerance or Withdrawal. Although the first seems behavioral, the specific criteria include "need for daily use of alcohol for adequate function" and "inability to cut down or stop drinking". Although the second seems clearly a disability category, it includes such specifics as "violence while intoxicated" and "arguments . . . with family or friends . . . ". "Tolerance" is explained as "need for markedly increased amounts of alcohol to achieve the desired effect . . . " which is perhaps closer to a disability notion than a behavioral notion.

The tension between the criterion of social impairment (disability) and the more behavioral criterion of tolerance or withdrawal is evident throughout the general category of substance abuse:

(p. 165) "The diagnosis of all Substance Dependence categories requires only evidence of tolerance or withdrawal, except for Alcohol and Cannabis Dependence, which in addition require evidence of social or occupational impairment from the use of the substance or a pattern of pathological substance use." No rationale is given for why Alcohol or Cannabis Dependence are exceptions; a plausible explanation is that alcohol and cannabis users are sensitive to having their political rights violated.

Or, again (p. 165), "Many heavy coffee drinkers are physiologically

dependent on caffeine and exhibit both tolerance and withdrawal. However, since such use generally does not cause distress or social or occupational impairment, and since few if any of these individuals have difficulty switching to decaffeinated coffee or coffee substitutes, the condition does not appear to be of clinical significance. Therefore, caffeine dependence is not included in this classification of mental disorders." In addition to exhibiting a sensitivity to the criterion of disability as contrasted with behavior, this passage also is one of those which supports the third paraphrase above (for "clinically significant", read "pathological").

C. Dysthymic Disorder

For this mental disorder, there are two clinical categories. The first is either "prominent depressed mood" or "marked loss of interest or pleasure in all or almost all usual activities or pastimes." Neither of these is behavioral; both are impairment/disability criteria. The second is "During the depressive period at least three of the following symptoms are present." Of the thirteen symptoms, only one is behavioral, i.e., "tearfulness or crying". The remaining include such impairment/disability symptoms as "low energy level", "feeling of inadequacy", "social withdrawal", "loss of interest", and so on.

Given the foregoing as a reasonable sample, together with the fact that the organic and developmental disorders have an extremely high proportion of impairment/disability/failure criteria as contrasted with behavioral criteria, it is clear that disability/failure criteria pervade the entire classification system and predominate over any other kind of criteria. Thus, inadvertently, DSM III is more compatible with the Deficit

Model than it is with either of the two models from which it is derived, i.e., the Medical Model and the Behavioral Model.

The DSM criteria have been rightly criticized as being taxonomically inconsistent in the sense of being a conceptually mixed bag, so that categorically different concepts are being combined arbitrarily in what should be a conceptually homogeneous system. As we have seen from the examples above, such criticism is justified on the face of it.

However, the Deficit Model, which extends beyond the mere definition of pathological states, provides a rationale for such heterogeneity and in that sense (only) makes it possible to reconstruct the DSM III taxonomy as a more or less conceptually coherent, if not literally homogeneous, system.

Recall that we derived several patterns of explanation and assessment in addition to the methodologically pure disability assessment. For example, we derived the formula (for our narcissistic friend), "It is extremely difficult to see how a person with this personal characteristic could have a set of personal characteristics or relationships which would enable him to participate adequately in the social practices of the community". Similarly, we have "It is highly implausible that a person who does this in these circumstances would have a set of personal characteristics or relationships which would enable him to participate adequately in the social practices of the community" (because it is highly plausible that he has this characteristic, which is expressed by that behavior, and it is extremely difficult to see how a person with this characteristic could have . . . , etc.).

By using such formulas as these we are able to draw the conclusion that someone is in a pathological state without literally surveying

abilities and disabilities. The convenience of such procedures often offsets the sacrifice in understanding which is involved--or it may be what motivates us to make such a survey. In any case, the use of such formulas allows us to see how the fact that a person engages in certain behavior (or fails to) or has a certain personal characteristic can be used diagnostically as the basis for identifying a type of pathological state.

Consider the category of "the kind of social restrictions a narcissistic person would have" or "the kind of social restrictions a person who is violent and tells lies would have". Not all narcissistic or violent persons in our culture will in fact have the same restrictions on their social participation, but there will be family resemblances among them, and they will not be merely a representative sample of pathology in general. This intermediate degree of looseness/tightness among the various instances of pathological restrictions for narcissistic (etc.) persons provides an in-principle (only) rationale for the kind of disjunctive provisos (e.g., "at least three of the following thirteen criteria are present") for which DSM III is notorious. What holds the set of criteria together is that they are "the kind of social restrictions a narcissistic person would have", and there is not some other, more direct, general way of specifying what these restrictions are.

Although such an approach is not so tidy as we might require for a systematic taxonomy, neither is it simply illogical. But, in the absence of the kind of explication provided by the Deficit Model, it would have to appear so.

Taxonomies for Psychopathology

Given the difficulties we have noted with DSM III, we have to ask whether taxonomies for psychopathology are necessary. If by "taxonomy" we mean a single, conceptually unitary, exhaustive classification system which subsumes all cases of psychopathology and nothing else, then it appears that for scientific or clinical purposes such a taxonomy is not necessary.

The kind of classification system that has utility for scientific purposes is one which (a) can in fact be used to classify individual cases; (b) embodies distinctions which enter directly or indirectly (e.g., as "moderator variables") into functional, empirical relationships; and (c) are sufficiently extensive for a given purpose, program, or genre of investigation. Such classification systems do not have to cover the entire range of psychopathology, nor do they have to be identical in different scientific programs or studies. On the whole, given the historical and geographic relativity of what qualifies as psychopathology, it seems moderately unlikely that any observationally satisfactory classification for the phenomenon will have any substantial scientific interest. The subsidiary disabilities or anomalies which enter into explanations of pathology may be stronger candidates for scientific interest than the phenomenon of pathology itself.

For clinical purposes no taxonomy or set of classifications for psychopathology is <u>necessary</u>. If nothing else, the historical development of status-dynamic psychotherapy within Descriptive Psychology shows in detail how one can generate completely individual case formulations on a systematic basis, and design and implement treatment in a

completely ad hoc and completely principled way (Ossorio, 1977, 1982).

However, the uniqueness of persons and their problems is complemented by a variety of similarities among them. Some of these similarities or commonalities are worth noting and using as a basis for functional classification. For example, various images, scenarios, and internal dialogues (Ossorio, 1977) serve as a basis for grouping problems or persons in such a way that, paradigmatically, the same kind of problem gets dealt with in the same range of ways. Similarly, the categories and limited typologies developed by Bergner (1981, 1982), Driscoll (1981), and Peek and Trezona (1982) refer to commonalities and distinctions which provide a basis for treatment which is principled without being stereotyped, and unique without being mystical.

All of the foregoing are strongly "grounded", in that they stem directly from clinical practice and have a direct applicability to certain individuals. Their utility does not stem from being capable of classifying everyone who comes along, for there will be many individuals for whom none of the images applies and many individuals for whom none of the self-criticism (etc.) categories apply. They contrast, therefore, with traditional theory-based appropaches to psychopathology, where much of the utility lies in being capable of giving some sort of account for any given person. (In Descriptive Psychology this is provided by the Person Concept and by the Status Maxims). An intermediate case would be a complex typology such as the Positive-Health Developmental Model, or "PDM" (Vanderburgh, 1982). The latter is a three-dimensional model with eleven developmental levels, three personal-approach categories, and three type-of-mastery categories. The PDM reflects considerable clinical

practice and applicability, but also is capable of classifying all persons. From the standpoint of the Deficit Model, the PDM has the advantage of classifying abilities (or disabilities) and achievements (or failures). It therefore meshes well conceptually with the use of the Deficit Model and the more general Descriptive-Psychology formulations.

In general, the effect of using classification schemes and classificatory concepts is that doing so sensitizes us to certain problems or features which we might well overlook otherwise. The value of such sensitization is that knowledge of those problems or features contributes significantly to the design or implementation of effective treatment. There will, therefore, be no absolutes or universals in this regard. The value of a classification scheme will vary with the personal characteristics of the person using it and the purposes for which it is used, the persons with whom it is used or the problems those persons have, the skill and experience of the user specifically in the use of the classification scheme, and so on.

Thus, the appropriate logic for evaluation and justification of the use of a given classification scheme is much more likely to be found in the Precaution Paradigm (Ossorio, 1981) than in the traditional challenges, such as "Prove to me empirically that it's effective" or "Show me empirically (or logically) why I should use this one rather than some other one."

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