Psychopathology

PSY 708 for Dr. Margaret Cramer

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March 13th, 2003

Alternative Models of Psychopathology

*Any psychological construct can be properly interpreted as pathological within the framework of an appropriate clinical or theoretical perspective, and in the light of an appropriate value system. The significance of all classification, description, etiology, diagnosis, and treatment derives from these perspectives. Legitimate nosologies vary dramatically in their criteria for pathology, in the extent to which they segregate description from etiology, and in the ontological status that they assign to psychological constructs generally. These factors both determine and justify the therapeutic posture and the treatment methods of each theoretical perspective. The "medical model" of psychopathology represented in the DSM-IV reflects a compromise position along each of these dimensions. Such compromises are essential in order to establish a reasonable standard of communication across theoretical orientations, but it establishes no framework for treatment. From this perspective the DSM simply catalogues a set of behavioral phenomena that are of common interest and which must be accounted for within any higher level nosology. The medical model provides a framework for the identification of behavioral phenomena that are commonly taken to be pathological. These phenomena may or may not be interpreted as either psychological or pathological within alternative or superordinate nosologies. This essay emphasizes the stratified nature of behavioral interpretation and distinguishes between hierarchical and alternative taxonomies, etiologies, and nosologies. It is argued that the real motive behind the commitment in recent editions of DSM to "*neutrality with respect to theories of etiology*" is actually the avoidance of controversy rather than the avoidance of etiology. Rivalry should properly focus on alternative interpretations that go beyond whatever has been established as objective reality, even in the field of psychology, as it does in the physical sciences. Properly understood, DSM and the medical model provide a common, non-controversial foundation for higher level models which are entirely compatible with it but which may be alternative to one another. The political nature of these considerations stems partly from a confusion of etiology with description, partly from the natural propensity of* Homo sapiens *to form into opposing camps, and partly from reasonable and genuinely divergent convictions regarding the nature of psychological phenomena. (American Psychiatric Assn, 1995; Hersen & Van Hasselt, 2001; Maxmen & Ward, 1995; Sutker & Adams, 2001)*

The ontology of psychological constructs

There is a tendency, even within the literature of scientific psychology, to regard psychological constructs as concrete entities. Although the DSM-IV purports to address the full range of "*behavioral, psychological, or biological dysfunction*" (American Psychiatric Assn, 1995) this claim is actually in support of the laudable retreat from etiological presumption that was manifest in earlier versions, rather than

an accurate description of its actual focus (Hersen & Van Hasselt, 2001; Maxmen & Ward, 1995). In fact, the disorders identified in the DSM are entirely behavioral even though some of their etiologies are more clearly and directly biological than others (e.g. Alcohol Intoxication vs. Social Anxiety Disorder). Also, the statistical aspect of DSM is epidemiological rather than descriptive of the disorders themselves. This orientation leaves open the interpretation of DSM disorders as concrete properties of individuals that exist as *static entities* within some percentage of a population, rather than as *transient entities* which manifest themselves with some frequency in the behavior of individuals.

In fact all behavior is inherently statistical rather than concrete in the sense that any particular behavior is not always manifested. The same may or may not be true of the constructs presumed to underlie any particular behavior. For example, the mechanisms underlying the startle response are quite concrete in the sense that their neural correlates are quite specific and persistent (Rosen, Hamerman, Sitcoske, Glowa, & Schulkin, 1996) whereas the etiologies of depression are multiple, often transitory, and generally intangible (Whybrow, 1996). The significance of this distinction among the ontologies of various psychological constructs is that it defines the boundary between description and etiology now intended in the DSM, and the basis for the exclusion of that which is considered to be etiology from it (Young, 1999).

The real motive behind the commitment in DSM-IV to "*neutrality with respect to theories of etiology*" is the avoidance of controversy rather than the avoidance of etiology. This amounts to the elimination of *debatable* etiology from the otherwise non-controversial description of behavioral sets that are commonly regarded as pathological (Sutker & Adams, 2001). The more concrete a particular construct, the less likely it is to be controversial. For example, it is difficult to find neutrality with respect to theories of etiology incorporated within the DSM-IV definition of amphetamine withdrawal (it is due to the cessation of heavy and prolonged amphetamine use) because that etiological explanation is not controversial. Neurosis however, was excluded from DSM-III because it is a controversial (psychoanalytic) etiological explanation of certain behaviors which, in and of themselves, are not controversial at the descriptive level (Bayer & Spitzer, 1985).

The medical model of psychopathology, as represented in the DSM, strongly favors concreteness in both the behaviors which constitute psychopathology and also in their etiologies. Where concreteness is lacking successive editions of DSM increasingly defer speculation to psychological models that go beyond the consensual, non-controversial corpus of description and etiology; whatever that might consist of at any point in time.

Description and etiology in reciprocal determination

I have suggested that the increasing emphasis on neutrality in successive editions of DSM actually applies to controversy rather than to etiology, and that DSM aspires to be the consensual body of both non-controversial description and non-controversial etiology. Description and etiology can be linked or combined in many ways; either explicitly or implicitly. The DSM-IV label "*amphetamine withdrawal*" itself is an explicit compound of description and etiology (American Psychiatric Assn, 1995). The implications in the DSM-II description of neurotic behavior for specific psychodynamic etiologies are less direct but equally leading (American Psychiatric Assn, 1970). This is perfectly fine to the extent that the non-controversial etiologies in question fully and accurately account for the specified behavior, as (presumably) in the case of amphetamine withdrawal.

Appropriate packaging of description with etiology summarizes knowledge and raises the level at which speculation, controversy, and discovery can operate (Follette & Houts, 1996; Popper, 1959). The fact that the periodic table inextricably compounds description and etiology is not a problem unless it is found that the etiology of chemical phenomena is not really quantum mechanical after all. It is important to recognize that when description and etiology are linked, confused for one another, or co-mingled, then they tend to obscure one another along with any errors that either might contain. It is also important to recognize that once they have been accepted as concrete realities, behavioral descriptions focus attention selectively on those etiological explanations that pertain to them, and etiological systems focus attention selectively on descriptions which justify them. In this sense, description and etiology are forever locked in a system of reciprocal determination which can evolve on the basis of its own internal logic until inconsistencies are encountered or external elements are somehow introduced into it (Sutker & Adams, 2001). It is wise to be careful about what you summarize in doctrine.

Criteria for psychopathology

Psychopathology is essentially a social judgment of behavior; established by consensus within some population (Cushman, 1996; Hersen & Van Hasselt, 2001; Wampold, 2001). Unlike etiology, which is subject to scientific validation, there are ultimately no objective criteria for the designation of pathology. Alternative models of psychopathology therefore have even wider scope in which to differentiate themselves from one another than they do with respect to description and etiology, which tend to consolidate over time in the face of experience and scientific progress. Since it is ultimately irresolvable on objective grounds, controversies about the designation of psychopathology can be extremely persistent.

As with etiology, the effective emphasis in recent editions of the DSM is not actually as stated on the exclusion of "conflicts that are primarily between the individual and society" (American Psychiatric Assn, 1995), but rather on the elimination of *controversial* designations. This is exemplified in the elimination of Homosexuality

from DSM-III while Oppositional Defiant Disorder has been retained. To carry through with the stated objective of the DSM would be to eliminate any designation of pathology to which its targets did not agree. Each alternative nosology applies and withholds the designation of pathology on the basis of its own peculiar theoretical framework and on the basis of the values and perspectives of its constituents.

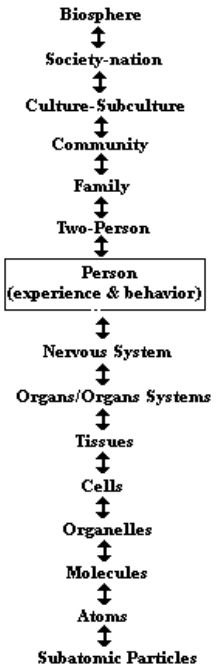
Stratified taxonomies: The biopsychosocial perspective

The medical model of psychopathology, misunderstood as a purely biological model, is often contrasted with psychological or sociological models as though these perspectives were mutually exclusive (Luhrmann, 2000; Wampold, 2001). A more comprehensive perspective which conceives of pathology as a multilevel phenomenon was introduced as the *biopsychosocial* model in 1977 by George Engle. The biopsychosocial model identifies several interdependent but distinct levels of organization that are all relevant to an understanding of psychopathology; including social, psychological, and biological elements (Engel, 1977). Engle pointed out that practically nothing in the realm of psychopathology can be properly understood without reference to more than one of these levels.

The two main elements of the biopsychosocial model are:

1. **Hierarchical Organization:** Various levels such as those listed in the table below can be organized in a hierarchical continuum. The more complex, higher units can be seen as superordinate to the less complex, smaller units. Each level of the hierarchy represents an organized system with distinct emergent properties and characteristics which cannot be meaningfully reduced to the levels which support them.

2. **Reverberation:** Hierarchically arranged levels can also be seen as part of an overarching system, where activity at one level reciprocally influences activity at other levels. The term *reverberation* has been artfully borrowed from the field of acoustical science to describe this interdependence. Although every level can be treated as an independent whole for specialized purposes none actually exists in isolation, except possibly at the very lowest level, if there is one. For example a comprehensive description of blood cells must involve a recognition the larger systems within which they operate.



The various strata in the biopsychosocial hierarchy are complementary rather than alternative to one another. The common portrayal of the medical model as in opposition to “alternative” psychological or sociological models is misconstrued. In the biopsychosocial view, alternative models are actually those which represent *horizontal and incompatible* differences of interpretation at each level of the hierarchy (Engel, 1980). This perspective applies equally to taxonomies, etiologies, and

pathologies represented in any nosology; any of which can support alternatives at any particular level of organization. In this sense behaviorism is alternative to psychoanalysis at the psychological level, and social cognitivism is alternative to Marxism at the sociological level but psychology is *not* alternative to sociology (Bandura, 1986; Coleman, 1986).

Stratified Biopsychosocial Alternatives

Taxonomy	Etiologies	Pathologies
Metaphysics	Religion Transpersonal Psychology Ayurvedic Medicine	Sin Alienation Vikruti
Sociology	Criminology Marxism Feminism Reciprocal Determinism	Crime Capitalism Oppression Maladaptation
Psychology	Psychoanalysis Humanism Transaction Analysis Behaviorism	Neurosis Anxiety Impasse DSM disorders
Neuropsychology	Psychology Neurophysiology	Agnosia Aphasia Apraxia
Psychiatry	Psychology General Medicine	DSM disorders
General Medicine	Physiology Endocrinology Molecular Genetics Organic Chemistry	Brain damage Metabolic pathology Disease Genetic pathology
Chemistry	Physics	None: Deviance is regarded as theoretical shortcoming.
Physics	None	None: Deviance is regarded as theoretical shortcoming.

Institutional fixation of nosology

Nothing is ever taken for granted in science. In principle, even the most fundamental constructs in firmly established theory are subject to revision. In practice however, assumptions must eventually be made at each stage of discovery in order to progress to the next. Knowledge must be consolidated and summarized in postulates for tractability (Brody & Grandy, 1989; Gell-Mann, 1994; Hofstadter, 1989; Reichenbach, 1938).

A body of postulates embraced by a group over time is the perspective of an institution, and it is reflected in its model of reality. Alternative models may or may not reflect objective reality and they may or may not contradict one another. In any case, knowledge and perspectives tend to become fixated in the literature, doctrine, culture, and practice of the institutions that embody them.

Evolution of the DSM

Some institutional models are more controversial than others, and some *institutions* are more controversial than others. The institution of scientific medicine strives to be uncontroversial, as the institution of scientific psychology should. The emphasis in recent editions of the DSM has been upon the elimination of controversial etiological biases and of controversial diagnostic categories. As this emphasis is extended into subsequent editions of DSM the diagnostic categories that it embraces can be expected to fluctuate with prevailing political and intellectual fashions, while its etiological component will reverse the recent trend and expand with the advance of well validated empirical knowledge in *every* category.

The DSM should increasingly embody the corpus of non-controversial description and etiological explanation for many non-controversial behavioral sets and psychological constructs. These entities may or may not be designated as pathological from the perspective of alternative nosologies.

Alternative models should account for the DSM

To the extent that DSM is successful in becoming uncontroversial, alternative models of psychopathology should be able to account for DSM constructs in one way or another. Any DSM element may fall outside the domain of interest to any particular alternative perspective, in which case it is irrelevant to the associated model as Alzheimer's Dementia is irrelevant to psychoanalytic theory. Any DSM element may be satisfactorily accounted for by an alternative model, in which case it is compatible with that model as Anxiety is accounted for by psychoanalysis. DSM entities which are neither irrelevant nor compatible constitute threaten the validity of either the alternative model in question, or else of DSM.

To the extent that DSM continues to evolve along the lines envisioned here, it should provide an ongoing empirical foundation upon the back of which many alternative models can productively compete in pursuit of more advanced and specialized discovery.

Diagnosis of Psychopathology

Diagnosis is the point at which the idiosyncrasies of an individual make contact with the accumulated knowledge of an individual, an institution, or a culture (Sutker & Adams, 2001). Diagnosis is apperception plus some sort of notation. It is facilitated by psychometric instruments, formal and informal nosologies, structured appraisal, personal experience, personal bias, empathy, common sense, psychological analysis, phenomenological insight, cultural insight, pattern recognition, and countertransference. The domain of diagnosis ranges across the spectrum of granularity from isolated behaviors through comprehensive personality profiles and can apply to surface features or deep hypothetical constructs. The centrality and nature of the diagnostic enterprise depends entirely upon the treatment method that is employed. Diagnosis informs discretionary action in the light of any intentional system; especially psychotherapy. Processes that are taken to be universal and generic within their domain of influence, such as the construct of self-actualization in a radically non-directive counseling method, require no diagnosis. Methods which apply specialized protocols designed to achieve specific results, such as CBT, are entirely guided by diagnosis. Diagnoses themselves can be destructive if they serve to promote beliefs and expectations that limit their subjects' freedom, adaptation, or development. Diagnosis can also be constructive in its own right for similar reasons (Merton, 1957; Shaw, 1951). Diagnoses are derived entirely from the observable behavior of their subjects; often on the basis of inferred or reported intermediate constructs such as anxiety and worry. In order to collaborate in treatment within any sort of institutional framework, a common understanding of diagnostic categories must be established; generally within the framework of some more-or-less formal nosology such as DSM, ICD, psychoanalysis, or the penal code.

I am a nuclear weapon

I am a nuclear weapon in detonation. My intention is simply to release my energy. That which is nearest to me will be annihilated and effects near the limits of my influence will depend upon the composition and configuration of whatever happens to be there. I do not care what effect my fixed unfolding process has upon my subjects, so I have no need for any diagnosis of their condition.

I am a policeman

I am a policeman in pursuit of evildoers. My life and my responsibility depend upon the accurate diagnosis of my subjects. At the level of triage, the criminal code is my governing nosology. As I apprehend each perpetrator I rule out deception, hostility, and violence only with good reason. A series of rapid diagnoses govern each arrest.

I am a domestic violence interventionist

I am a domestic violence interventionist facilitating groups of men and women on probation for harming their beloveds. The referral diagnosis is the same for all my clients and my central therapeutic objective is prescribed by statute; although I am free to determine my own treatment protocols and intermediate objectives. I diagnose sociopathology early because I do not believe that sociopaths are motivated by the personal attachment that my primary intervention strategy assumes (Ferguson, 2003). I assess the linguistic and cognitive abilities of each group member in order to calibrate the delivery of my material to their capabilities. I strive to formulate an AXIS-II diagnosis that adequately captures the common essence of men and women in the circumstances which bring them to me.

I am a transaction analyst and a redecision therapist

I am a transaction analyst and a redecision therapist engaged with my client as though she were a pilgrim on the road. My task is not to suggest her destination or to rush her along but to follow slightly behind, responding to non-rescue requests with non-rescuing help; offering empathy, insightful reflection, warmth and non-possessive praise for accomplishments; and no strokes for trying (Kerfoot, 2003). I keep my frequent diagnoses of psychopathology largely to myself, but I bestow my common diagnosis of self-actualization-in-progress lavishly upon all of my clients.

Diagnosis = Apperception + Notation

Diagnosis is the interpretation of a current situation in the light of past experience, plus the notation of a label that designates a diagnostic category with some sort of public or institutional definition. The diagnostic enterprise can utilize empirically established psychometric assessment instruments, but it is certainly not limited to these. Clinical diagnosis usually also involves some combination of structured appraisal, personal experience, personal bias, empathy, common sense, psychological analysis, phenomenological insight, cultural insight, pattern recognition, and countertransference. It is the assignment of a label with some common definition which renders clinical apperception into clinical diagnosis (Hersen & Van Hasselt, 2001; Maxmen & Ward, 1995; Parker, Georgaca, & Harper, 1995).

Domain of diagnosis

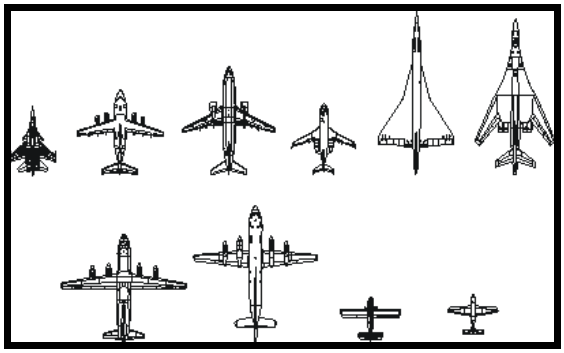
The scope of diagnoses in psychopathology can range from isolated personal idiosyncrasies such as the observation of handedness, right up through social phenomena such as crime (Braun, 1995). The domain of the diagnosis to which any sort of intervention is addressed is enormously important to the intervention approach that is taken, and to the results that can be reasonably expected. Intervention in the wrong domain is often fruitless, as when alcohol intervention targets drinking behavior without addressing lifestyle issues.

The concept of diagnostic domain is partially reflected in the multiaxial structure of the DSM (American Psychiatric Assn, 1995), but DSM itself is not entirely consistent in this regard and there is much that is controversial about the axis to which various disorders properly belong (Hersen & Van Hasselt, 2001). This confusion is partially due to the fact that the placement of any diagnosis into its proper domain is dependent upon the theoretical structure of the diagnostician. Is anxiety an isolated behavior, a syndrome, a personality trait, a symptom of an underlying cause, or a natural existential entity in its own right (Kierkegaard, 1939)?

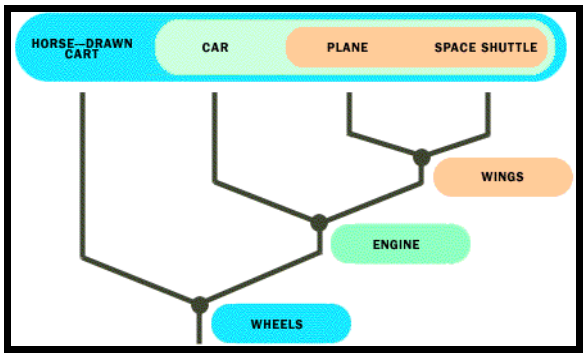
Depth of diagnosis: Descriptive and cladistic taxonomies

Descriptive taxonomies in any field of inquiry eventually give way to cladistic classifications as underlying mechanisms are illuminated. The descriptive approach classifies entities according to their observable attributes whereas cladistic classification is based upon commonality of the underlying structures which give rise to them. This principle applies no less to psychopathology than it does to biology, although the relatively primitive state of scientific insight into the mechanics of psychology tends to obscure this process in our field (Sutker & Adams, 2001).

The DSM taxonomy identifies a set of "*syndromes with unity*" which are framed largely in the language of clinical phenomenology (Poland, Von Eckardt, & Spaulding, 1994). These are operationally defined clusters of associated behaviors that exhibit a typical course, outcome, and responsiveness to treatment. DSM is silent on the question of whether or not its categories should be taken as "*natural kinds*", sharing common causal structures (i.e. core pathologies). Cladistic perspectives on psychopathology strive to organize behavior on the basis of some theory about the underlying structure and etiology of the psychological constructs to which they refer (Baron-Cohen, 1997; Gilbert, 1998).



Descriptive Taxonomy



Cladistic Taxonomy

The consequence these two perspectives is to locate the emphasis of intervention on quite different targets. A descriptive perspective encourages a focus on observable behavior whereas a cladistic perspective places the emphasis on underlying constructs which may or may not be visible at any point in time. For example, CBT nosologies tend to be descriptive since CBT encompasses no structural theory of

mind which refers to unobservable underlying constructs. CBT therefore tends to address behavioral phenomena directly. Psychoanalysis, on the other hand, tends to assume deep structural roots of behavior which are the real targets of intervention in that system.

Diagnosis and identity

Regardless of the intentions that inspire them, the application of any diagnostic label can result in unintended consequences related to the client's personal identity and her expectations for development and/or recovery:

The Pygmalion effect: Individuals fulfill the expectation of others they positive or negative (Casparis, 1980; Merton, 1957; Shaw, 1951). It is therefore advisable to dispense constructive and encouraging diagnoses that are appropriate to any theoretical approach liberally, and to be extremely conservative in the dispensation of those that are derogatory or oppressive.

The Hawthorne effect: Individuals are directly influenced by their perception of the therapeutic process itself. The potential of an individual has much to do with the social forces and relationships to which she is exposed; to some extent independently of the content of those relationships (Adair, Sharpe, & Huynh, 1989). This effect can work either positively or negatively in psychotherapy. If the psychotherapeutic process is framed in a positive light (e.g. development or actualization) then those expectations may tend to be automatically fulfilled. If psychotherapy is framed in a negative light, then dependency and regression may result.

Diagnostic stigma: The stigma of a psychopathological disorder can be devastating. It can disturb relationships, effect social opportunities such employment and education, and disrupt self-confidence and self-esteem (Scheff, 1984; Szasz, 1974; Wilson & Plumly, 1984).

The relevance of diagnosis to treatment

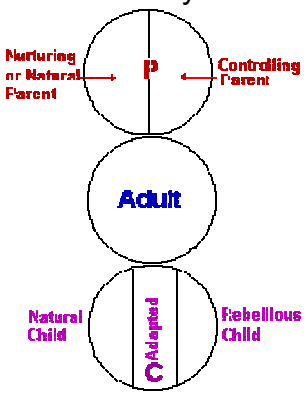
It is by no means axiomatic that the formal diagnosis of psychopathology necessarily has anything to do with treatment (Bedi, 2001; Parker et al., 1995; Szasz, 1974; Wampold, 2001), but it is impossible for human therapists to act without a conception of who and what they are dealing with (Millon, 1999). If used appropriately, diagnosis can be beneficial to both the therapist and the client by leading the intervention in a direction that is backed by solid clinical experience and/or empirical research. Diagnoses are ultimately only as good as the diagnostician; they inevitably and properly reflect the orientation, experience, and biases of the clinician. At its best, diagnosis can capture the essence of a client's situation to provide a reliable guide to treatment and communication. At its worst, diagnosis can mask the complexity of the individual, stigmatize the client, and misdirect the course of therapy.

Psychopathology in TART

Where the domain of DSM encompasses a range of pathology from general medical conditions on Axis III through environmental considerations on Axis IV, TART restricts its domain to that which is within the scope of the client's ability to change, directly or indirectly, by their own decision or act of will. No formal diagnosis of psychopathology is required within the framework of TART because the targets of intervention are chosen by the client, and pathology is not explicitly designated. There are several significant constructs in TART that are functionally equivalent to pathology, however, in the sense that they are the ongoing objects of diagnosis and intervention. These are taken as pathological for the purposes of this essay. The essential criterion for the guidance of intervention within the TART framework is distress, although strong biases are evident throughout the TART literature against the restraint of personal freedom, and against the manipulation of others. These biases effectively provide additional criteria for intervention and, for that reason, can even be thought of as pathological within the TART framework. Distress arises either from the frustration of innate "hungers" or else from cognitive dissonance. Psychopathology has its root in the client's interpretation of the mixed messages that she receives as a child from her parents, and the strategies that she adopts in her attempt to accommodate and reconcile them. The structures of psychopathology and the targets of intervention within TART are the scripts and games that clients consciously or unconsciously pursue, as well as the underlying injunctions and counter injunctions that they have consciously or unconsciously accepted. (Berne, 1961, 1964, 1972; Berne, Steiner, & Dusay, 1996; Goulding & Goulding, 1979; Kerfoot, 2003; Lennox, 1997)

Mixed messages are at the root of psychopathology

People are taken to be essentially rational in TART, and they interpret each message that they receive from their parents in the light of the worldview that they have already developed up until that point. Conflicts, inconsistencies, and fluctuations in the way that parents feel about their children reflect themselves in the mixture of the messages that they deliver to them. Messages like "I wish you didn't exist" are destructive in themselves since they threaten the child directly, even if they are covert. Messages like "Be perfect", or "Be childish and dependent", create problems only indirectly as a result of the strategies that the client adopts in his attempt to accommodate them. Such problematic injunctions and counter-injunctions may be inconsistent with each other, and with more nurturing messages that parents also deliver.



Scripts embody intentions and expectations

> *"Each person decides in early childhood how he will live and how he will die, and that plan, which he carries in his head wherever he goes, is called his script. His trivial behavior may be decided by reason, but his important decisions are already made: what kind of person he will marry, how many children he will have, what kind of bed he will die in, and who will be there when he does. It may not be what he wants, but it is what he wants it to be."*
>
> (Berne, 1972)

EPI => Pr => C => IB => Payoff

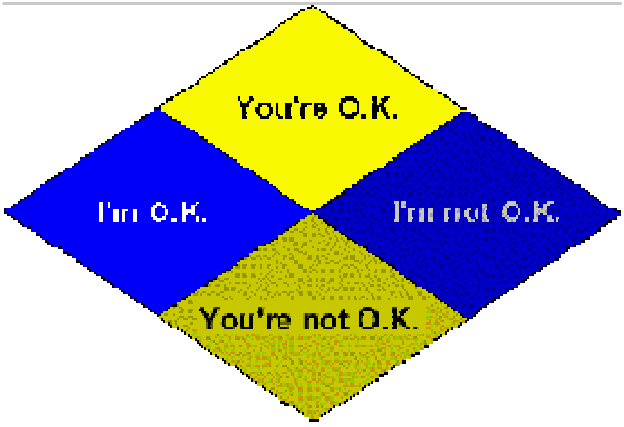
Eric Berne's script formula

EPI = Early Parental Influence
Pr = Program
C = Compliance
IB = Important Behavior
Payoff = Enjoy important benefits and **suffer necessary distress**

Every client has an overarching life script that embodies the basic strategies that he has consciously or unconsciously adopted. A life script develops as a composite of the expectations and intentions that are formed as the child interprets the mixed messages he receives and attempts to accommodate, reconcile, and integrate them. Scripts are pathological to the extent that they entail tissue damage, emotional distress, or frustration of the client's basic needs; or to the extent that they require the exploitation of others.

Pathological life positions

Life positions arise from scripts, which determine feelings of either OK or Not OK regarding self and others. *I'm* Not OK is pathological because it is distressful. *You're* Not OK is pathological both because it is immoral and because it fosters unhealthy, distressful relationships.



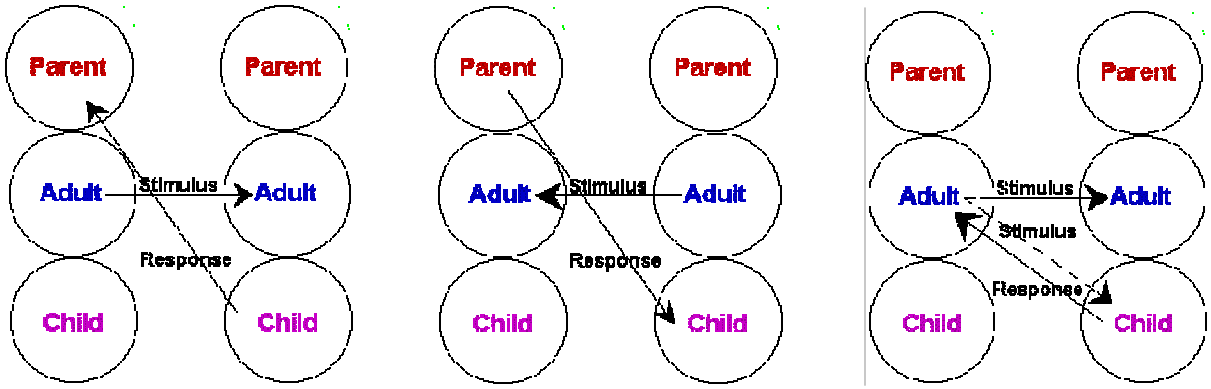
Inconsistency is frustrating and distressful

Transactions are the basic unit of study in TART. They consist of an exchange among two or more of six "ego states" when two people interact. Each ego state has its own characteristic modality and motivation, which can be at cross purposes with other people or with other elements of the same individual. Transactions can become crossed or self-contradictory in many ways, but three of these account for disproportionate share of the grief in the world (Berne, 1972):

Type I Crossed Transaction: An adult message receives a childish response. A husband asks his wife, "*Have you seen my cuff-links?*" to which he receives the response "*Why do you always blame me for everything?*"

Type II Crossed Transaction: An adult message receives a parental response. A teenaged son asks his father, "*Can I borrow the car tonight?*" to which he receives the response "*You can't expect to get the benefits of hard work unless you work hard.*"

Angular (Ulterior) Transaction: The overt transaction has a covert ulterior motive. "*John seems to get along well with Judy*." means "*John has thrown you overboard for Judy*".



Type I Cross Type II Cross Angular

In each case there is an inconsistency of some kind, which can be distressful either because it is confusing or contradictory (resulting in cognitive dissonance) or else because it is frustrating (thwarting the explicit objective with a manipulative response). These and other types of inconsistent or disingenuous transactions constitute the medium of TART psychopathology and are frequently the targets of intervention.

Hunger is distressful

In addition to acknowledging the usual humanistic hierarchy of human needs (Maslow, 1976), TART recognizes three fundamental categories of what Eric Berne called “hungers” in the interpersonal domain (Berne, 1961; Goulding & Goulding, 1979):

Stimulus hunger: Also called “sensation hunger”, human beings have an innate need to seek out stimulating situations. This is why roller coasters make money and why prisoners will do whatever they can to avoid solitary confinement. Social interaction itself is thus seen as the gratification of stimulus hunger.

Recognition hunger: The need for interpersonal feedback, which can only be supplied by other human beings or, sometimes, domestic animals. Human beings seek personal recognition from other individuals in order to establish their own identities. The unit of recognition in TART is the “stroke”, which can be either positive or negative recognition.

Structure hunger: The need to create order and to feel engaged in something meaningful. This is essentially the existential search for meaning, and it leads people to produce interpretation of everything that they encounter, whether there is meaning inherent therein or not (Frankl, 1992; Yalom, 1980). Structure hunger is the engine which drives the young child to interpret the mixed messages he receives from his parents, and to formulate elaborate life scripts, games, and other tactics to rationalize, reconcile, and accommodate them.

These fundamental needs for the basic motivational structure in TART, and they provide the raw material of psychopathology because human beings will accept pain and suffering in order to accommodate them. All of the transaction analysis and redecision therapy that takes place in TART is structured around these reinforcement assumptions. The goal of therapy is generally to find new ways in which these needs can be satisfied without tissue damage or suffering (Lennox, 1997).

Games cause distress and damage relationships

> *"The con hooks into a gimmick (C+G), so that the respondent responds (R). The player then pulls the switch (S), and that is followed by a moment of confusion, or crossup (X), after which both players collect their payoffs (P)." (Berne, 1972)*

C + G = R => S => X => P

Eric Berne's basic game formula

Mark:	The victim
Gimmick:	A weakness in the mark
Hook:	The gimmick used to hook the mark
Switch:	Diverts the transaction, hooking the mark
Crossup:	The point at which the mark is hooked and becomes distressed
Payoff:	The player gains and/or suffers and then gloats

Games are repetitive scenarios that are intended to *artificially* reinforce the characterizations of self and others that are called for in the client's life script. Since the driving force behind the creation of games is support of the life script rather than the immediate consequences of the game, damage and distress can be inflicted on all parties involved without extinguishing the gaming behavior. Since there is always a deceitful trick (crossup) involved in every game, they are pathological by definition.

Restraint of freedom is pathological

> "*We believe the universe to be an alive, conscious, and self-organizing entity. As an integral part of this organism-a microcosm of the macrocosm-the human is more than a biological being. In interaction with others and all of nature, each person engages in a process of on-going self-development, geared to fulfillment of an innate potential. This inherent impulse to self-actualization motivates each individual to develop in his or her own unique manner. Human potential includes not only wisdom inherent in the organism, but the capacity to experience emotional and intellectual growth. Individuals are animated by a curiosity of unbounded openness to learning. Yet, as agents with wide scope of choice, humans sense the exercise of free will entails responsibility for the effects of their actions*."
>
> - Old Saybrook 2 Conference Statement

The Humanistic perspective emphasizes a hopeful, constructive view of human beings and of their capacity for self determination. It assumes that in the absence of obstructions there is a natural, indeed inevitable flow of positive development, which is an operational definition of freedom. All of the psychopathological constructs discussed above are seen within TART as having the effect of blocking the natural process of self-actualization; or the innate freedom of the individual to flower. At the end of the day, TART recognizes no psychopathology within the individual herself.

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