THE POSITIVE-HEALTH DEVELOPMENTAL MODEL OF TREATMENT AND PSYCHOPATHOLOGY

Jan Vanderburgh

ABSTRACT

A Descriptive Psychology approach to psychopathology and treatment is suggested and discussed briefly, using the Positive-Health Developmental Model (PDM) as an example of Ossorio's deficit model. The PDM is a conceptual framework for classifying persons and/or their behavioral capabilities in respect to developmental Level, Degree of Mastery, and personal Approach, or perspective on the world. Because the PDM provides an assessment of a person's abilities or disabilities, it is a fairly direct implementation of Ossorio's definition of pathology: "When a person is in a pathological state there is a significant restriction in his ability to (a) engage in deliberate action, and, equivalently, (b) participate in the social practices of the community." Two brief case studies and some preliminary notes on treatment are included.

Advances in Descriptive Psychology, Volume 4, pages 281–302.
Editors: Keith E. Davis and Thomas O. Mitchell.

ISBN: 0-89232-358-2.

PDM TREATMENT AND PSYCHOPATHOLOGY

The Positive-Health Developmental Model (PDM) is a conceptual framework for classifying persons and/or their behavioral capabilities (Vanderburgh, 1983). It provides a great deal of differentiating power at a molar, or observational, level of description, and the discriminations are useful in dealing with many individual, family, and organizational problems.

The PDM

To review briefly, the PDM classifies persons and/or behaviors in respect to three major aspects: Developmental Level, Degree of Mastery, and Personal Approach. Eleven Developmental Levels, three categories of Degree of Mastery, and three categories of Personal Approach are distinguished (Vanderburgh, 1983).

Personal Approach

Power, Relationship, and Information are distinguished as Approaches. Each of these corresponds to a personal perspective on the world, including a value orientation. Ossorio's recent (1982) discussion of status as perspective provides an appropriate explication. Just as to be a banker (mother, Baptist, etc.) is to have the reasons that a banker *would* have in a given situation, to be a Power-oriented person is to have the reasons that a Power person *would* have in a given situation. To act on those reasons successfully involves the exercise of a variety of abilities which are different, in general, from the abilities required to act on Relationship or Information reasons. Thus, one can speak of Power, Relationship, and Information abilities as well as perspectives and value orientation. Authentic and satisfying social existence appears to require all three perspectives. Certainly, in general, to live well requires more than minimal sensitivity to all three kinds of reasons, and more than minimal exercise of all three kinds of abilities, or skills.

Although ideally a positively healthy person would have ready access to, and comparable skills based upon, all three perspectives, in practice persons seem to function preferentially and more skillfully in terms of a primary Approach. This most common method of relating to the world affects the social practices in which the person chooses to engage, his most likely forms of describing events and experiences, his acquisition of specific skills, his priorities and values, and his basis for judgments. A person's primary Approach also makes a difference in the forms in which he chooses to use the other perspectives (Vanderburgh, 1983).

Developmental Level

This dimension of the PDM reflects the degree to which the person can manage his affairs as a social individual. Thus, like Approach, Developmental Level is a way of classifying abilities. Because of this, it is also a way of classifying the behaviors which express these abilities and the persons who have these abilities.

At each level, some skills, behaviors, functions, and abilities—cognitive, social, and physical—are identified that would enable a person to engage successfully in the social practices appropriate to a particular age or stage of development, from birth to an outstanding degree of adult function. From Level 0, which indicates the absence or gross impairment of minimal function, the Developmental Levels form a progression roughly by healthy chronological development through adolescence to generally adequate, but not outstanding skills and judgments, Levels 4 and 5. Levels 6 to 8 designate outstanding quality of the same functions developed in prior levels. Levels 9 and 10 refer to extraordinary mastery of the skills, sensitivities, and critical judgments of each of the Approaches—sufficient for the generation of new social practices as well as the significant refinement of existing social practices.

Degree of Mastery

This dimension of the PDM reflects the criterion that full mastery of any form of behavior consists of all three modes—Actor, Observer, and Critic. That makes the behavior accessible to the person's self-regulating structure, and therefore something that he can appropriately choose to do, or not do, or modify. For any practice, the full range of Deliberate Action requires not only the capacity to act (or not to act) in that manner, but also the capacity to reflect upon, and to assess, correct, or modify the action (Ossorio, 1969/1981). Thus, Degree of Mastery is a way of classifying a person's ability to function as Actor, Observer, and Critic with respect to any given behavior, social practice, or type of activity.

Since Approach, Developmental Level, and Degree of Mastery are all ways of classifying abilities, they can be used simultaneously in that task. Correspondingly, they can be used to classify the behaviors which express those abilities; and the perspectives which those behaviors express; and the people who have those abilities, engage in those behaviors, or have those perspectives. Essentially, the PDM provides a vocabulary and taxonomy congruent with the grammar of Descriptive Psychology. While it is neither exhaustive nor in any sense a privileged description, it does suggest a useful set of discriminations for an assessment of a person's ability to engage in social practices at a wide range or levels and varied

proficiency. The developmental dimension is a direct implementation of a Descriptive Psychology definition of health function—the sufficient ability to participate in the relevant social practices. The PDM as a whole is primarily a framework for making judgments about positive resources rather than deficits.

Psychopathology

The PDM as a Deficit Model

Since the PDM was developed as an alternative to pathology-oriented ways of assessing individual capabilities and ways of functioning, it is ironic that one of its major uses lies in the area of psychopathology and treatment. Because the PDM is a framework for classifying what a person can do and prefers to do, it is also a framework for representing what a person cannot and will not do. Assessment of this sort provides one implementation of the deficit model of psychopathology (Ossorio, 1985).

The deficit model generates a specific definition of pathology, i.e., "When a person is in a pathological state there is a significant restriction in his ability to (a) engage in deliberate action, and, equivalently, (b) participate in the social practices of the community" (Ossorio, 1985, p. 158). The basic judgments relevant to psychopathology are normative judgments concerning adequate adult functioning in a cultural context.

Based on these judgments, we can also make normative judgments concerning normal functioning at any age. Any sequence of changes in the personal characteristics of children which, without special intervention, routinely eventuates in normal adulthood may be considered developmentally normal. On the basis of knowledge based on prior observation of which sequences are of this sort and which are not, if we can assess what a person can and cannot do, then we can make judgments concerning pathology and normality of that person at any age. The PDM offers a convenient way of approximating a global assessment of the person's abilities and disabilities with regard to social practices, and provides a systematic conceptual articulation for that process of assessment.

This conceptual structure makes two contributions to Descriptive Psychology. First, it provides a direct implementation of the definition of pathology, since the definition refers to social abilities and disabilities and this is what is assessed using the PDM. In turn, the assessment leads to a general treatment approach and a body of practices which are primarily competence-oriented. This approach provides a desirable complement to other approaches which are primarily motivation-oriented, knowledge-oriented, or performance-oriented.

Second, it provides a framework for stating certain empirical hypotheses

having to do with discrepancies among levels of functioning (the developmental dimension of the PDM) in the nine categories generated by the combinations of Actor-Observer-Critic functioning (the AOC dimension) and Relationship-Power-Information orientations (the RPI dimension). The general hypothesis is that a person who is positively healthy has full AOC Mastery of the skills of all three Approaches (Relationship, Power, and Information) at comparable and age-appropriate Developmental Levels. Corresponding specific hypotheses involving various examples of such discrepancies and normative deficiencies follow from the general hypothesis.

Ideally, then, a positively healthy person will have satisfactory behavior potential in virtually all circumstances, and will also have the means of increasing his behavior potential without undue stress in ways appropriate to the situation. Conversely, a person who lacks AOC Mastery of the skills of all three basic Approaches at appropriate Developmental Levels can be considered to be functioning in a less than optimal—perhaps less than satisfactory—manner. For instance, a five-year-old who has only Actor functions will be unable, as a consequence of that state of affairs (disability), to do what most five-year-olds can do without supervision. He will either be handicapped in his participation or need specially favorable circumstances to function well.

Those conditions which are commonly called pathological correspond to one category of reduced behavior potential, i.e., a disability, as against, e.g., lack of opportunity. It is important to notice, however, that radically limited opportunity can, over time, so drastically reduce a person's behavior potential that it is almost indistinguishable from what is commonly called pathology—and, in the long run, can be literally pathogenic.

Using the PDM

In Descriptive Psychology terms, pathology is seen stemming from significant restrictions in regard to social practices, skills, behavioral options, and judgment, whatever their origin. This enables us to view psychopathology as a deficit resulting from some constellation of such restrictions, rather than an entity of some recondite sort. The disabilities and limitations themselves, rather than any explanations or theories about them, constitute the pathology (Ossorio, 1985). Identification of behavioral restrictions can be made by reference to status assignments, as states, as personal characteristics, as functional deficits or disabilities, or as deficits in experience, and so on.

The personal characteristics identified by means of the PDM assessment may reflect organic or neurological involvement; disorders of thinking, feeling, or behavior; or developmental deficits. Any significant reduction

or limitation in a person's ability to engage in appropriate social practices can be expected to show up in a PDM assessment—often in all three dimensions. With the PDM, then, we are looking at a range of personal characteristics designed to indicate ways in which a person will—or will not—be able to engage in appropriate social practices. Looking at pathology in this way (rather than according to a medical-model or behavioral-model approach) both acknowledges the reality that identifications of personal characteristics as pathological are contextual, and preserves the relationship between a person's characteristics and setting without postulating causality. What is of concern in judgments of pathology is a person's disabilities and the significance of those disabilities for the person himself and for other persons, particularly with regard to how the behavior potential of everyone involved is affected.

To assess a person's available resources and compare them with what he needs and desires for health function does not require that the observer identify a specific "condition", nor is it necessary to refer to standard diagnostic nomenclature to generate a serviceable description of a person's abilities and disabilities (although it is often useful to do so). The primary reasons for such assessment are social (e.g., to assist others in making appropriate decisions about their own actions with that person) and therapeutic (e.g., to assist a person to increase his behavior potential in appropriate ways). Making use of the specific categories presented in the PDM offers a rapid summary assessment, in terms of which specific abilities and disabilities (and consequent probable limitations) are indicated. In this context, the PDM is highly responsive to change, providing a continuous, flexible, easily-corrected status report.

Although the PDM is not directly related to, or dependent upon, either the medical or the behavioral model of psychopathology, certain constellations of behavior (and, therefore, patterns of ratings on the PDM) correspond roughly to the standard diagnostic categories. This phase of work with the PDM is in its early stages.

The structure of the PDM suggests possible avenues of treatment: in general, the most common of these are identification, instruction, and practice (or other enablement procedures) for skills which are below the person's current overall level of function. Particular patterns also suggest specific interventions directly related to the disabilities.

Because the PDM deals with skills, judgments, and values, incongruities or imbalance in a person's resources are considered significant. For instance, a wide spread in Developmental Levels among the three Approaches can limit a person's behavior potential. The person may not see any reason to acquire the skills of the least-skilled Approach unless he is very uncomfortable with things as they are. A person with significant restrictions in his ability to engage in certain social practices may also fail to assess the restrictions accurately.

It appears that positively healthy persons' skills and judgments reflect their values. If, however, a person strongly affirms the values of a less-skilled Approach, that can be regarded as an indication that there is an issue worth examining in that area. Why has the person not acquired the related skills? Why has he chosen to affirm those particular values without reflecting them in his behavior?

In this, as in many instances, the developmental dimension and the person's history provide useful information. Whether or not one understands the process of maturation to include certain specific, sequential, necessary developmental (cognitive, affective, moral, and practical) tasks, one can take it that in a given culture there are clusters of skills and judgments which are generally common to persons of various ages. When a particular skill, or pattern of skills, is deficient or absent, knowing both the roots and consequences of that deficit can be helpful in the process of healthy change.

Significant restrictions in behavior potential can accompany a variety of personal characteristics or circumstances (as, for instance, blindness, extreme poverty, developmental disabilities, or incarceration). Such factors as serious or protracted childhood illness or injury, or the absence or death of a parent or sibling, for instance, can influence the development of a particular cluster of skills and judgments. Each of these possible influences can delay, distort, impair, or prevent the acquisition of a set of abilities necessary for effective function at a particular level (and, often, subsequent levels). However, only if these characteristics or circumstances constitute or produce a *significant* impairment would they be considered pathological (Ossorio, 1985).

Family Influences

Because the family, or a family surrogate, is the common arena for the acquisition of a major portion of the requisite skills for function in the world, family influences, resources, and lacks are considered particularly significant developmentally. We will look briefly at some of the issues involved in a person's growth within his childhood family.

Each family system is well adapted to fostering certain types of development. Family resources, behavioral and cultural, both enhance and limit a child's early options. For example, sometimes a child's natural talents and interests differ greatly from his parents', and no one in the nuclear family is able to provide him with informed support. The child may then be effectively isolated within the family structure, and the parents may find his behavior puzzling or distressing. In these circumstances, the child has several options: He may identify himself as deficient or aberrant (and act accordingly). He may acquire the family resources reluctantly in order to gain parental approval. He may reject the family resources and

pursue his own preferences actively and exclusively. He may—most desirably—choose to learn and use both sets.

Some families interact using a very limited set of behavioral options, and thereby foster the development or manifestation of particular limitations. If family resources for interaction with the rest of the world are meager, for instance, the children of the family may fail to acquire some much-needed skills. If the family is also geographically or socially isolated, the child's opportunity for getting what he needs outside the family is greatly restricted. The child's own primary Approach, Developmental Level, and AOC Mastery affect his development, as well.

If enough of the family behavior is sufficiently limited, inappropriate, bizarre, contradictory, or destructive, the likelihood of some kind of psychopathology among family members is increased. Some examples of such behaviors, characteristics, and practices on the part of parents and other family members are:

1. inappropriate responses or expectations: (a.) rigid or unresponsive schedules for infants; (b.) battering, especially in response to hunger or fear; (c.) expecting a child to take care of parents or of other siblings on a regular basis without consent, training, or support; (d.) denying, making fun of, or resisting the child's perceptions or preferences, particularly in matters of survival or identity (self-assigned status); (e.) radically restricting the child's options for experimentation, success, or failure; and (f.) discounting, or teaching the child to discount, biological needs.
2. inaccurate, irrelevant, or insufficient information: (a.) extreme prejudice; (b.) misidentification of feelings or perceptions; (c.) frequent redefinition; (d.) routine confusion or contradiction; (e.) excessive secretiveness; and (f.) idiosyncratic cognitive processes.
3. severely limited or distorted relationships: (a.) problems of bonding and separation; (b.) inappropriate symbiosis; (c.) extreme isolation or lack of privacy; (d.) incest; and (e.) rôle substitutions [see 1(c)].

Some of these can be present occasionally or to a moderate degree in an otherwise constructive family without apparent serious damage to the family members.

Of course, no small system—family or sub-group—possesses the total range of behavioral resources potentially present in a society. A healthy family *does* have a broad set of cognitive, affective, social-relational, and developmental skills and practices, sufficient for the healthy growth of family members. And an individual does not need every conceivable societal resource to become positively healthy—only a sufficient set.

Some families lack skills in significant areas for several generations, and only acquire the missing skills by marrying into a family that has them, or by outside intervention (e.g., education, therapy, or other deliberate change processes). There appears to be a significant difference between lacking and withholding a particular set of resources (e.g., loving, caretaking, explaining, teaching, supporting, approving, solving problems, etc.). In general, *withholding* family resources from one or more members still permits each person to know that those resources exist and perhaps to acquire them in another context. This is also the case when behavioral options are unequally and inappropriately restricted among family members. A family which *lacks* significant resources, however, may permit persons to grow up unaware of the existence of additional options common in the general culture. This can perpetuate a family pattern of inadequate or inappropriate behavior (e.g., violence, consistent negative judgment, frustration, hostility, spitefulness, isolation, incest, sociopathy, diminished expectations and low self-esteem, and other non-problem-solving behaviors).

Other Factors

There are many possible ways for a person to reach adult life with significant deficits. In addition to the family-related difficulties mentioned above, personal history, physical or developmental limitations, gross lack of experience, and external events can all contribute to restrictions on a person's ability to function appropriately in his setting. For example, historical events that lead to radical changes in behavioral options—natural disasters, emigration and other dislocations, wars, famines, or the Great Depression—and personal crises, like death or severe illness, loss of employment, or marital difficulties, can call for skills a person does not possess and never expected to need. The acquisition of those skills in such circumstances is often accompanied by discomfort or distress; failure to acquire them may constitute a significant abridgement of the person's behavior potential.

Severe disorders of thinking or feeling, whatever their etiology, seriously limit a person's resources and options. The person who believes that the cracks in the pavement are poisonous snakes will attend to different aspects of his circumstances—and walk differently—from the person who does not share that belief. The person who is still actively grieving over his father's death thirty-seven years ago will view his own love, work, and play differently from the person whose attention and feelings are more thoroughly involved in the present. A person whose view of himself and his own status is radically different from what others accept or affirm will have difficulty operating in the world.

A person who is disordered or deficient in the skills and judgments of one Approach is highly likely to show corresponding deficiencies or anomalies in the skills and judgments of the other two Approaches. In general, any disability will lead to other concurrent disabilities, and will inhibit or prevent the later acquisition of certain abilities. For example, being unable to read and write restricts a person's ability to find his way in a strange town, to maintain relationships by telephone or mail, to learn how to operate an unfamiliar machine, or to understand a legal document without assistance. (A person who can read and write, but cannot understand the legal document, is faced with a different problem, as is a person who can read and write, but only in Braille or Urdu.)

Patterns

Although there is a very large number of logically possible configurations in PDM assessment, empirically it appears that most cases of psychopathology exemplify one of the following structural patterns:

1. The person significantly lacks the skills and judgments commonly associated with one or more of the Approaches, and has need of them to function satisfactorily in his setting.
2. The person's range of development in all three Approaches is wider than three levels, and this disparity is related to significant limitations of his behavior potential.
3. The person has a significant deficit in one or more factors in the Development Levels.
4. The disorder is manifested primarily in the person's inability or unwillingness to function in one or more of the AOC modes (e.g., the person's actions are significantly restricted, he fails to make accurate observations necessary for adequate function in his setting, he uses his skills without apparent concern for their appropriateness in a given situation, or he makes inappropriate or inadequate Critic assessments of self, others, or situations).

Similarly, although the possibilities of explanations are almost limitless, most of the actual formulations developed in connection with the use of the PDM would exemplify one or more of the following explanatory patterns:

1. The person has a specific personal characteristic (e.g., blindness, faulty thinking, illness, biochemical or glandular imbalance, development delay), that is manifested in significant disorders or limitations.

2. The person has a personal history which has caused or contributed to his significant disorders or limitations.
3. The person significantly misperceives or misunderstands his status, or assigns himself an impossible status, and therefore cannot function appropriately in his setting.
4. The person shares beliefs with his family or another group which are not commonly held, and which, if acted upon, issue in behavior commonly identified as pathological.

TRADITIONAL NOMENCLATURE AND THE PDM

In looking at psychopathology in terms of the Actor-Observer-Critic/Relationship-Power-Information combinations, it is valuable to consider the ways in which things are likely to go wrong. What kind of failures can there be? If the distinctions made in the PDM are useful in the assessment of function, there may well be constellations of limitations which characteristically correspond to various locations on the model.

The relation of traditional nomenclature and the several common patterns on the PDM is of some interest. No neat or simple correspondence is to be expected. However, anomalies in one of the (Actor, Observer, or Critic) modes in a particular Approach seem to be most closely related empirically to various traditionally-defined psychopathologies. Table I below lists a few of these, along with the initial Approach and Degree of Mastery to which each appears to be related. Note that any significant disability can be expected to manifest itself in more than one location on the PDM, so the full PDM assessment would include a constellation of

Table 1

Relationship	
Actor:	Simple depression, catatonia
Observer/Critic:	Hysterical neurosis
Critic/Actor:	Mild character disorders
Power	
Actor:	Simple schizophrenia
Observer/Critic:	Cyclic disorders
Critic/Actor:	Sociopathy
Information	
Actor:	Anxiety
Observer/Critic:	Paranoia
Critic/Actor:	Obsessive-compulsive neurosis

affected personal characteristics, rather than a single instance. The correspondences shown in Table 1 are elaborated below.

Persons skilled in each of the Approaches make some characteristic assumptions, which are essentially healthy. However, each Approach also carries with it the tendency or temptation to make other sorts of assumptions which are likely to contribute to pathology.

Persons skilled in healthy forms of the Relationship Approach take for granted that people are connected, that appropriate caretaking of self and others is desirable and possible, and that one can be close to others. Persons skilled in healthy forms of the Power Approach take for granted that often someone needs to be responsible and in charge, that there *is* enough to go around, and that achievement and closure are valuable. Persons skilled in healthy forms of the Information Approach take for granted that adequate understanding and accuracy can be attained through [enough] information, that problems can be solved, that one can learn, and that some degree of trust is essential for human relationships. However, even these beliefs can be maintained in such extreme form that a person's behavior potential is significantly restricted.

Although AOC functions in each Approach are both important and interrelated, typically the Mastery functions are differently valued in the three Approaches. In the Relationship Approach, Actor and Observer functions are most highly valued, and Critic functions are often slighted or assigned to other persons. In the Power Approach, Actor and Critic/Actor functions are emphasized, and Observer/Critic functions are less valued. In the Information Approach, Observer and Critic functions are considered more important than Actor functions.

In general, then, Relationship disabilities take forms in which desirable or necessary judgments and assessments are not made, and in which full and responsible self-regulation is lacking; Power disabilities are exemplified by judgments made without full Observer/Critic participation; and Information disabilities are manifested in inability or unwillingness to act effectively on information and judgments.

It is important to notice, however, that, no matter whether it is Actor, Observer, or Critic which is conceptually most closely related to the pathology, in fact, all three kinds of mastery are involved in some way.

Relationship

Some of the common and relatively pathogenic *Relationship* assumptions are: *Reality is what you (or they) say it is; I am what you (they) say I am; you (they) are responsible for what I do; I am responsible for how you (they) feel; feelings and intentions are more important than what one does; it is not all right for me to be overtly and independently angry; it*

is not all right for me to compete openly, effectively, and on my own initiative; I am in danger if you (they) do not like or love me. A Relationship-oriented person who believes some or all of these statements is likely to act in ways that exhibit extremes of feelings, that shift or abdicate responsibility for decisions, and that he believes will please or placate other persons.

So, a person with simple depression is likely to give his feelings priority over actions, and experience himself as helpless with respect to changing the way he feels, and powerless to act effectively in his world. He will assign himself a correspondingly low status, in terms of which he is likely to disclaim responsibility for his feelings and actions. A catatonic person is manifesting a position in which he is essentially refusing to do what Relationship-oriented persons commonly do, e.g., accept the judgments of others and try to please them or take care of them.

A hysteric may attempt to perform in ways that please the most important persons in his environment, whether or not those behaviors are intrinsically pleasing to him or effective in the situation. The accommodations to other-defined reality in these performances often either impeach the person's own Observer/Critic functions or issue in anger which the person believes he may not express. The person defends against accusations on the grounds that he meant well, or did not intend to offend or fail. He will often given his feelings preemptive position over external events, and may reject common understandings of those events.

A Relationship-Approach person may choose to participate in group or gang activities in order to acquire an apparently functional and supportive Critic (the group and/or its leaders); to achieve a satisfying, though derivative, status; and to have a clear chain of responsibility (the leader, members of higher status) outside himself. He may not consider the significance or appropriateness of the group's activities. He is likely to arrange his assessments on the basis of praise and blame, approval/disapproval, or popular/unpopular, rather than true/false or right/wrong. When he is in a pathological state, these characteristics are associated with significant limitations on his ability to function appropriately and effectively in the world.

Power

Some of the common pathogenic *Power* assumptions are: *Reality is what I say it is; what I want is more important than anything else; getting something done is more important than how it is done; if anyone is uncomfortable, someone must be at fault; accepting something new means that the old way (belief, practice, behavior, understanding) was wrong or bad; if something is worth knowing, I should have known it already;*

assigning blame is important; winning is the primary good, and losing is dangerous; what a person does is more important than what he thinks or feels.

The most common Actor disorders in the Power Approach are those in which a person essentially creates or invents a world of his own in which to live, without competent regard for the possibility that things are not that way. We think of many forms of the creative arts, which are also invented worlds, as healthy: a novelist, a dramatist, an artist or musician, an architect—all create something new and original from their own imagination. Political thinkers and philosophers also may be healthy Power-Approach persons, and invent new structures or universes of discourse that increase behavior potential. When there *is* a disorder—when the self-created world is drastically limited or destructive or in some way impossible—it is likely to involve behaviors commonly called schizophrenic. This differs from the Relationship disorders mentioned above in that the person treats his invented world as the *only* real world or viewpoint. Essentially, he fails to construct a world in which he can interact powerfully and effectively with other persons who also have power.

New learnings are sometimes difficult for Power-oriented persons with Observer disorders, because of their belief that change requires the absolute rejection of any prior position. Therefore, new observations to update a prior understanding of reality do not come, as they normally would, as a development of the earlier observations, but are seen by the person to be contradictory to them. For people with this disability, sequential learnings are stressful, and building on experience is difficult. To change from one good thing to another good or better thing seems to go against the highly competitive orientation of the Power Approach; a preferred view is to change from a bad thing to a good thing. However, in order to maintain this position, the person may need to impeach his earlier judgment of the previous state as good. Adequate observation and reality-testing can modify this position considerably, and enable many Power-oriented persons to be highly flexible and effective.

Deficits or distortions in Observer/Critic function support extremes in thinking, feeling, and action. Essentially, the person is considering each aspect of a situation either in isolation or in opposition to some other aspect. This makes it far more difficult for him to maintain a sense of proportion about feelings or events. Such disabilities seem to limit not only behavior potential, but also awareness of the process by which behaviors are chosen or change and growth take place. From the standpoint of behavior, for instance, manic-depressive disorders generally involve a repetitive sequence in which a person's periods of high activity (with inadequate reality-testing and significantly inappropriate behavior) end suddenly with a crash. The crash, a major mood swing, begins a period of

low activity and depression, in which reality-testing is comparably inaccurate. During most of the cycle, the person's Observer-Critic function is faulty or absent, and memory and judgment are impaired. He cannot describe or explain from one position in the cycle how he felt or why he behaved as he did at another position. Only as he moves from depression into the beginning of the next high-activity period does he make effective use of his Observer/Critic skills.

Alternatively, in the absence of effective self-evaluation and self-regulation a Power-oriented person may become actively sociopathic, exhibiting little or no concern for others and working as an independent adversary of common social values and practices. It is the Critic function that provides for acculturation and socialization. A Power-oriented person with inappropriate Critic function may blame society for his own decisions about what to do, or he may simply not care about society's values or the needs and rights of other persons. He may be a dynamic and successful antisocial force, either individually or as the leader of a gang or group of other Power- or Relationship-oriented persons with limited or aberrant Critic functions.

Information

Some of the common pathogenic *Information* assumptions are: *Reality is what I can test absolutely; you can't be really sure of anything; trust is the most important issue; it is more important to understand fully how things work than to get them done; not knowing enough is dangerous; inaccuracy is dangerous; thinking is more important than feeling or doing.*

The most usual Actor disorders in the Information Approach are anxiety-based. The person's world does not have the kind of clarity that enables him to act in one way rather than another. He may immobilize himself when faced with a decision. At the extreme, the person may so complicate the process of decision-making that he may not act in even very important matters. Procrastination is common. Cognitively, the Information-oriented person is likely to overdetail, where both Relationship- and Power-oriented people tend to overgeneralize. Self-esteem depends upon the person's assessment of himself as trustworthy, ethical, moral, and accurate, rather than lovable and approved-of (as for Relationship-oriented persons) or successful and effective (as for Power-oriented persons).

Observer/Critic disorders in the Information Approach have to do with the logical consequences of significant inaccuracy. The most common disorder of this kind is paranoia, an attempt to come to terms with what the person experiences as unbearable inconsistency, or to explain a perception not consensually shared. The person supplies an additional piece of [false] information, or an unverifiable conclusion, in terms of which his experience

then makes sense; e.g., although I have been doing what I think is right (and ought to work), things have gone badly; therefore someone is out to get me. An excellent Descriptive Psychology examination of paranoia is found in Bergner (1985).

The Critic disorders in the Information Approach are usually based upon rigid, perfectionist standards of judgment, inherently impossible of achievement. Obsessive-compulsive neuroses are the most common. The compulsive hand-washer, for instance, (a) considers it of primary importance that his hands be absolutely clean, and (b) defines "clean" so rigidly that he cannot achieve and maintain that state.

Combinations and Sequences

In addition to individual constellations of personal characteristics that correspond roughly to particular traditional diagnoses, we are observing that some combinations of Approaches and deficiencies in Degrees of Mastery are fairly common. For instance, the characteristic behavior of a person who usually functions in a Power-Relationship Approach with an Observer/Critic deficit may be described as passive-aggressive; the corresponding Relationship-Power constellation may be described as passive-dependent.

We are also beginning to notice and identify family and generational sequences, in addition to the individual patterns. This is an area of particular interest in family therapy, though it can be helpful in individual psychotherapy, as well. Some of these sequences are widely discussed in the literature (e.g., battered children often become battering parents). We hope that, over a period of time, looking at persons with these disabilities will give us additional information about such sequences. For instance, we have found several families in which Power-Information parents who are harsh and judgmental raise an Information-oriented child with impaired Critic function (e.g., obsessive-compulsive). This child in turn marries a harsh and judgmental Power-Information person and raises one or more Relationship-Power children with hysteric disorders or anorexia nervosa.

TREATMENT

It is desirable, when working with a person for healthy change, to have an accurate understanding of the way the person himself describes what is going on. A deficit or anomaly in any location in the PDM will of course have consequences elsewhere; identifying and remediating the primary disorder also affects more than that one factor. It is therefore possible to take the client's account of what is wrong as the starting point for treat-

ment, since that account can be reformulated by the therapist as a description of one of the manifestations of the pathology. In this way, the therapist can gain the informed and willing cooperation of the client in the process of his growth and change. With such cooperation, this approach has been useful within a wide range of degrees of dysfunction, and has been particularly effective with a variety of persons showing severe pathology. However, it is not suited for working with persons who are consistently very confused or unable to communicate, and seems less likely to be effective with extreme character disorders and sociopathy than more structured or confrontive methods would be.

Driscoll (1981) and Ossorio (1976) have written extensively about direct clinical uses of Descriptive Psychology. The PDM provides related conceptual guidelines for employing a wide range of ways to improve behavior potential by increasing a person's resources (Know-How) and clarifying options for desire or intention (Want). In general, the process of using the PDM in psychotherapy is as follows:

1. Observe the person and find the placement of his current function on the PDM. Placement may be described by giving Developmental Levels for the nine combinations of Approach and Mastery, or by giving Developmental Level and Level of Mastery for each of the three Approaches.
2. Confirm this evaluation by discussing the person's history and self-perceptions with him and (with his permission, of course) with other persons, as needed.
3. Look for strengths, deficits, patterns of action that do or do not accomplish what the person wants or says he wants.
4. Work cooperatively with the person to increase his options.
   a. Explain, describe, teach, and/or model the missing or less-developed skills, making use of existing skills and strengths.
   b. Provide opportunities for the person to acquire and practice those skills through rôle-playing, homework assignments, direct practice, self designed procedure, and the like.
   c. Explore with the person the belief systems underlying both old and new skills and resources.
   d. Invite the person to consider and incorporate the values which usually accompany the new skills.
5. Encourage the person to use all of the skills, distinctions, judgments, and values he has acquired (including the new ones) as fully and as appropriately as possible. Here is a sample process for structuring this:
   a. Is there a way to do this task (engage in this practice) that makes use of all three Degrees of Mastery and one's highest Developmental Level in each Approach?

b. What would that look like, and how would it work?
c. Would it be effective, useful, appropriate to do it that way?

Psychotherapy is here viewed as essentially a process of increasing a person's capacity to make and act skillfully upon responsible choices.

Case Summaries

The following case summaries briefly illustrate some uses of the PDM in psychotherapy. Note that the practices involved are not greatly different from practices used in conjunction with other theoretical orientations. As in Ossorio's (1983) heuristic of car repair, anything seriously wrong will show up in almost any type of diagnostic framework, and fixing it is likely to look much the same, no matter how it is described. Also recall Ossorio's warning (1983) about certain problems of description (Q: "What do you *do* that's different when you do therapy successfully as against when you do it unsuccessfully?" A: "Nothing—you *do* the same things.")

Case Summary #1

This family consists of:
father—engineer, high Power, high Information, low Relationship, strong negative Critic functions, from high-Power family in which he received approval
mother—teacher, high Relationship, high Information, low Power, strong Observer functions, strong positive Critic functions for others and negative for self, from high-Power family who did not value her skills or priorities
son—high Relationship, moderate Information, very low Power
daughter—high Power (made to look like Relationship), moderate Information, low Relationship
daughter—high Information, low Relationship, low Power

The presenting complaint was constant quarreling between father and son, mostly about father's anxiety that son was homosexual (he was not). An equally serious problem was the psychological battering of mother and son by father and older daughter, and father's occasional physical battering of son.

At the beginning, the therapist worked with the family to gain a common (and reasonably accurate) description of each person's practices and values. During this period, the therapist also taught basic information about the PDM—particularly the Approaches with their skills and values, and Observer and Critic functions. (The family had asked for this in response to the therapist's offer of such information.) Some of the specific skills

were modeled by the therapist and restated in terms of other Approaches. Some information about cultural expectations (e.g., Relationship skills as ''feminine'', Power skills as ''masculine'') was also included. Family members were asked to assess their own skills and values and the skills and values of other family members. Interestingly, father and older daughter both identified older daughter as high in Relationship skills and values; mother, son, and younger daughter (correctly) identified older daughter as high in Power, low in Relationship.

During the first month, the task of stating advantages and disadvantages of all three Approaches was assigned as written homework for all family members. Then, in rôle-playing, each was asked to be himself with his least-skilled Approach as primary. At first father rejected any situation which put him in a primary Relationship position, saying that Relationship skills and values made no sense to him. With the help of older daughter, he began to experiment with new ways of looking at his own and others' behavior.

During the second month, dinner (formerly a particularly stressful time for this family) was set aside as a time for all family members to practice unfamiliar skills. The structure was that each family member would speak to any other person in both his own and the other person's primary Approach. After about two weeks of this practice, family members reported that it no longer seemed stressful or cumbersome to say something both ways or in another person's primary Approach. Each reported new respect for other ways of operation.

During the third month, specific problem-solving structures were developed, to give non-toxic ways of fostering change. With improved communication, it was also possible to address specific issues more directly. Father and older daughter came to appreciate the benefits to them in mother's Relationship skills and orientation. Son began to understand father's anxiety, and reassured father both about his being heterosexual and (perhaps more important) about his respect and admiration for father. All reported a decrease in hostile behaviors and anxiety. A side benefit, not part of the original problems, was the increased respect of other family members, especially father, for younger daughter's logical approach to problems.

Case Summary #2

This 46-year-old woman, clinical director of a social agency, was very high in Information and Observer skills, high in Relationship skills, and very low in Power skills at the beginning of treatment. The presenting complaint was that she found it difficult to deal with Power-oriented psychiatrists and psychologists (both staff and consultants) and with the level

of competition that existed among the administrative and clinical staffs. She was experiencing similar difficulties with her five adolescent and adult children and with her husband, a middle-management administrator in a large manufacturing company.

Treatment involved two concurrent processes. Power skills and judgments were examined and discussed from a non-pejorative point of view (a new experience for this woman) as possible additions to her behavioral repertoire. Low-risk opportunities were designed for her to learn and practice these skills in individual and group sessions with the therapist and in daily life. The accompanying values were presented in positive fashion, and the implications of incorporating them into her existing value system were explored. At the same time, client and therapist traced the development of the client's existing skills and the ways in which her early experience affected her attitude toward—and acquisition of—Power-Approach skills and judgments.

The increase of Power skills enabled the client to function more effectively both at work and at home, with new appreciation of the values and pleasures of closure, achievement, and challenge. Although she continued to prefer and manifest the Information-Relationship skills and values, she made timely and appropriate use of the Power skills to forestall many of the conflicts that she had formerly believed to be an inevitable part of both her job and her family relationships.

Side benefits from this were a significant increase in playful and creative behavior on her part, and an increase in respect for both Information and Relationship skills and values from her family and from the agency staff. For instance, a very Power-oriented young social worker who had regarded the client's Relationship skills and values as a sign of weakness began to see her kindness as admirable, rather than as something to be exploited.

Current Status of PDM

At the present time, both diagnosis and treatment based on the PDM are in the early stages of systematic articulation. The explicit formulation of the PDM was the first step. Diagnosis and assessment are done clinically, although a comprehensive assessment is in its sixth year of development.

In addition to simply using the PDM to provide conceptual guidelines for conducting psychotherapy, the therapist may introduce the model or portions thereof explicitly as part of the procedure. The therapists who are using the PDM commonly offer to teach clients this way of looking at human behavior and resources, just as many proponents of other views teach their own structures to clients. Most of our clients are pleased to be offered an opportunity to look at human behavior in an orderly and

non-pejorative way and to participate actively in their own treatment planning.

Some clients regard the model as very complicated at first; however, most clients learn to use the concepts quickly and fairly accurately. It usually takes about three months for a person to gain an independent working knowledge of the PDM.

Clients report that the following aspects of treatment with the PDM are valuable to them:

1. It provides manageable and positive descriptions of behavior and options.
2. It is not punitive or insulting.
3. It offers considerable flexibility in defining and solving problems.
4. The assumptions made are explicit and by mutual agreement.
5. The client is respected and trusted.
6. Because the PDM deals with the whole range of behavioral options, both client and therapist can retain a sense of proportion about the need for and the processes of change.
7. The material integrates well with prior learning and experience.
8. Values are acknowledged, but neither promulgated or attacked.
9. The resources used in treatment are also useful in other settings—a high transfer of learning.
10. It is not coercive, but fosters cooperation, mutual trust, and respect.
11. Because it is cooperative, it is less stressful for both therapist and client, reducing client dropout and therapist burnout.
12. It is applicable to a wide range of situations, from situational difficulties to psychosis.

SUMMARY

A Descriptive Psychology approach to psychopathology and treatment is suggested and discussed briefly, using the Positive-Health Developmental Model (PDM) as an example of Ossorio's deficit model. The PDM is a conceptual framework for classifying persons and/or their behavioral capabilities in respect to Developmental Level, Degree of Mastery, and personal Approach, or perspective on the world. Because the PDM provides an assessment of a person's abilities or disabilities, it is a fairly direct implementation of Ossorio's definition of pathology: "When a person is in a pathological state there is a significant restriction in his ability to (a) engage in deliberate action, and, equivalently, (b) participate in the social practices of the community." Two brief case studies and some preliminary notes on treatment were included.

ACKNOWLEDGMENTS

I am deeply indebted to Dr. Peter G. Ossorio for his clarification of the issues discussed in this paper and for his critiques both of material presented here and of the treatment on which it is based. Mary McDermott Shideler, K. E. Davis, and Thomas O. Mitchell have all given invaluable editorial help, refining and tightening the paper through many changes. The generosity of these scholars is greatly appreciated. Address: 10645 Tancred, Denver, CO 80234.

REFERENCES

Bergner, R. M. (1985). The paranoid style: A descriptive and pragmatic account. In K. E. Davis & T. O. Mitchell (Eds.), *Advances in Descriptive Psychology* (Vol. 4, pp. 203–230). Greenwich, CT: JAI Press.

Driscoll, R. (1981). Policies for pragmatic psychotherapy. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1, pp. 273–279). Greenwich, CT: JAI Press.

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

Ossorio, P. G. (1969/1981). Notes on behavior description. In K. E. Davis (Ed.), *Advances in Descriptive Psychology* (Vol. 1, pp. 13–36). Greenwich, CT: JAI Press. (Originally published in 1969 as LRI Report No. 4b. Los Angeles, CA and Boulder, CO: Linguistic Research Institute.)

Ossorio, P. G. (1982). *Status maxims* (LRI Report No. 30b). Boulder, CO: Linguistic Research Institute.

Ossorio, P. G. (1983). Personal communication.

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.

Vanderburgh, J. (1983). The positive-health developmental model. In K. E. Davis & R. M. Bergner (Eds.), *Advances in Descriptive Psychology* (Vol. 3, pp. 271–298). Greenwich, CT: JAI Press.