THE DROPPED OUT:
REDESCRIBING CHRONIC MENTAL ILLNESS AS A QUESTION ABOUT COMMUNITIES

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ABSTRACT

Concepts from Descriptive Psychology are used in redescribing chronically mentally ill persons as individuals who have been "dropped out" of their various communities. These communities can include the entire range of possibilities: friendships, families, neighborhoods, municipalities, nations, and cultures. An approach to treatment is outlined that stresses changing these communities as a way to increase the client's behavior potential. This formulation is presented as an alternative to those approaches that stress changing the mentally ill individual as the main goal of treatment.

A term becomes part of a language because a distinction must be made and because the success of someone's behavior hinges on making it. For mental health researchers, practitioners, and policy makers, the term "chronic mental illness" distinguishes a population that presents a serious challenge to the successful application of their professional competence. For the more general population the term can and does form the basis for a wide variety of emotional behaviors that range

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anywhere from derisive amusement, under the cloak of entertainment, to fearful rejection, when the chronically mentally ill are perceived as more dangerous than they are. For whatever purpose, it seems clear that our current uses of the term need close examination.

Bachrach (1987) has pointed out three recurrent themes that underlie the various attempts to define chronic mental illness: psychiatric diagnosis, level of functional disability, and length of duration. Beyond these three ingredients, however, little headway has been made to differentiate among the chronically mentally ill. These observations were made in a report from a recent conference, convened by the National Institute of Mental Health, to define the chronically mentally ill (Bachrach, 1987).

What was wanted was a definition broad enough to reflect the population's diversity and specific enough for application in a variety of service settings and research efforts (Bachrach, p. 4). What was achieved was:

> Chronically mentally ill individuals are persons who have severe and persistent disabilities that result primarily from mental illness (p. 5).

To be fair, while this definition may look somewhat "bare bones" in its curtness, the conference participants elaborated a large array of cogent issues identified from a variety of perspectives. Without going into detail, it is clear that many of the issues identified pointed either directly or indirectly to the sufferer's community as the critical context in which to evaluate the problem. The spareness of the above definition illustrates limitations inherent in the use of definitions (Ossorio, 1981a) rather than a lack of professional insight among those attending the conference.

To go on, the need for a more useful conceptualization of the term increased markedly in the period following the movement to deinstitutionalize the thousands of mentally ill individuals who occupied hospitals across the nation (Bachrach, 1987). Prior to deinstitutionalization, to be "a patient in a state mental hospital was virtually to be identified as having a chronic mental illness; and the motivation . . . to draw distinctions among members of the patient population, was largely absent" (Bachrach, p. 1).

Communities now face the prospect of hosting sizeable populations of persons who, by definition, are difficult to live with but about whom clinicians, researchers, policy makers, and program planners admit to being inarticulate. Disturbingly high estimates of the number of chronically mentally ill persons among the nation's homeless (Lamb, 1984) attest even further to the need to conceptualize communities as

a necessary ingredient in providing solutions to the spectrum of problems related to chronic mental illness.

What I want to do in this paper is to use concepts from Descriptive Psychology to reformulate the domain of chronic mental illness to include relevant facts about communities. Specifically, I will draw upon the ideas of Ossorio (1985), using his explication of the Deficit Model of pathology; and of Putman (1981), using his conceptualization of the community concept. Practical aspects of this reformulation will be illustrated by conceptualizing access to communities, first, as a general criterion of well-being and, second, as a general model for instituting improvements in the well-being of chronically mentally ill individuals.

By describing the relationship of chronic mental illness to communities I hope to accomplish two goals. The first is to extend the range of facts to which the community concept has practical application. The second goal is to encourage the development and refinement of community-based treatment possibilities for a population of persons characteristically underserved and often misunderstood by those in the helping professions.

THE DEFICIT MODEL OF PATHOLOGY

Ossorio (1985) constructed the Deficit Model of Pathology in contrast to prevailing models that stress either a set of underlying, or inner causes of outward manifestations (the Medical Model); or an outward normative context within which certain behaviors can be objectively considered pathological (the Behavioral Model).

To outline the contrast further, under the Deficit Model pathology is neither a type of anomaly—medical, social, or otherwise—nor a type of behavior. Rather, pathology is a type of state; specifically, one in which there is a significant restriction on a person's ability to engage in deliberate action, and equivalently, to participate in the social practices of the community. Furthermore, the restrictions involve the person's powers and/or dispositions which are changed under the pathological state resulting in limitations relative to what one ought to be able to do. Pathology, per se, does not consist of restrictions a community places on a person's opportunities for engaging in social practices, neither does it include patterns of behavior that are merely deviant or nonconventional (Ossorio, 1985).

This is not to say that what a community does to constrain a member's actions has no bearing on that member's well-being. In fact, the pattern of restrictions encountered by persons with a history of pathological states is of central concern in the present formulation of chronic mental illness as a question about communities. Two points can

be made in this regard. First, the enormously disqualifying status assignments communities reserve for chronically mentally ill persons may account in large measure for the problem's chronic endurance. Second, the assignment of pathological status to persons with a history of pathological states is not a mere problem of "labelling," one to be warded off by chanting: "sticks and stones, etc.". Rather, it is a problem that reflects a totality of interests being worked out in the larger context of appraisals made when a member of the community is debilitated. More will be said about pathological status in the course of conceptualization. For now, the Deficit Model has the important function of emphasizing the real problem of pathological states, that the affected person is not able to participate in the social practices of the community.

Because persons meet their Basic Human Needs by participation in social practices (Aylesworth & Ossorio, 1983; Ossorio, 1985), pathological states carry intrinsic significance for social intervention. Anyone socially related to the affected person has reason enough to want to do something about the pathological state without any further end in view. That is, when a person becomes worse off (i.e., by being in a pathological state) there is a built-in reason for someone to try to do something about it. Who has those reasons and what kinds of interventions they attempt in any particular case depends on the context of relations and resources surrounding the onset and course of the pathology. This point is worth discussing in more detail.

Behavior Potential and Pathology

The concept of behavior potential (Ossorio, 1977) will help elaborate the logical relationship between a pathological state and the community's response to it. Behavior potential is a general purpose concept used in Descriptive Psychology to summarize the totality of a person's real world behavioral possibilities. For example, the acquisition of new knowledge increases a person's potential to engage in social practices that require that knowledge. Generally speaking, behavior potential can be described in as much detail as necessary depending on the purpose and conceptual sophistication of the describer.

For the present discussion it is enough to say that chronic mental illness is a form of pathology in which the affected person suffers an extreme loss of behavior potential. A pathological state isn't, however, limited to reducing the behavior potential of the person whose state it is. The entire community has less behavior potential because there is a net loss in potential participation in its fund of available social practices. The more critical a person is to the enactment of a social practice, the greater the impact of the pathology on the community.

Moreover, this loss of communal behavior potential is proportional to the closeness of the relationship between the affected person and others in the community.

The general impact of a person's pathological state on other members of the community can be visualized as what happens when a stone is thrown into the middle of a still pond.[1] The greatest disruption is, of course, at the center of impact with less and less effect as the waves dissipate concentrically away from the disturbance. The center of impact represents, of course, the disruption of behavior potential of the person in the pathological state. The next concentric zone would be the loss of behavior potential experienced by those in the person's community most closely related to the affected person, usually the family. Part of that loss shows up in the amount of caring and support they choose to devote to the affected family member. Friends, to the extent they can no longer participate in valued social practices are in the next zone of impact. This zone is followed by community institutions that function less well because the affected person was important to their operation. The last zone of the model would be occupied by those (merchants, farmers, auto mechanics, tax-payers, etc.) who have merely lost the affected person as a competent consumer of the community's goods or gained the affected person as a recipient of services paid for by taxes.

There are, of course, members of the community who *gain* behavior potential when someone enters a pathological state. The host of clinicians, case managers, researchers, pharmacists, priests, and others in related services, who operate the substantial infrastructure of social practices that can only be engaged in when or because pathological states occur. Their increased behavior potential stems from the various reasons (e.g., financial compensation, professional reputation, personal satisfaction as a helper, community appreciation, etc.) they have for intervening on the community's behalf to ameliorate the loss of behavior potential experienced by its other members. Without belaboring the point or the metaphor, it can be seen that a complex system of "stakeholders" exists to connect the community to the pathology.

As such, the Deficit Model is a clear reminder of the logical connection between what it is to be a person and what it is to be a member in good standing in a community. To quote Ossorio, "a viable society requires that its members have and exercise a variety of basic capabilities in engaging in social practices in normative ways" (1985, p. 164).

The Treatment of Pathological States

According to Ossorio (1985), treatment under the Deficit Model focusses mainly on "efforts designed to increase the person's relevant

abilities to the point where he is no longer in a pathological state" (p. 59). This treatment focus involves redescribing the pathological state as a case of a more specific deficit or deficits reflected in the person's failure to meet the cognitive, motivational, or competence requirements of specific social practices.

This treatment approach also reflects the grounding of the Deficit Model in traditional versions of psychotherapy and rehabilitation; repair the individual by removing the disabilities, faulty cognitions, inappropriate motivational priorities, incompetence, etc., that lead to pathological states. With certain conceptual extensions, however, the Deficit Model can also be shown to encompass other therapeutic approaches that are community oriented—milieu therapy, therapeutic communities, or recreational therapy, for example, and others to be outlined in the final three sections of this paper.

The Treatment of Pathological Status

The main conceptual extension needed is to show that every case of a pathological state is necessarily an opportunity for the community to assign a status to that state and to the person whose pathological state it is. The significance of this appraisal and the subsequent status assignment comes when the community decides the individual is ineligible to participate in some number of its social practices. The reduction in eligibility accompanying a pathological state is referred to here as pathological status. There is a point to distinguishing between pathological states and pathological status because these status assignments may supercede the actual state either in fact, in importance, or in duration. That is, with respect to a particular social practice, a person with a history of pathological states may truly be unable to participate. On the other hand, such a person may be merely treated as ineligible regardless of ability. It is in the latter sense that the chronically mentally ill person is "dropped out" by the community, a process codified in the concept of pathological status. In both cases the person is less well off but for different reasons which need to be dealt with in different ways.

Pathological status can now be seen as a version of the classic degradation ceremony (Garfinkle, 1956; Ossorio, 1978b). In the case of chronic mental illness it is important to see the ceremony not as a judicial proceeding, which it can certainly include, but as realistic emotional behavior (Bergner, 1983; Ossorio, 1976, 1978a) in which persons in a community appraise a member with a history of pathological states as dangerous, provocative, sinful, possessed, intractable, or hopeless, etc. The community then acts according to its standards, choice principles, procedures, etc. for dealing with such cases.

The broadest implication of the above is to see two possible kinds of intervention, one that addresses the individual in a pathological state and one that addresses the community's pathological status assignments. That is, treatment can be a joint operation combining repair work on the individual to remove pathological states with repair work on the community to remove pathological status assignments.

The main function of this paper is to outline approaches to individual and community repair work most likely to benefit chronically mentally ill persons. The logical relationship between pathology and participation in social practices points to the need for systematic and practical ways to represent social practices as parts of communities. To this end I turn next to the analysis of the community concept.

THE COMMUNITY CONCEPT

The ordinary sense of the term "community" connotes the various ways in which persons group themselves to conduct the everyday business of living. In the broad sense communities are complete and self-sufficient. That is, communities have the necessary institutions to provide cradle-to-grave life support, at least within the infrastructure of the larger world context (Ossorio, 1983). The term also refers to smaller groupings formally established to pursue particular interests such as science, Catholicism, and the game of Bridge; or particular informal relationships such as a friendship between two school mates or a sand lot baseball game.

Up to this point I have relied on the reader to assume these ordinary uses of the community concept. A more elaborate treatment is now called for. In this section I go into the community concept in enough detail to provide a systematic conceptualization for examining chronic mental illness as a community question.

What characterizes a community?

That is, what are the features that distinguish one community from another? Putman (1981) originally described communities as having the following six parameters, briefly:

1. Members—paradigmatically, persons that make up the membership of a Community
2. Statuses—the positions, roles, etc., played by individuals in a Community
3. Concepts—the set of distinctions made by the Members in carrying out the activities of the Community

4. Locutions—the language that corresponds to the Community's Concepts
5. Practices—the configurations of behavior that constitutes what is done in the Community
6. World—the shared idea of reality that goes with being a competent Member of the Community.

Shideler (1988) has, following the analysis of culture by Ossorio (1983), included Choice Principles as a seventh parameter of Communities. This addition reflects an important aspect of behavior within Communities, as within cultures, that there is a climate of optionality for choosing from among social practices and from among different versions of a social practice. As Ossorio (1983) puts it:

> To the extent that behavior is not specifically prescribed, then in light of the significantly varied options available, some coherent set of principles is needed for choosing behaviors in such a way as to express and preserve the coherence of human lives and the stability of the social structure (p. 32).

Of these seven parameters I will focus primarily on three: Members, Statuses, and Practices. This is not to say that the remaining parameters are unimportant, only that they are less germane to the present task of relating chronic mental illness to the community concept. For a more complete discussion of the individual parameters the reader is referred to Putman (1981), Ossorio (1983), and Shideler (1988).

Members

The Members of a Community are persons who have the requisite powers, dispositions, and, importantly, eligibility to participate in the Community's social practices. This participation includes competent use of the Community's concepts and locutions. "Paradigmatically a Member knows that he is a Member and is known by others to be a Member of this Community—both by other Members and by outsiders" (Putman, 1981, p. 197).

Entrance into a pathological state is an occasion to raise questions about a person's eligibility for Membership in a Community. Where the basis for concern resides in the Member's loss of, or not having acquired, the requisite powers and dispositions for participation, these questions are legitimate and natural. Such cases can be, and are intelligibly resolved by exclusion of the subject person from Community Membership.

It is possible, however, for a Community to exclude from its Membership persons who are presumed to lack the needed powers and dispositions when indeed they do not. The fairness of exclusion in this

case is a serous issue resolvable by reappraising the excluded Member as having the needed powers and dispositions after all. The premise of the present paper is that even the former case, where the required powers and dispositions are truly lacking, can be resolved by other than Membership exclusion. More will be said about that later. In either case, when the pathological state is an enduring one, as it is in chronic mental illness, Membership in Communities is a major issue, both for the Member and the Community.

Statuses

The Status parameter codifies facts about any object having a position in a Community. To have a Status is, fundamentally, to have a place in the Community's social practices. For example, among nonhuman objects—streets, buildings, trees, etc., each has the Status of either relevant or not relevant to each of the Community's social practices. Further details regarding what kind of relevance an object has for a social practice would be codified as additional Statuses.

Persons, of course, occupy a special set of Statuses reserved only for persons as such. In this regard, Status includes the behavioral roles one is eligible and competent to play as a Community Member. By playing these roles one not only expresses the Status one has but participates in the Community's social practices as well. Recalling the earlier discussion of behavior potential, this is also the general paradigm for how persons meet their Basic Human Needs.

As with roles in a play, some Statuses are more important than others in maintaining the coherence and viability of the Community. For the individual person, however, it can't be determined in advance which Statuses are necessary to meet his Basic Human Needs or, for that matter, which needs are being met by having that Status. Nonetheless, the relationship between Status and behavior potential serves as a public standard for why restrictions on accessibility to certain Statuses might be considered a threat to a person's well-being.

It was indicated above that Membership in a Community may be withheld on the basis of unfair appraisals—the classic problem of "false positives." This is also true of the other Statuses Members might be eligible for in that Community. That is, a Member's Status may or may not coincide with his actual personal characteristics—powers, dispositions, etc. The best qualified applicant may not always get the job, one can "play politics" to get ahead in the organization, or be victimized by a campaign of rumors, a witch hunt, etc. One important implication of this state of affairs is that Statuses, including pathological Statuses such as "chronically mentally ill" are socially negotiable. Bergner (1981), Kirsch (1982), and Roberts (1985) have put Ossorio's (1978a, pp. 114-

120) general work on negotiation to especially good use in this regard. The present paper takes this element of Status negotiability as fundamental to involving Communities in the treatment of pathology. More will be said of this in the final sections of the paper.

Practices

Putman notes that "the point of being a Member is to be eligible to engage in the Community's Practices" (1981, p. 199). The Practices parameter of the Community concept refers to its social practices, configurations of behavior patterns that constitute what there is for its Members to do.

Any social practice has two general sets of requirements (specifications) that must be met in order for it to be engaged in (Orvik, Emerson, Green, & Sutton, 1987; Orvik & Sutton, 1987). The first set of requirements specifies how the social practice can be done, i.e., what courses of action are allowed, mandatory, optional, etc., in order for each of its versions to be accomplished.

The second set of specifications stipulates the particular personal characteristics a participant must have in order to engage in the social practice. These requirements include the motivational priorities, knowledge, and competence that go with each Status in each version of the social practice. A deficit in any of these requirements would make it impossible for a person to participate successfully except by accident.

Each Community has distinctive Practices that give it the particular identity it has and that mark that Community as the one in which those Practices have meaning. Putman (1981) distinguishes two kinds of Practices in this regard—Intrinsic Practices and Core Practices.

An Intrinsic Practice is one that could be engaged in for its own sake, i.e., with no further end in view. For example, in a bridge club, playing bridge, reading about bridge, planning bridge tournaments, etc., are Intrinsic Practices. No one in that Community would question why one of its members would be doing that sort of thing.

One need not, however, do all of those things to be a Member except the first, play bridge. Playing bridge is a "Core" Practice because it would be nonsensical to claim Membership and also to refrain from ever doing it. With eligibility come obligations as well as rights. Core Practices are obligatory for Community Members.

One important concern regarding the operation of Communities is the relationship of Intrinsic and Core Practices to Membership eligibility. How deeply one is involved in a Community, as well as how important one is to the operation of the Community are expressed by one's participation in its Intrinsic and Core Practices. There is a range in levels of involvement possible in any Community. An individual Member

can be anything from an onlooker to someone absolutely essential to the Community's survival, depending on the Community. The extent to which a person's level of involvement is correlated with his behavior potential is, of course, an empirical question answered on a case-by-case basis. As a rule of thumb we can take it that more behavior potential corresponds to more involvement unless we have reason to think otherwise.

With the same rule of thumb in mind, a person's behavior potential is directly related to the number and quality (for him) of social practices he is eligible to participate in (unless etc.). With regard to Communities, this relationship also holds, i.e., that there is a logical connection between how well off a person is, in terms of behavior potential, and participation in the Community's Practices.

Because of this relationship a person's behavior potential is also subject to change. Changes can come about through changes relative to either of the two sets of requirements noted earlier. That is, specifications for how the Practice can be done can be strengthened, repealed, or modified; or the person can gain, lose, or modify his personal characteristics relative to those required by the Practice. Both kinds of change are possible ways to lose, increase, or restore behavior potential in cases of pathology.

As a final note on the Community concept, by now it should be clear that a person is typically a potential Member of many Communities each of which meets a relevant set of Basic Human Needs. Furthermore, the concept is comprehensive enough in principle for every human activity to come under one kind of Community or another.

One problem with the concept, as developed thus far, is that it doesn't normally distinguish between the self-sufficient general Community and the special purpose, specific Communities that operate within its boundaries. The former—towns, villages, municipalities, neighborhoods, families, etc., are clear-cut cases of the concept. Yet one would be hard pressed to name their Intrinsic and Core Practices as easily as one would, for example, identify the conduct of experiments as a Core Practice of the science Community.

There are many social practices one does that are not intrinsic to any specific (special purpose) Community (one identified by Core Practices) but still are done in order for such a Community to function smoothly within the general Community context. Many examples come to mind—child rearing, writing checks, driving a car, shopping for dinner, collecting a pay check, etc., all of which have general utility for conducting ways of life but are neither the province of any specific special purpose Community nor are they usually done as ends in

themselves. Rather, they are in the domain of the general Community and their open-ended significance is what gives them their utility.

What is offered here, then, is a distinction between (a) Specific Practices (Intrinsic and Core) that go with Membership in Specific Communities and (b) Practices (call them Generic) done as a Member of the General Community. The latter, Generic Practices refer to the myriad subsistence activities one must be able to do in order to do anything else more efficiently, the former, Specific Practices, included.

It goes without saying that successful participation in Generic Practices not only identifies one as a member in good standing in the General Community, but makes it easier to be one as well. In contemporary urban settings, for example, driving a car is a Generic Practice that literally provides access to many Specific Communities. It isn't that other Communities would necessarily be inaccessible so much as the efficiency the car provides in getting to them.

This dimension of Generic utility suggests, then, that some Practices are more important than others by virtue of their multiplier effect on the behavior potential of anyone who can successfully do them. It also follows that deficits relative to Generic Practices impose restrictions on behavior potential proportional to their open-ended utility for gaining access to other Practices, Generic as well as Specific. To the extent performance of one Practice provides opportunities to engage in others, its Generic utility can be used as a choice principle for establishing priorities in treatment planning, an application to be discussed in a later section of this paper. From this point on the term Community will be understood to include General and Specific Communities unless otherwise indicated.

PATHOLOGY AND COMMUNITIES

The Community concept, together with the Deficit Model of pathology, provide a basis for redescribing chronic mental illness as a question about Communities. The following statements summarize the rationale as developed thus far:

1. Our standard for appraising someone's behavior is that persons do things on purpose and know what they are doing. With respect to this standard, the standard of deliberate action, we (a) identify certain cases as needing intervention and (b) decide what intervention, if any is needed.
2. Behavior never occurs privately, in a vacuum; it always depends on a real-world, public context for its performance to make sense.
3. Behaving is what persons do to meet their Basic Human Needs. Something is always at stake, therefore, when a person engages in

behavior, i.e., it always makes a difference whether the behavior is successful or not.

4. Because behavior is essentially, not accidentally, public, having a Community is a requirement for behavior. Moreover, different kinds of Communities make different kinds of behavior possible. In connection with the previous statement, persons meet their basic human needs, paradigmatically, by Membership in some number of Communities.

5. Because a Community is organized as a set of behavioral possibilities (Practices), and because persons engage in behavior to meet their basic human needs, a Community comprises what there is for its Members to do in order to meet at least some basic human needs by engaging in its Practices.

6. Any Practice has two sets of specifications that must be met in order for it to be performed. The first set specifies the ways in which the Practice can be done, i.e., what courses of action are allowed, mandatory, optional, etc., as well as where, when, how often, and at what level of skill they must occur in order to count as a successful performance.

The second set of specifications stipulates the personal characteristics a person must have for (a) being eligible to participate (i.e., having a Status) in the Practice and (b) having a reasonable chance to succeed. Among these requirements are the needed motivational priorities, knowledge, and competence. Deficits in meeting any of these requirements would make it impossible to perform the Practice successfully except by accident.

7. Both of the above sets of specifications are subject to change either to make it easier or more difficult for the Practice to be performed. A change in the Practice counts as a change in the Community whose Practice it is.

8. A person's potential for behavior and, thus, for meeting basic human needs, is reflected directly in the number and quality (for him) of Practices he is eligible for. That is, a person's well-being is logically related to participation in the Practices of Communities.

9. A person's behavior potential is subject to change. Changes can come from changes in the person's personal characteristics or in his potential Communities, as in (7) above. Correspondingly, the ways in which persons who suffer pathology can be made better off are not limited to healing the individual; their Communities can be healed as well.

An Illustration

The following case will illustrate key aspects of the relationship between pathology and Communities. The example is drawn from the

author's experience with a client in a day treatment program for the chronically mentally ill. Details about the actual client have been changed here to preserve confidentiality.

This case, the case of Ralph, exemplifies how the specifications for a particular Practice can be modified to accommodate particular deficits. Ralph is a 19-year-old young man with a diagnosis of autism with psychotic features. He is small in stature but good looking and quite verbal. His verbal productivity is often either tangential or obsessively related to his esoteric private interests. He does, however, have a substantial repertoire of social formulas that roughly fit the social requirements of small talk, at least for short periods, about three or four turns, especially if the topic can be brought around to one of his areas of interest.

Among Ralph's deficits are those that make it impossible for him to lead a life in the Community independent of institutional and family support. As simple a performance as making a purchase at a grocery store exceeds his grasp at this time. This is because "making a purchase" is a social practice and, as such, has the two general kinds of specifications outlined earlier; specifications Ralph can't meet.

In the case of Ralph, he is cognitively deficient, he can't make change; and he is socially deficient, he doesn't exercise a standard normal level of vigilance when strangers hold his money. On one occasion, however, Ralph and I, enroute to a pot luck celebration, needed to make a purchase at a local convenience store. I decided to let Ralph make the purchase and, having found the item, I said to the cashier, "Ralph is just learning to do money," no more and no less. The cashier, instantly and creatively, without any special training, sized up the situation and improvised a way for Ralph to make the purchase successfully. This was the first of what turned out to be a long and continuous series of daily purchases at the same store, accomplished by Ralph, more and more independently.

This case illustrates the main aspects of the relationship between pathology and communities. I note them briefly.

First, under any other circumstances Ralph could not have performed the Practice because it would have imposed requirements he could not meet. Moreover, had he attempted to he would have had a relatively high risk of being assigned an otherwise avoidable pathological Status.

Second, there are two ways a deficit can be removed as a contingency for participation in a social practice, i.e., by changing Ralph, so he meets the requirements for participation, or by modifying, suspending, or dropping the requirements Ralph doesn't meet. Either way would count as treatment because either way increases Ralph's behavior potential by increasing his access to a Specific Community.

Third, what took place in Ralph's case was that someone negotiated a suspension of certain requirements particularly for him in a particular setting in order to perform a particular Practice. This experience indicates, however, that more requirements can be negotiated in more settings to increase access of more clients to more Practices. The range of possibilities will be outlined formally in the next section of this paper. For now it can be seen that treatment can involve combinations of approaches applied on a deficit-by-deficit, client-by-client, or Practice-by-Practice basis.

Fourth, Ralph's increased behavior potential came from another Member of the Community being eligible to negotiate on his behalf. Furthermore, this eligibility was, itself, negotiated more or less spontaneously, informally, and naturally, suggesting a richness of possibilities for engaging healing resources already resident in the Community.

Fifth, being able to participate in this new Practice, even in a limited non-paradigmatic way, counts as an increase in Ralph's behavior potential and, equivalently, as an improvement in Ralph's Status as a Member of the Community.

Sixth, this improvement in Ralph's Status counts as an improvement in the Community at large because at least one of its Member's has gained new access to at least one of its Practices.

A COMMUNITY ACCESS MODEL OF TREATMENT

Returning to the concerns introduced at the beginning of this paper, we can now develop more fully the implications of the Community concept for the treatment of chronic mental illness. So far, I have outlined a structure of concepts about the participation of persons in the life of their Community. Where chronic mental illness is involved we see that Community participation is acutely and enduringly restricted, not only for the individual but for others in the Community as well. In the Community Access Model the point of treatment is to restore the client's access to a significant set of Practices lost to the client and, equivalently, to Status in Communities in whose context they are performed.

The first step in presenting the Community Access Model is to formulate access to Communities as the pre-eminent criterion for evaluating a person's well-being. To reiterate, the most fundamental expression of any person's well-being is codified in that person's position (Status), in a Community or Communities of other persons, as a participant in its Practices. The more possibilities a person has, and

partakes of, for participating in Communities of choice, the better off the person is.

Every person has a unique position in the community and, hence, is different in how his well-being comes about, is maintained, or lost. It would seem, therefore, that trying to find a single indicator for everyone would be impossible (Ossorio, 1981d). Of course, it would be impossible if it weren't for the fact that any state of affairs is subject to redescription by persons. Thus, gaining or losing a Status in a Community can be redescribed as a more general case of having more or less behavior potential than one would have otherwise. In other words the significance of Status is the behavior potential that comes with it.

By formulating Community Access as a criterion of well-being it becomes unnecessary, even unhelpful, to limit ourselves to technical formats (e.g., DSM-III-R, ICD-9-CM) in the description of pathology. Rather than being conceptually segregated from the Community, the access criterion places the chronically mentally ill person on the same continuum all members use to appraise their own and each other's position. Everyone is on common ground with the same things at risk, i.e., Statuses in Communities. An important implication of the Deficit Model applied thusly is that treatment does not stop with symptom removal unless it can be shown that doing so has restored lost behavior potential. In other words, the *significance* of symptom removal is not only preserved, it is given priority.

For the chronically mentally ill especially, the absence of symptoms is no guarantee that lost Statuses will be self-restoring. Nor is there a guarantee that the continued presence of symptoms is an insurmountable barrier to new Status acquisition. The Community Access Model is designed to increase our sensitivity to these facts by identifying opportunities among the Community's Practices for a Status to be restored, in cases of symptom remission, or modified, in cases of symptom continuation. Where those opportunities don't currently exist they may well be created. Sensitivity to each possibility will increase the chance that particular clients will have the best possible grounds for enhanced behavior potential.

The next part of the Community Access Model conceptualizes a system of Community-based possibilities for treatment. In this system there are three main types of Access to a Community (or a Status, or a Practice): (1) Standard Normal Access, (2) Contingent Access, and (3) Alternative Access. To explain more fully:

Standard Normal Access

Standard Normal Access to a Practice refers to the kind of participation a person is eligible for unless there is reason to think otherwise. Standard normal is the kind of participation most of us already have

because we have the personal characteristics—knowledge, skill, motivation, etc., and eligibility the Practice requires. Any limitation to access is by virtue of there being no opportunity for participation at the time, not because the candidate is in or has a history of pathological states. Another feature of Standard Normal Access is that it reflects the fact that the person who enjoys it has been successfully socialized into the Community that hosts the Practice to the point where he is a Member in good standing. Loss of such standing, or failure to acquire it, by having entered into one or more pathological states has the effect of significantly restricting one's Standard Normal Access to that Community's Practices.

Contingent Access

Given that a person has lost, or has failed to acquire Standard Normal Access to a Community, Contingent access to its Practices refers to the creation of alternative routes to eligibility. That is, access to those Practices depends on something else happening first. There are three general kinds of things that can happen in this regard, each of which constitutes a sub-type of Contingent Access:

1. Client-Contingent Access.

One thing that can happen to improve a person's access is to acquire (or have restored) whatever personal characteristics he is currently deficient in that the Practice requires for participation. This kind of access is referred to as Client-Contingent because it requires the client to change before the Practice is accessible. An example of this kind if access is where a client who habitually talks to himself acquires the ability to discriminate an occasion, such as attending a movie, as a time not to do that.

2. Practice-Contingent Access.

The second kind of contingency is for the requirements of the Practice to be modified so they are no longer problematical for a particular client or for clients like him. This kind of access is referred to as Practice-Contingent because it is the Practice that changes in order for the person to participate. The case of Ralph, presented earlier, provides a good example of Practice-Contingent Access. I refer not to the initial purchase, discussed below, but to subsequent purchases made by Ralph independently once the store employees got used to him and could accommodate to his deficits.

3. Relationship-Contingent Access.

In the third kind of contingency, someone acts as mediator between the client and other participants in the Practice. Access in these cases

depends on the client having a relationship with someone—a family member, case manager, therapist, etc., acting on his behalf to accomplish one or all of the following: (a) to communicate the requirements of the Practice to the client in terms the client can understand and respond to successfully, (b) to negotiate the requirements of the Practice to fit the personal characteristics of the client (a variation on the Maxim: if the situation calls for something a person can't do, he will do something he can do if he does anything at all (Ossorio, 1981b) as in the case of Ralph's initial exposure to the convenience store where the negotiator announced Ralph's deficit to the other participants and relied on them to create modifications in the Practice's requirements, or (c) otherwise to resolve, by social negotiation, participation problems associated with the prior lack of fit between the client's deficits and the requirements of the Practice.

This kind of access is called Relationship-Contingent because it depends on the contemporaneous presence of another person to make it work. A general observation in Descriptive Psychology is that having a relationship increases a person's behavior potential for any Practice that requires it. In fact the structure of Communities requires relationships of some kind for virtually all Practices. Relationship-Contingent Access, however, is distinguishable from other situations (e.g., a Father-Son banquet) that call for particular relationships as a condition for participation. In the Community Access Model, Relationship-Contingent Access refers to relationships not normally existing or not normally needed by a participant. It is set apart here as a reminder of its place in the full spectrum of possibilities for increasing the behavior potential of chronically mentally ill persons whose need for relationships is often difficult to fulfill but is, nevertheless, acutely experienced.

Alternative Access.

Alternative Access refers to the establishment of a specialized version of a Practice, segregated from the Community, in response to the likelihood that a client's deficit can't be removed or adjusted for in the Community. The creation of such Practices is to provide access to some form of Community for persons appraised not to be able to participate under any known or currently available contingency. An example of Alternative Access would be "Movie Night" where, each Friday at 7:00, the clients of an inpatient treatment program watch rented video tapes in the confines of the hospital setting. In fact, inpatient institutions could, themselves, be redescribed as comprehensive arrays of Practices to provide Alternative Access.

Logically, the need for Alternative Access would arise (1) if a particular client (or type of client) will presumably always lack the personal characteristics required by the Practice for which the Alternative Access substitutes, (2) if the client has other personal characteristics that make him generally ineligible for Community participation (e.g., the Status reduction that goes with a judgement of "criminally insane"), (3) if the requirements of the Practice cannot be modified sufficiently to allow the client's participation without jeopardizing the Practice's essential character (e.g., the requirement of respectful silence in a movie is probably not negotiable among most theatre managers), or (4) if there are no sufficient forms of Relationship-Contingent Access within the resources (including technical and motivational resources) either of the client or of the general community.

Two additional considerations regarding Alternative Access are worth mentioning. First, there is always some risk of being wrong about any of the four above named conditions applying to a particular client. One way to be wrong, of course, is to overlook either a deficit or a relevant requirement and, in so doing, fail to provide Alternative Access to a Practice the client is likely to fail at in the Community. Another way to be wrong is to treat the above named conditions as permanent when at least one of them is not and, thus, provide Alternative Access in place of a less restrictive form (i.e., one reflecting more behavior potential). Second, as stated earlier in this paper, whenever a Member of a Community loses access to its Practices, the entire Community suffers some loss of behavior potential so there is built-in reason to proceed with caution in the establishment of Alternative Access.

One way to introduce caution in the provision of Alternative Access to Practices is to establish them as transitional until they are proven to be needed permanently. That is, any instance of Alternative Access can simultaneously be described as an alternative and as a simulation of the "real thing" (see the Simulation Paradigm, Ossorio, 1981, pp. 120-123). A simulation has two helpful features in this regard. One is that training for the real thing is going on, and the other is that further observation (research) can take place relevant to the client's readiness to try out the real thing. In the example of Movie Night, rather than presume that these clients will always need the alternative, the setting could be designed to simulate in as many particulars as possible, a real commercial theatre so that training, observation, and participation are accomplished simultaneously. Organized this way, the process increases the likelihood that mistakes made either about client deficits or Practice requirements are self-correcting.

The above conceptualization of Community Access is presented roughly in the order of the behavior potential each form of access

reflects, starting with the least and ending with the most restricted cases. Taken in reverse order, these forms of access also correlate generally with their relative cost. Both perspectives imply that the client should be moved upward in the Community Access hierarchy as a general rule whenever there is a choice.

APPLICATIONS OF THE COMMUNITY ACCESS MODEL

Beyond these general ideas there are some specific ways the Community Access Model can be used to enhance the well-being of chronically mentally ill persons. These applications can ge classified into the three general areas of treatment planning, program development, and evaluation.

Treatment Planning

Treatment under the Community Access Model follows the rule articulated in Maxim 7 (Maxims for Behavior Description, Ossorio, 1981b). Paraphrasing: a person (re)acquires concepts and skills (and, equivalently, Status and behavior potential) by practice and experience in one or more social practices which involve the use of that concept or the exercise of that skill. In the present context, this maxim provides the foundation for community-based treatment of chronic mental illness. The first rule of treatment planning, therefore, is that the treatment is based in the community.

It is logical, from the above, that if treatment is to be community-based, so should case formulation; the assessment of what went wrong in a client's life and why. Case formulation in Descriptive Psychology includes the general rule: when you have enough details to see a pattern, drop the details and go with the pattern (Ossorio, 1976). The Community Access Model, as articulated throughout this paper, provides a very specific budget of details and patterns to look for in planning a comprehensive community-based approach to a client's treatment. Once these patterns are determined, the Community access Model can be further used to add elements to the treatment plan as opportunities for access attempts are revealed and resources identified.

A second use of the Community Access Model in treatment planning is to test the intelligibility of treatment plan elements. The Community Access Criterion provides a "highest common denominator" for predicting the potential worth of prospective services. Should art therapy be part of the plan? What might be the goal of psychotherapy or medication? Any such questions can be tested against their potential significance for increasing Community Access. In its simplest form such

a test would amount to asking of any potential service provider; "what would you be doing by doing X (e.g., art therapy, medication trials, horseback riding, psychotherapy, etc.) in the particular way it is being proposed?". If the significance of X for increasing the client's access to some Community can't readily be shown, X should be redescribed, modified, or discarded in favor of a more significant element.

The use of the Model for testing the intelligibility of treatment plan elements can also be extended to guiding the day-to-day execution of those elements. Presuming that there is more than one way to do X (e.g., Art therapy), how will it be done in this case? Today? For this client as opposed to that one? The answer to all of those questions would be: in the way that gives each client the most access to the Community. For one client the goal might be to use art to gain more impulse-control in the use of materials. The client could be encouraged to experiment with increasingly harder pastels on increasingly delicate papers. The significance of the control thus gained is that the client would know how to act more carefully in a wider variety of settings calling for care in the use of materials. For another client, however, the goal may be to increase spontaneity of expression, the significance of which is to counteract the flattening of affect frequently experienced in chronic mental illness, thus allowing the client more access to relationships where conventional displays of emotion are valued, which, in turn, gives access to Practices that require those relationships.

With this example in mind, a third use of the Model in planning treatment is to assess the client's existing relationships to significant persons in the community. Recall that with relationships there is behavior potential relative to Practices that call for those relationships. A client-specific description of relationships would focus on (1) those that are now giving the client behavior potential—family, friends, etc. (2) those that have been lost to the client, e.g., death of a caring spouse, (3) those that could increase the client's behavior potential if they were cultivated, e.g., other clients, a helpful and caring store manager in the client's neighborhood, a caring family member whose behavior potential would be less negatively impacted if respite help were available, etc., and (4) those that could be assigned to the client as a formal part of Relationship-Specific Access under the Community Access Model, e.g., a recreational therapist, an apartment supervisor, a Community-wise case manager.

Under the Community Access Model, each element of a treatment plan would have an obvious part/whole relationship to the larger domain of effort. It would be naive, however, to expect any one element of a treatment plan to do the entire job. The Community Access criterion articulates what that larger domain is so that the elements can

be coordinated into an intelligible, coherent, and unified treatment plan with a reasonable hope of success.

Program Development

Where the chronically mentally ill are concerned, the object of treatment should not be to cure in the traditional sense of the term, even though the possibility of cure is a very real one. Rather, the point of treatment should be to set in place a perpetual ability for the community to respond to the eventuality of chronic mental illness and the desirability for that response to be made as close to home as possible. For example, with no particular client in mind, a treatment program might include frequent orientation of local police, state troopers, and emergency medical units in how to deal with chronically mentally ill persons in states of acute crisis. An individual treatment plan would be unlikely to have such a component unless it were part of a larger program effort.

Using the Community Access Criterion as a guide, treatment planning organized into a larger context of community-based program development can be done efficiently. Recurring elements of treatment plans (e.g., medication monitoring and compliance, supervised housing, nutrition counseling) are an obvious place to start. Other program elements can be developed that are less client-specific, such as Community-wide education about mental illness, respite care for stressed families, or experienced foster care for non-degrading crisis intervention, giving the affected person an alternative to criminal incarceration.

The choice principles that apply to treatment planning (e.g., when in doubt, plan for access) also apply to program development. The difference is that program development is larger in scale and more generic. For example, a larger scale program can be developed under an umbrella organization, such as a community mental health center, that acts as a service broker among several agencies for several clients. This kind of arrangement has the advantage of using pre-existing configurations of known social practices, e.g., using the facilities and programs of the local parks and recreation department, as a general treatment plan element. Not only is this approach to community-based program development cost-effective, it presupposes community support in a way that makes it difficult not to be forthcoming (see Ossorio, 1976, for a discussion of how Move 2 makes Move 1 difficult not to have happened).

Community-Based Evaluation

One direct application of the Community Access Model is in program evaluation. Here, the Community Access Criterion brings us full circle

by its power to unify and make coherent the delivery of services to the chronically mentally ill. In fact, the Community Access Model was designed initially to evaluate a day-treatment program for the chronically mentally ill (Orvik, et al., 1987; Orvik & Sutton, 1987). The program was envisioned as a community-based approach so the articulation of the Community Access Criterion was a natural outgrowth of what was trying to be accomplished. It soon became apparent that the Community Access approach to evaluation would have general utility for gauging the success of virtually any program for the chronically mentally ill.

The general strategy of Community-Based Evaluation is to provide the program with an analysis of (1) the status of individual clients in the community before entering the program and how the program changes that status, and (2) the general performance of the program as a way for the community to care for its chronically mentally ill citizens. In the above mentioned evaluation, five different perspectives were used. They are briefly mentioned here to show at least one way to approach Community-Based Evaluation.

1. The first perspective was to describe the array of personal characteristics exhibited by the clients relative to their need for a program of some kind. This perspective was intended to give the reader an idea of (1) how debilitated was the target population, and (2) what strengths there were among the clients around which to organize treatment plans.
2. The second perspective analyzed the array of formal and informal program elements brought to bear on the range of personal characteristics shown by the client population. This perspective was intended to evaluate the relevance of program offerings to treating specific client characteristics seen in perspective 1, above.
3. Perspective three evaluated the Status of each client relative to the Community Access criterion focusing on four domains of Practices: (1) Subsistence, (2) Personal maintenance, (3) Leisure, and (4) Trafficways (recall the earlier discussion of Generic Practices).
4. The fourth perspective was a client-by-client analysis of the range and quality of their relationships relevant to the Community Access Criterion. The kinds of relationships listed above (under Treatment Planning) were of particular interest.
5. The fifth perspective used case studies to highlight two kinds of limits within which the program operated. One case study described the part of the program that best exemplified the Community Access Model at its most cohesive and elaborated within the larger structure of possibilities. The other case study was used to exemplify what kinds of personal characteristics exceed the program's limits for providing Community Access to its clients.

It is beyond the scope of the present paper to discuss the outcome of this evaluation. What is important to see is the range of perspectives Community-Based Evaluation can adopt. The flexibility of the approach makes it possible to entertain a number of procedures and adapt them to the local setting. It should also be clear that there is no hard and fast distinction between program evaluation and program management. The universal intelligibility of the Community Access Criterion combined with the hierarchy of possibilities represented in the Community Access Model provide the structure for doing either, at both the individual client and general program levels.

Finally, there is no reason why the Community Access Model couldn't be extended to the development of a comprehensive information system for keeping track of client and program progress. The heart of such an information system would be the use of Symbolic Action Descriptions (Ossorio, 1981, p. 783) to portray the significance of (1) treatment plan elements and (2) program components for increasing the Community Access of (a) individual clients, (b) clients with particular characteristics, or (c) clients in regard to particular Communities. Other systematic applications would, of course, be possible, for example, in the implementation of a comprehensive mental health research program.

CONCLUSION

Generally speaking, the Community Access Model is not a treatment plan. Rather, it provides a general perspective for organizing more specific approaches to the treatment of chronic mental illness. Specific treatment approaches cannot, by their very nature, be outlined in advance of knowledge about specific clients, deficits, Statuses, Practices, Communities, and the specific resources available for effecting changes. Why specific treatments can't be developed in advance of this knowledge can be expressed by the same set of "brute facts" that impose limits on the generality of treatment evaluation (Ossorio, 1981d). They are briefly as follows:

1. Improvement does not occur in "pure form", but is always an instance of some specific individual undergoing "a more specific change in personal characteristics, behavior, relationships, achievements, etc . . .", even though it is the fact of change we are interested in.
2. There is no specific change that universally counts as an improvement, it always depends on human judgement in the context of the individual.

3. Improvement exhibited by different individuals will be exhibited in different specific ways.
4. Different observers will have different ideas about whether a specific change counts as an improvement; these differences are subject to negotiation. (pp. 123-124).

One thing that is known in advance, however, is that some states of affairs are preferable to others and this provides reason enough to choose one treatment process rather than another in order to achieve them. The Community Access Model outlines states of affairs roughly in order of their preferability for enhancing the client's behavior potential. Each generic type of Access, translated into real Status in real Communities, can then be coordinated with treatment processes most likely to actualize them at the highest possible level for the greatest number of clients. Under this Model, treatment amounts to choosing specific ways to enhance access within that structure of possibilities.

There are other choice principles implicit in the Model that are worth mentioning. One has been suggested in a number of indirect references to resources available for application to the treatment of chronic mental illness. As is all too often the case, the resources are too few and too thinly spread. The Community Access Model can be implemented in such a way as to target deficits that provide access to the greatest number of Practices for the greatest number of clients. Similarly, Practices can be modified with the same sense of priority, targeting Practices and Communities with the greatest potential for increased access. An example of the latter, albeit in another field, is the passage of legislation requiring affirmative action to remove from public buildings architectural barriers to the handicapped. An example relevant to chronic mental illness is the Media Watch arm of the National Alliance for the Mentally Ill. This group seeks to sensitize the general public to unfair, biased, or otherwise damaging portrayals of chronic mental illness.

We may not think of these examples as forms of treatment but, under the Community Access Model, they have a place in the full spectrum of possibilities. Nothing rules out acting to increase the behavior potential of clients we don't even know and may never see. In the Community Access Model these approaches express a general choice principle: look for multiplier effects, then look for more.

I have tried to convey in this paper a new way of thinking about chronic mental illness. My hope is that practitioners will sense an expanded arena for defining their therapeutic activities. I hope also that practitioners will now see more kinds of activities as therapeutic. By involving the resources of the community in caring for the chronically

mentally ill, the prospect of these conditions becoming less chronic than they need to be may be that much closer upon us.

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NOTES

1. Orvik and Dailey (1985) used this image as a model for identifying potential informants in an assessment of needs for facilities to treat the chronically mental ill population of the northern region of Alaska.

REFERENCES

Aylesworth, L.S. & Ossorio, P. G. (1983). Refugees: Cultural displacement and its effects. In K. E. Davis & R. Bergner (Eds.), *Advances in Descriptive Psychology* (Vol. 3) (pp. 45-93). Greenwich, CT: JAI Press.

Bachrach, L. L. (1987). *Consensus and issues: Report on a conference to define the chronically mentally ill* (Contract No. PO #87MO30492501D). Washington, DC: National Institute of Mental Health.

Bergner, R. M. (1981). Marital conflict resolution: A conceptual framework and its empirical evaluation. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1) (pp. 305-320). Greenwich, CT: JAI Press.

Bergner, R. M. (1983). Emotions: A conceptual formulation and its clinical implications. In K. E. Davis & R. M. Bergner (Eds.), *Advances in Descriptive Psychology* (Vol. 3) (pp. 209-227). Greenwich, CT: JAI Press.

Garfinkle, H. (1956). Conditions of successful degradation ceremonies. *American Journal of Sociology, 61*, 420-424.

Kirsch, N. L. (1982). Attempted suicide and restrictions in the eligibility to negotiate personal characteristics. In K. E. Davis & T. Mitchell (Eds.), *Advances in Descriptive Psychology* (Vol. 2) (pp. 249-274). Greenwich, CT: JAI Press.

Lamb, H. R. (1984). Deinstitutionalization and the homeless mentally ill. In H. R. Lamb (Ed.), *The homeless mentally ill: A task force report of the American Psychiatric Association* (pp. 55-74). Washington, DC: American Psychiatric Association.

Orvik, J. M., & Dailey, D. P. (1985). *Mental health in northern Alaska: A needs assessment* (Project II No. R20073). Fairbanks, AK: Alaska State Department of Transportation and Public Facilities.

Orvik, J. M., Emerson, S. E., Green, K., & Sutton, D. (1987). *A community based model for the evaluation of the Fairbanks Memorial Hospital Multi-purpose Center and Voc/ED Program* (Grant No. 34125-25685). Fairbanks, AK: University of Alaska.

Orvik, J. M., & Sutton, D. (1987, October). *Community based evaluation for the chronically mentally ill.* Paper presented at the meeting of the Society for Descriptive Psychology, Boulder, CO.

Ossorio, P. G. (1976). *Clinical Topics* (LRI Report No. 11). Whittier, CA. and Boulder, CO: Linguistic Research Institute.

Ossorio, P. G., (1977). *Positive health and transcendental theories: A seminar in Descriptive Psychology* (LRI Report No. 13). Boulder, CO: Linguistic Research Institute.

Ossorio, P. G., (1978a). *Personality and personality theories: A seminar in Descriptive Psychology* (LRI Report No. 16). Boulder, CO: Linguistic Research Institute.

Ossorio, P. G. (1978b). *"What Actually Happens": The representation of real world phenomena.* Columbia, SC: University of South Carolina Press.

Ossorio, P. G. (1981a). Conceptual-notational devices: The PCF and related types. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1) (pp. 83-104). Greenwich, CT: JAI Press.

Ossorio, P. G. (1981b). Notes on behavior description. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1) (pp. 13-36). Greenwich, CT: JAI Press.

Ossorio, P. G. (1981c). Outline of Descriptive Psychology for personality theory and clinical applications. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1) (pp. 57-81). Greenwich, CT: JAI Press.

Ossorio, P. G. (1981d). Representation, evaluation, and research. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1) (pp. 105-135). Greenwich, CT: JAI Press.

Ossorio, P. G. (1983). A multicultural psychology. In K. E. Davis & R. M. Bergner (Eds.), *Advances in Descriptive Psychology* (Vol. 3) (pp. 151-201). Greenwich, CT: JAI Press.

Ossorio, P. G. (1985). Pathology. In K. E. Davis & T. O. Mitchell (Eds.), *Advances in Descriptive Psychology* (Vol. 4) (pp. 151-201). Greenwich, CT: JAI Press.

Putman, A. O. (1981). Communities. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1) (pp. 195-209). Greenwich, CT: JAI Press.

Roberts, M. K. (1985). Worlds and world reconstruction. In K. E. Davis & T. O. Mitchell (Eds.), *Advances in Descriptive Psychology* (Vol. 4) (pp. 17-53). Greenwich, CT: JAI Press.

Schideler, M. M. (1988). *Persons, behavior, and the world: The Descriptive Psychology approach.* Lanham, MD: University Press of America.