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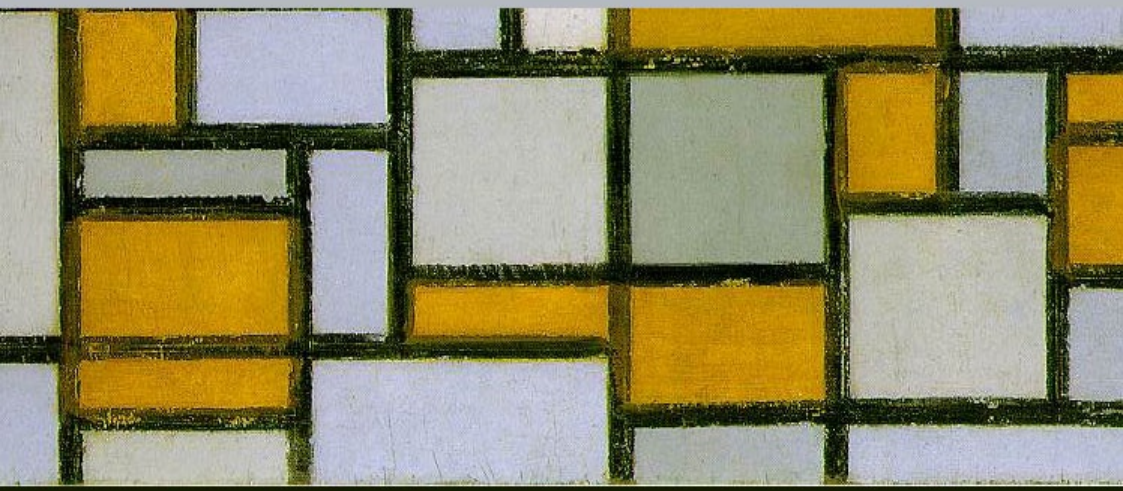
The Concept of Normality



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The Concept Of Normality

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Contents

Introduction

Why has the study of normality and health been a relative newcomer to psychiatry? One obvious reason is that it is a result of training, since training produces not only a set of skills but also what Kaplan calls a trained incapacity. Trained to recognize the abnormal, the psychiatrist and his teacher have had difficulty in recognizing the normal. Recently there has been a surge of interest among mental health professionals in studying normality. In part it is important to study normality because it serves as a base line for all behavior whether pathological or not. Reference to the normal also gives empirical validation to theoretical constructions concerning any kind of behavior. That is not to say, however, that the concept of normality is a clear and concise one. On the contrary, the concept is ambiguous, has a multiplicity of meanings and usages, and is burdened by being value-laden.

In the past, within the behavioral sciences in general and specifically within psychiatry, there has been an implicit understanding that mental health could be defined as the antonym of mental illness. Given such an assumption, the absence of gross psychopathology was often equated with normal behavior. A number of recent trends have cast doubt on the usefulness of this assumption and have made it increasingly important for psychiatrists to become concerned with providing more precise concepts and definitions of mental health and normality.

As psychiatrists began to move out of their consulting rooms and hospital wards into the community, they began to come into contact with segments of the population not previously seen in their more traditional role functions. The broader acceptance of preventive, social, and community psychiatry has necessitated a re-examination of preventing *what* in *whom.* Psychiatrists have also become increasingly involved in agency consultation, where they are called upon to make decisions about who is healthier rather than about who is too sick for various positions. Interest in evaluating the outcome of psychiatric therapeutic endeavors has also brought the issue of what is mental health or normality into focus. Indeed, assessing therapeutic outcome has been handicapped by lack of clarity regarding the concepts of normality and mental health.

This chapter is written with the intent of clarifying some of the conceptual issues related to normality and mental health. We cannot provide a definitive answer to the question, "What is mental health or normality?" since such an answer must eventually evolve out of new research and new experiences. Because cultural and personal values and biases are so intimately tied to one's conception of normality, it is doubtful whether, even in the long run, we will have *one* definition of normality. We shall attempt, however, to delineate the perspectives of normality, evaluate some of the current research on normal populations, and point to newer directions that promise to elucidate the issues still further.

The Four Perspectives of Normality

In our review of the literature on the theoretical and clinical concepts of normality, we were able to define what we called the four "functional perspectives" of normality. Although each perspective is unique and has its own definition and description, the perspectives do complement each other, so that together they represent the total behavioral and social science approach to normality. The four perspectives are (1) normality as health, (2) normality as utopia, (3) normality as average, and (4) normality as process. Let us now define these four perspectives in more detail.

The first perspective, *normality as health,* is basically the traditional medical psychiatric approach to health and illness. Most physicians equate normality with health and view health as an almost universal phenomenon. As a result behavior is assumed to be within normal limits when no manifest psychopathology is present. If we were to transpose all behavior upon a scale, normality would encompass the major portion of the continuum and abnormality would be the small remainder. This definition of normality correlates with the traditional model of the doctor who attempts to free his patient from grossly observable signs and symptoms. To this physician the lack of signs or symptoms indicates health. In other words, health in this context refers to a *reasonable* rather than an *optimal* state of functioning. In its simplest form this perspective is illustrated by Romano, who states that a

healthy person is one who is reasonably free of undue pain, discomfort, and disability.

The second perspective, *normality as utopia,* conceives of normality as that harmonious and optimal blending of the diverse elements of the mental apparatus that culminates in optimal functioning. Such definition emerges clearly when psychiatrists or psychoanalysts talk about the ideal person or when they grapple with a complex problem such as their criteria of successful treatment. This approach can be dated directly back to Freud who, when discussing normality, stated, "A normal ego is like normality in general, an ideal fiction." While this approach is characteristic of a significant segment of psychoanalysts, it is by no means unique to them. It can also be found among psychotherapists of quite different persuasion in the field of psychiatry and psychology (for example, Rogers).

The third perspective, *normality as average,* is commonly employed in normative studies of behavior and is based on the mathematical principle of the bell-shaped curve. This approach conceives of the middle range as normal and *both* extremes as deviant. The normative approach that is based on the statistical principle describes each individual in terms of general assessment and total score. Variability is described only within the context of groups and not within the context of one individual. Although this approach is more commonly used in psychology and biology than in psychiatry, recently

psychiatrists have been using pencil and paper tests to a much larger extent than in the past. Not only do psychiatrists utilize results of IQ tests, Rorschach tests, or T.A.T. but they also construct their own tests and questionnaires. Conceptually the normality as average perspective is similar to Kardiner's "basic personality structure" for various cultures and subcultures. In developing model personalities for different societies, one assumes that the typologies of character can be statistically measured.

The fourth perspective, normality as process, stresses that normal behavior is the end result of interacting systems. According to this perspective, temporal changes are essential to a complete definition of normality. In other words, the normality as process perspective stresses changes or processes rather than cross- sectional definitions of normality. Investigators who subscribe to this approach can be found in all the behavioral and social sciences. Most typical are Grinker's thesis of a unified theory of behavior encompassing polarities within a wide range of integration and Erikson's conceptionalization of the seven developmental stages that are essential for mature adult functioning. The recent interest in general system theory (Von Bertalanffy Gray, Duhl, and Rizzo) further stressed the general applicability of general system research for psychiatry. Normality as a system has been recently outlined by Grinker; variables from the biological, psychological, and social fields all contribute to the functioning of a viable system over time. The integration of the variables into the system and the

loading (or significance) assigned to each variable will have to be more thoroughly explored in the future.

Illustrative Research Strategies

Studies on normal population have to a large extent concentrated on normality as health and normality as utopia perspectives. The epidemiological studies of Srole focused on disturbed signs and symptoms that interfered with the person's functioning and behavior. Leighton and his colleagues concentrated on gross psychopathology. On the other hand, studies of superior or very competent individuals have been undertaken by Silber, *et al.,* White, Cox, Heath, Westley and Epstein. There have been very few clinical or longitudinal studies illustrating the normality as average or normality as process perspectives. In the section below we have chosen two research strategies that illustrate the usefulness of the latter two perspectives in empirical studies of normality and health.

Normality as Average—The Modal Adolescent Project

The overall aim of the Modal Adolescent Project has been to study intensively and over a long period of time one representative group of "typical," "average," or "normal" adolescents. A modal student was defined as one whose performance on a specially constructed Self-Image Questionnaire (Offer and Diesenhaus) was within one standard deviation from the mean in nine out of ten scales. As such it was our aim to study one population of average students by eliminating both extremes; the disturbed adolescent as well as the teenager who functions on a superior level. Since the above study

was undertaken in two suburbs of Chicago, the adolescents represent average middle-class suburban teenagers. Data were collected in order to provide a base line for comparative data collected on other populations both in our culture and cross-culturally as well as in future generations. It will become part of a data pool that will give scientists a better understanding concerning the totality of the phenomena of adolescence.

At the onset of our project we wanted to select our modal group from the widest possible spectrum of teenagers living in a particular community, so a natural choice was a high school attended by all teenagers in the community. We chose two different high schools that were limited to middle-class populations but, nevertheless, represented the full range of the middle class. For our selection procedure we devised a Self-Image Questionnaire that we administered to the two total entering freshmen classes. "Normal" or modal subjects were chosen on the basis of a statistical approach, normality as average. This method was selected in order to attempt to eliminate the extremes of psychopathology and of superior adjustment.

Our research strategy helped us understand the kind of problems typical teenagers have, the way they cope with them, and the reasons behind their successes and failures in the coping process. Our findings are summarized below:

1. There was a history of almost complete absence of gross

psychopathology or severe physical illness.

2. There was a history of mastery of previous developmental tasks without serious setbacks.

3. Our subjects demonstrated ability to experience affects flexibly and actively bring their conflicts to a reasonable resolution. In general, our subjects coped well with anxiety, depression, shame, guilt, and anger.

4. Our subjects had relatively good peer relationships as well as a capacity to relate to and identify with adults. During high school the father is seen as reliable and the mother as understanding. The adolescents feel closer emotionally to the mother. After high school the subject gets closer emotionally to the father.

5. Twenty-two percent of our subjects experimented with delinquency between the ages of 12 and 14. They had a capacity to learn from their experiences and did not become chronic delinquents. During high school they handled their aggressive impulses mainly by channeling them into sports. After high school and particularly during the first year away from home, we noted some mild depression among our subjects.

6. There was evidence of discomfort but no marked conflict with the increasing strength of the sexual impulses. Our subject moves slowly in the direction of heterosexuality. There is no evidence of a “sexual revolution” in behavior among our subjects. Nevertheless, in their attitudes they seem open and

willing to discuss sex.

7. There was no evidence for the existence of serious "adolescent turmoil." The lack of serious "adolescent turmoil" was not a reflection of denial or closed off communication with the self. Indeed, introspection was prominent and communication with the self is present. The adolescents show some awareness of conflicts with parents and authority figures, but the conflicts do not spin out of control. They have surprisingly realistic self-images and are actively bringing their conflicts to a successful resolution.

8. There was a great deal of continuity between their values, those of their parents, and those of the social milieu of their community.

We discussed our findings concerning one group of normal or typical teenagers in detail to illustrate how such a research strategy can be useful. It tells us how a specific group of adolescents feels and behaves. It serves to establish the beginning of behavioral norms for one group of adolescents; thus when future groups of teenagers are studied, especially from the same sociocultural backgrounds, they can be meaningfully compared with the group described above.

Similar studies on modal populations have to be performed on a variety of populations throughout the life cycle in order for us to have a better understanding of the factors that contribute to adaptation and health as well

as those that contribute to the development of psychopathology and maladaptation.

Normality as Process—Parental Anticipatory Mourning

In the previous discussion we have indicated that a process conception of normality involves an investigation of multiple systems of adaptation transacting over a period of time. In contrast to cross-sectional perspectives, a process analysis emphasizes temporal progression of coping techniques and assumes the continuity of change in behavioral patterns. While this particular perspective has been espoused by many mental health professionals on a verbal level, the empirical evidence supporting this understanding has been less convincing in the behavioral sciences than in several of the biological sciences (for example, embryology and evolutionary theory). In part the understanding has been hampered by a lack of empirical data so that the discussions of the process perspective have often appeared to be abstruse and divorced from concrete behavior. Consequently we have selected a particular research program to illustrate a more comprehensible picture of normality as process. The illustration is intended to summarize the formulation of a process analysis derived from empirical data in a longitudinal study.

The particular work that we have selected as an illustrative paradigm

for normality as process is the work during the past five years by Futterman, Hoffman, and their colleagues in the area of family adaptation to the fatal illness of a child. In this study each of the four perspectives is utilized to a certain degree. However, the overriding interest of the investigators is in studying coping behavior over time. The specific interactions of the various defensive structures (or subsystems) and their contributions to cluster behavior arc being investigated. Their method is similar to the one utilized by Vaillant in his 30-year follow-up study of healthy adults. The central question is what were the contributing factors that helped bring about successful adaptation.

These investigators have studied the coping mechanisms of parents with leukemic children. They have interviewed and observed a normative sample of parents and their children from the initial communication about the fatal illness up to, and in some cases following, the death of the child. To carry on such studies is in itself a most formidable task considering its extreme poignancy. Indeed, recent work by Paykel has indicated that the death of a child is considered to be the most upsetting event conceivable to an adult population of psychiatric patients and their families. Nevertheless, several research teams (Friedman, *et al.,* Richmond and Waisman, Bozeman, *et al.,* Natterson and Knudson, Hamovitch, Binger, *et al.,)* have carried on investigations in this area with the realization that much can be learned by studies of a normative population undergoing stress of high intensity over a

substantial period of time.

Futterman and Hoffman conducted formal interview's with 24 sets of parents supplemented by informal contacts with many other families, in collaboration with the Department of Pediatrics at the University of Illinois. From the very beginning the observers were impressed with the wide repertoire of coping strategies utilized by the involved families. While the exact criteria for successful coping with this dreadful stress remain to be worked out, the research team has focused upon the modal processes of adaptation in their sample. Examination of the data after two and a half years of observations indicated that each set of parents had to cope with the following adaptational dilemmas:

1. To trust the caregivers (physicians, *et al.)* and yet to accept their limitations.

2. To be active in mastery of the chronic stress and yet to delegate appropriately to the caretakers.

3. To acknowledge helplessness periodically and yet to maintain their own sense of worth.

4. To cherish and cling to the leukemic child and yet to allow the child to separate from them and continue to grow.

5. To invest in the leukemic child and yet to invest also in the child's siblings.

6. To accept medical reality and yet to maintain a certain amount of hope.

7. To develop acceptable outlets for anger and yet to avoid excessive bitterness at others or persistent self-blame.

8. To mourn the impending loss and yet to maintain investment in the child's further development until death becomes imminent.

9. To focus on the immediate crises and yet to plan for the future of the family.

10. To protect significant others (relatives, friends, teachers) from too great a stress and yet to prepare them also for the child's death.

11. To maintain strategies of continued existence and yet face feelings of hopelessness, helplessness, and grief.

After analyzing these dilemmas the investigators further postulated the following interdependent five areas as major adaptational tasks of parents with leukemic children:

1. Maintaining family integrity.

2. Maintaining confidence (worth, mastery, trust) in themselves and the child's physicians.

3. Maintaining meaningful value orientations (for example, causality, meaning of life and death, hope, and so forth).

4. Managing their awareness process and feeling states.

5. Anticipatory mourning.

Each of the above adaptational tasks was further analyzed into its various components, and efforts were made to follow these adaptational subtasks throughout the course of the child's illness and even beyond the death of the child.

The concept of parental anticipatory mourning was developed empirically from the data as a series of adaptive part-processes interwoven throughout the trajectory of the illness (Futterman, Hoffman, and Sabshin). Preliminary inspection of the data showed that certain components emerged and reached prominence earlier in the child's illness while others peaked in the latter stages of the disease. The part-processes emerging from qualitative analysis of the data included the following:

1. Acknowledgment: development of explicit awareness (Glaser and Strauss) of the fatal prognosis; becoming convinced that the child's death is inevitable.

2. Grief and grieving: experiencing and expressing the emotional impact of the anticipated loss and the physical, psychological, and interpersonal turmoil associated with it.

3. Reconciliation: coming to terms with the child's expected death in a manner that preserves a sense of appreciation of the value of

the child's life and of life generally.

4. Detachment: withdrawal of emotional investment from the child as a growing being with a real future.

5. Memorialization: development of a relatively fixed internal image of the child with investment in his memory replacing investment in the real child, occurring before the death of the child.

These phases were postulated after the data were examined qualitatively; they are being checked currently by quantitative analysis to assess the frequency of their occurrence, their precise phase-specific relationships, and the various deviations from modal patterns. Several of these variables have been discussed by other investigators of parental adaptation to fatal childhood illness. However, other authors have not treated the course of parental anticipatory mourning as a total process, nor have they described the progression of each of its part-processes and their dynamic interactions over time. In addition, a number of specific constructs, among them "reconciliation" and "memorialization," are formally introduced by Futterman, *et al*., for the first time as integral aspects of anticipatory mourning.

Parental anticipatory mourning is still a relatively unexplored field. In this chapter we do not wish to focus on it as a clearly defined entity; rather

we wish to illustrate empirical research in which the processes of coping over time are studied in a sample of individuals who do not specifically seek psychiatric help. We envisage a variety of such longitudinal studies as helpful in elucidating processes of adaptation so that normality as process becomes much more understandable as a perspective complementing the others discussed in this chapter.

Coping and Adaptation

Normality and health have often been associated with terms such as adaptation, competence, and most recently coping. We have to keep in mind that these concepts, like normality and health, are complex theoretical constructs that have not been adequately explained on the basis of any past or present single theory or hypothesis. One of the major problems that has plagued investigators in the behavioral sciences has been the great difficulty in making successful predictions about the long-term future behavior of an individual, or even of a majority within a group. Current research endeavors in the behavioral sciences have, therefore, tended to identify operationally clusters of traits and behavior that describe the variety of healthy or normal populations. (See, for example, Silber, *et al.,* Grinker, *et al.,* White, Heath, West- ley and Epstein, Cox, Offer, Beiser, and Vaillant).

The interest of behavioral scientists in studies of coping and adaptation has increased rapidly in the past two decades. A variety of definitions of coping has been offered in the literature. Hamburg and Adams define coping as "seeking and utilizing of information under stressful conditions." Heath defines adaptation as "to so regulate behavior as to optimize simultaneously both the stability of the self structures and their accommodation to environmental requirements." Coping is defined by Lazarus, *et al.* as consisting of problem-solving efforts made by an individual when the

demands he faces have a potential outcome of a high degree of relevance for his welfare (that is, a situation of great jeopardy or promise), and particularly when these demands tax heavily his adaptive resources. Competence, according to White, means "fitness or ability. The competence of an organism means its fitness or ability to carry on those transactions with the environment which result in its maintaining itself, growing or flourishing."

Ability to cope is another way of assessing the type of character of the defenses utilized by individuals; the "healthier" the defenses the better the coping abilities. (See, for example, Grinker and Vaillant.) A recent review by Weinshel includes a discussion of the direct correlation between ego strength and health and normality. Here again the stronger (or healthier) the ego the easier it is for the individual to adapt to his internal as well as to his external environments.

From a physiological point of view studies of coping mechanisms tended to agree that: "It is not the stimulus that is specific but the response. Response specificity clearly is based on phenotypic patterns based on combinations of genic and experiential factors." Recognizing the importance of response specificity, the most significant investigations of coping behavior have involved analysis of variations in responses to stressful situations. The fact that a large variety of stimuli from either the external environment or the internal environment (for example, affects such as anxiety, anger, fear, or

depression) all have a common physiological pathway has made it easier to study the somatic responses to stress. It has not, however, made it any easier to study the coping behavior of people from a psychological point of view. The individualized response, which is based on constitutional, experiential, familial, social, and cultural factors, is not uniform. Hence the 20 universal stressful situations[1] outlined by Hamburg are coped with in a variety of ways rather than having a uniform pattern of "response specificity." Thus what causes one person to be unable to cope (for example, death of a close relative or friend) *at a particular time* will not necessarily cause the same response at a different developmental state. A knowledge of the individual's background can tell us what defense mechanism (or coping behavior) an individual will choose to combat a particular stress. However, psychiatrists have not been too successful in the past in predicting who will cope successfully under stressful conditions.

In the section on parental anticipatory mourning above, we have described a specific study that deals with one of the stressful situations outlined by Hamburg. The physiological system that has been activated by the parents in acute stages of grief is not intrinsically different from the system that the soldier activates in battle. The psychosocial response, however, is less specific. Hamburg and Adams state that there are basically four stages in relieving stress of major proportions: "1. Personality attributes that tend to facilitate involvement in and mastery of the new situation or task; 2. Ego

processes that serve to develop an adequate self-image in regards to the new task or situation; 3. Ego processes that help to maintain otherwise distressful affects within manageable limits; and 4. Personality processes that tend to maintain and/or restore significant inter-personal relationships."

The basic assumption still is that the royal route to studying psychosocial coping is through deviancy, be it psychopathology (Jones) or unusual (that is, stressful) situations or conditions (Hamburg and Adams, Grinker and Spiegel, and Lazarus).

To many investigators the term "coping" implies that there is something negative to which one has to attend. This view of coping is conceptually similar to the psychoanalytic theory of defense mechanisms—the defenses are erected to protect the person against the upsurge of powerful aggressive and sexual instinctual demands from within and to protect him from undue pressure from without. From this perspective the best way to study coping is by observing populations that are experiencing stressful reactions in highly conflictual situations.

Erikson presents human growth from the point of view of conflict, crisis, and stress: "For man, in order to remain psychologically alive, constantly resolves these conflicts just as his body increasingly combats the encroachment of physical deterioration" (p. 91). He postulates that during the

eight specific crisis periods one can study the human condition better because both the potential for growth and the emergence of pathological defense mechanisms are more evident. It remains unclear whether Erikson extends the crisis periods to include all substages or phases of the eight crisis periods. The concepts that delineate the beginning and end of each crisis period have not as yet been operationally defined. Erikson assumes that crisis, like stress, elicits emergency defenses; hence the study of crisis serves as 3 way to decipher how well a person is able to cope.

An alternative perspective to sequential life crises is one that assumes periods of relative equilibrium and disequilibrium. Tire modal adolescent described above goes through adolescence without reacting to it *in toto* as a stressful situation or even as a series of *major* crises. Coping can, therefore, be studied in this context by observing quantitatively different phenomena, for example, the most ordinary life situations of one group of teenagers. Adolescence is certainly not conflict-free, and the adolescent must disengage himself from parental domination. He can do this without total renunciation of parental values, but rather through conflicts or minor issues that have been endowed with major importance for the adolescent's own growth and development. At least in the modal adolescents the reactions do not give rise to the storm and stress described by investigators studying intensive experiences of adolescence and experiences such as combat conditions (for example, *Men under Stress).* To describe the adolescent period as a period of

great inner turmoil, rebellion, storm and stress is true for a segment of the adolescent population, but is not universally observed. Like any period in life it is highly stressful for some individuals. For the latter group their coping abilities are often inadequate, and hence they commonly seek help in the psychiatrists' offices. The adolescents who cope successfully with the period are an enigma to many clinicians. We need new terminology that will describe the nuances in coping behavior and that will take into account the tremendous variability in reactions of individuals to stress and crisis. It will allow us to view a continuum of stressful situations from most stressful to the least stressful, with crisis being at one end of the continuum and successful coping with everyday tasks at the other end.

Studies of adaptation and coping would enable us to formulate what Jahoda called "positive aspects of mental health." While psychiatrists have always been quick to extrapolate from psychopathology to normative theory, it has not been simple for psychiatrists to focus upon adaptive aspects of human behavior. Until very recently our theoretical concepts have facilitated the examination of nuances and details in studying psychopathology. In addition, psychiatrists are adept in perceiving coping behavior correctly, but still clothing it in the garments of psychopathology.[2] With the developing sophistication of ego psychology, it has become increasingly obvious that there is a need to investigate the correlation between the behavior and specific coping ability of people and their overall psychological health and

normality.

Returning full circle now to our original question: What is normality and health? We believe that there are a number of adaptational routes open to individuals. Based on a complex interaction of biopsychosocial variables in a system that we call an individual, a person will have developed a coping style unique to him early in life. It is our opinion that in a majority of individuals the psychological system that an individual erects in order to cope with crisis, stress, and everyday life will by and large remain relatively constant through life, since the repertoire of adaptive mechanisms, including defenses, is relatively fixed in early childhood. Some individuals will undergo *Sturm und Drang* at every major crossroad through the life cycle. Others will go through life with little turmoil. We postulate that the healthier individuals will have a variety of coping techniques available to them, will have a larger array of defenses at their disposal, will utilize the more adaptive and object-seeking defenses, and will show more flexibility in dealing with internal as well as external events. Whether the ones who show less overt (behavioral) turmoil are the ones who are optimally healthier cannot be determined without intimate knowledge of the biopsychosocial variables that contribute to the behavior. In other words, behavior has to be studied in the context of the individual, the family, the group, and the society. Only then can it be fully understood.

It is imperative that we study the behavior, psychodynamics, and coping styles of a large segment of the population in order to understand the contributing factors to adaptation or maladaptation. Recent trends in social and community psychiatry afford us some new opportunities to achieve part of this goal.

Social and Community Psychiatry

The issue of normality has already become a visible question in the development of social and community psychiatry. Although some investigators have clearly recognized that conceptual dilemmas regarding the definition of normality exist when one conducts epidemiological studies or attempts primary preventive programs (Mechanic and Bolman), the problem is rarely acknowledged. There is reason to expect, however, that a series of events will force even greater consideration by community mental workers of perspectives of normality. Discrepancies in prevalence and incidence rates of psychiatric illness across subcultural and geographic boundaries are determined, at least in part, by variations in the operational definitions of normality or health. Furthermore, efforts at evaluation of preventive programs (primary as well as secondary prevention) must include criteria for successful as well as negative outcomes. Comparative analysis of such results in community mental health programs across the nation will necessitate consideration of the operational definitions of illness and health, and there will be increasing pressures to improve upon our gross definitions of psychopathology and healthy adaptation.

There is another reason why normality will emerge as a central research and pragmatic issue in social and community psychiatry. The development of community mental health programs affords an excellent

opportunity to begin a series of investigations of normative behavior not heretofore possible. Although the image of communities as laboratories for research has brought about resistance as well as consternation in some areas, there is reason to believe that the efforts to conduct investigations *with* communities will, after some hesitation, supplant our tendency to do research *on* communities. Evidence already exists indicating the advantage to communities of increased understanding of its population's behavior as compared to stereotyping and its attendant distortions. Furthermore, communities will be interested in evaluation of intervention programs within their borders, and they will cooperate with investigations that facilitate such evaluation.

One of the best illustrations of *access* to a normative sample and community *sanction* for research in the area of psychological adaptation and maladaptation has been the pioneering investigations by Kellam and Schiff. They have demonstrated the feasibility of such studies and have also contributed significantly to our understanding of behavior in a large sample of schoolchildren. It is to be hoped that over time many more populations will be investigated so that our empirical evidence will be considerably augmented.

Summary

Concepts of health and normality are not universal or all-encompassing. They tend to reflect the particular orientation or values of the investigator and are often tied to the social context in which the research is undertaken. We have described four major perspectives on normality: normality as health, normality as utopia, normality as average, and normality as process. We further described two research strategies that can be seen as illustrating two of the four perspectives on normality.

The trend toward increased study of normative population by mental health professionals can be well documented in a variety of other mental health areas. It is important to note that convergences have already begun to take place, as, for example, in the convergence of community psychiatric studies and human development within an epidemiological framework. We have seen in the past decade a dramatic increase in investigators studying the factors contributing to coping under stress, as well as the psychological processes relative to successful adaptation in everyday life. Many more studies will be necessary before a useful integration of the concepts of healthy adaptation, coping, and normality will be possible.

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Notes

[1] (1) Separation from parents in childhood; (2) displacement by siblings; (3) childhood experiences of rejection; (4) illness and injuries in childhood; (5) illness and death of parents; (6) severe illnesses and injuries of the adult years; (7) the initial transition from home to school; (8) puberty; (9) later school transitions, for example, from grade school to junior high school to college; (10) competitive graduate education; (11) marriage; (12) pregnancy; (13) menopause; (14) necessity for periodic moves to a new environment; (15) retirement; (16) rapid technological and social change; (17) wars and threats of wars; (18) migration; (19) acculturation; (20) social mobility.

[2] For example, in diagnosing or labeling precision work as "compulsive."