The Physician's Role in the Assessment of Normal Behavior

MELVIN SABSHIN

Department of Psychiatry, University of Illinois College of Medicine, Chicago 60612

I am pleased to have this opportunity to talk to you about the physician's role in the assessment of normal behavior. One source of my appreciation relates to the fact that this topic is rarely discussed explicitly in symposia organized by psychiatrists for non-psychiatrist physicians. A major reason for underemphasis of this subject is that psychiatrists are quite divided in their perspectives and opinions regarding normal behavior. Not surprisingly, we psychiatrists are much more comfortable when talking to non-psychiatrists about the nuances of maladaption or of emotional illness. The history of our profession, our concepts, our style of thinking, and our language reflects this tendency in more ways than we know. For example, when some psychiatrists become involved in assessing non-patient populations, they utilize language derived from psychopathological theory to describe specific persons even when they try to provide plausible explanations for these individuals' superior functioning. To oversimplify the point—a well-organized administrator is described as compulsive; a polished speaker who enjoys contact with large audiences is said to have hysteroid exhibitionistic tendencies; a shy, somewhat taciturn but quite creative research scientist may be seen as schizoid—and so on. These "diagnostic" labels fail to capture the adaptive qualities inherent in being well-organized, having the capacity to communicate, or possessing the ability to be genuinely creative. They are gross descriptive terms which serve to provide a minimal value for communication; furthermore, they lack shading or nuances and, consequently, seem divorced from the life and blood reality that, for example, distinguishes one well-organized administrator from another.

Other psychiatrists demonstrate even less interest, let alone capacity, to describe *positive* features of normal behavior. Here I refer to those members of my field whose concept of mental illness equates psychopathology with severe and gross mental disturbances. This rather classical model defines normal behavior as the absence of the vital signs of emotional turbulence. My colleague who follows this "antonym" model may be very helpful to the non-psychiatrist in providing him with a description of the diagnosis and treatment of major emotional illnesses. Normality, for this psychiatrist, however, is an arid wasteland; he demonstrates little interest in searching for distinctions among the population who are not grossly ill. In this attitude regarding normal behavior he joins forces with his colleague who views psychopathology as ubiquitous.

Hence, on the one hand there are psychiatrists who perceive of normality as an ideal never to be seen in a living person; on the other hand there are those who view normal behavior as the absence of illness, which at any given time pertains to the overwhelming preponderance of people. Implicitly, both groups question the validity of studies of normal behavior. For those who espouse the idealized concept of normality, the language of psychopathology has been sufficient to explain much of human behavior despite some intermittent inroads by those who talk about adaptation or coping. For those who follow the antonym model, there does not appear to be any functional utility to studying individuals who are not grossly disturbed, as compared to the great need to clarify our concepts of schizophrenia, serious depressive disorders, and severely crippling neuroses. Psychiatrists advocating these polar positions clash in many circumstances. Repeatedly we hear them give differing testimony in the witness chair as to whether or not the defendant suffers from a mental illness related to his purported crime. Often a perspective of universal psychopathology will render a psychiatrist more prone to connecting behavioral problems to the alleged criminal act. These polar positions lead to confrontations in many extrajudicial contexts, including training, research, and clinical areas. Nevertheless, both positions converge to serve as subtle resistance against clarifying the meaning of normal behavior.

The aforementioned positions are slowly being opposed by a development which may have considerable significance for the non-psychiatrist physician as well as for the psychiatrist. In a previous publication

(Sabshin, 1967) I have described what I consider to be a neoempiricist trend in American psychiatry. This trend represents the coalescence of several significant forces. First of all, it signifies a retrenchment from our professional penchant for hypergeneralization and our proclivity to "shoot from the hip" with all-purpose deductive armamentaria. Non-psychiatrist physicians have recognized these "symptoms" in us, but by and large they have patiently awaited our "growing out" of them. Secondly, the empiricist trend reflects a slight diminution in our somewhat phobic reactions to epidemiological data, statistical analyses, and quantitation in general. Every day more of us are asking, "How often does X occur?" There are increasingly fine examples utilizing such quantitative data for new hypothesis formation and anterospective predictions. Social and community psychiatry have provided an enormous impetus to the neo-empiricism, although much of this is still in the formative stage. In brief, the newer responsibilities for care of patients and their families in the context of a geographically defined community have, among other consequences, made available a pool of data not heretofore accessible to many psychiatrists. The necessity for empirically derived data becomes paramount in evaluating our efforts in primary, secondary, and tertiary prevention of emotional problems. For example, we must study segments of the population other than patients to judge whether our interventions have reduced the incidence and prevalence of previously expected emotional problems. The relation of this empirical data to the question of normal behavior becomes apparent when one is forced to assess outcome of psychiatric care by techniques more subtle than the decline of hospitalized psychiatric cases, albeit the data on hospitalization rates is useful in its own right.

Another example of increasing psychiatric commitment to empiricism is the growing number of investigations using normative samples to test hypotheses derived from our patient population seen in hospitals or in consultation rooms. Psychiatrists have studied "superior" college students (Silber et al., 1961), groups of modal or typical adolescents (Offer and Sabshin, 1969), astronauts (Ruff and Levy, 1959), Peace Corps volunteers (Fisher, Epstein and Harris, 1967), families of children with fatal illness (Friedman et al., 1963), and many others.

Although my bias toward this neo-empiricism is obvious, I wish to stress my awareness of the continuous need to generate new hypotheses and deductions. Empiricism, in isolated form, has many weaknesses and few examples of brilliance, but in psychiatry it helps provide an undergirding which most non-psychiatrist physicians take for granted. The empirical undergirding of modern medicine has been solid, even though medicine as a whole will undergo complex changes as it approaches increasingly subtle definitions of the early stages of disease.

What significance does the empiricist trend in psychiatry have for the non-psychiatrist physician, and how does it affect his role in the assessment of normal behavior? Above all, the non-psychiatrist medical practitioner is an empirical observer when dealing with human behavior. No other group in our society has greater access to direct information regarding man's attempt to cope with such a range of the exigencies of life and death. In sorting out his observations the medical practitioner is repeatedly called upon to make practical decisions reflecting his own implicit, if not explicit, perspective on normal behavior. For example:

1. Should I let this patient know that he is dying, and how can I titrate his response to my method of communicating the seriousness of his illness? He seems to be reasonably objective about himself and indicates that he prefers the truth, but is he pressing too hard?
2. Is this child retarded cognitively and behaviorally to a degree where I should commence to request special testing? He is quite persistent in learning, even though he has been a slow learner.
3. How common are these fears of sexual inadequacy, and how can I predict their long-term implications? She seems to be able to discuss them frankly and openly without apparent shame or guilt.
4. Does this university student's single experience with marijuana constitute a significant threat to his health? He seems to have been swayed by group pressure to experiment with psychedelic drugs but doesn't appear to have strong feelings one way or the other about repeating the experience.
5. Should I sedate this woman who is so grief stricken about her husband's death? She's crying a good deal, but she's beginning to talk about him in the past tense.
6. Should I give him more details about the dangers of his surgical procedure? He's not visibly anxious about the operation, but he doesn't seem to recognize its seriousness. I wish that there were family members with whom I could discuss this question.
7. Should I recommend that he take a short vacation several times a year or a longer one in the summer? He gets bored easily but, nevertheless, comes back from vacation with much energy and many new ideas.
8. It's hard to judge how uncomfortable this Japanese-American patient is in the postoperative period. He seems impassive—even apathetic—but is that unusual for a member of his group under these conditions?

Indeed, the examples that could be cited appear to be limitless. The relevance of these examples for this presentation relates to several significant points. First, none of these mini-vignettes involves behavior of a grossly abnormal variety. These are not psychiatric emergencies, nor in any of the examples is there a *clear* indication of severe pathology. Second, each of the examples could be interpreted as indicating a modicum of psychopathology. Those who subscribe to the point of view which stresses the ubiquity of pathology might overemphasize this aspect while minimizing the cues indicating coping skills evident in each vignette. The physician's decision to use a particular therapeutic strategy must involve a balancing of the significance of the adaptive forces and potential against such tendencies. Most experienced physicians, whether they are conscious of the process or not, do make such an assessment, and their actions reflect such an evaluation. A latent but functional concept of normal behavior is included in their evaluation. For example: Most young people in this town have sexual concerns, yet they seem to benefit from competent guidance; Japanese-American patients from this type of middle-class family tend to be reticent about asking for medication in the post-surgical period, yet they appreciate being offered analgesics by an interested physician; when people have ordinary grief after the death of a close relative, they seem to do better in the long run. (As long as I see signs that death is being accepted as a reality, albeit slowly, I need not try to intervene at this time.) In each case the clinical generalization may be related significantly to the physician's prior professional experiences. While his experiences may have led to idiosyncratic biases and distortions—each of us has blind spots—the essential process involves *articulation* of the concept of what is common or ordinary, in groups of individuals with the concerns of the particular patient, in order to achieve a pragmatic solution. To this extent the non-psychiatrist physician most often equates normal behavior with typical or average expectable behavior in a particular context.*

There are many problems associated with rigid adherence to this perspective. Obviously, the typical person on a mental hospital ward, in a jail, or in an institution for mentally retarded children would not be normal. Numerous criticisms have been made regarding the weaknesses of a statistical-empirical model of normal behavior by citing such discrepancies as well as other blatant problems which may evolve from equating typicality to normality. Nevertheless, the fact remains that we lack the raw data to know what is typical or ordinary in many circumstances. The neo-empiricist trend in psychiatry, as I have indicated previously, may serve to provide more of this data, and I have lauded its efforts. In my judgment, such information will have special utility for the non-psychiatrist practitioner in his day-to-day decision-making roles, and he should encourage these trends, especially when he perceives their utility for his practice. In addition to supporting such trends and being a consumer of the new data, I should like to suggest a much more active role for the non-psychiatrist physician. This change of role function is predicated on the opinion that most often the non-psychiatrist physician sees a larger sample of behavior than do his psychiatric colleagues. He observes the families who cope with a fatally ill child by normal mourning and, at the same time, provide effective support for the child; the psychiatrist's observations are skewed by those who suffer a depressive reaction in such circumstances. This distinction is a significant paradigm for the complementary skills and experiences of the non-psychiatrist and the psychiatrist.

Mention of this paradigm leads me to the central message of this presentation and what I expect might be a surprising answer to the question implicit in the title of this paper, "The Physician's Role in the Assessment of Normal Behavior"—i.e., *What is it?*" My answer to the question is that the non-psychiatrist physician should become a prime mover in clarifying the concept of normal behavior. In addition to utilizing information obtained by others, he should become increasingly capable of transferring his storehouse of latent information into explicit and manifest statements or even hypotheses. Currently the non-psychiatrist physician tends to derogate his capacity to achieve such a clarifying role as well as ask, "Where would I get the time to do it?"

The first step in developing motivation to accomplish this task involves being aware of its potential and utility. This includes the realization that no other group has more intimate access to fundamental areas of human behavior. The second step might involve recognizing that the psychiatric empiricists might serve as useful colleagues, collaborators, and allies inasmuch as this type of psychiatrist is quite likely to be genuinely interested in the primary behavioral data provided by the physician. He perceives this data as providing a potential contribution to his own concepts of both normality and psychopathology, and this possibility for greater *reciprocality* of information sharing has a good deal of significance for such a psychiatrist. Furthermore, this type of psychiatrist is very likely to be interested in community health and newer methods of health care delivery to be carried out conjointly with his non-psychiatrist colleague. The *opportunity* for sharing of

* In our monograph on normality, Offer and I (1966) have labeled this perspective "Normality as Average," as compared to the "Normality as Health" or "Normality Vs Utopia" perspective.

relevant behavioral information between a psychiatrist and his other medical associates has never been greater than in the context of community health programs. It is not fortuitous that non-psychiatrists interested in community health have a very high degree of interest in mental health and the behavioral sciences. This is the reciprocal of the psychiatrist's willingness to learn from his colleague's experiences. In the process of developing a program to meet the health needs of a specific community, there is high motivation to understand the behavioral norms within the social context of that geographic area. Such motivation bodes well for the non-psychiatrists's interest in clarifying the concept of normal behavior. The community hospital also offers an excellent arena for the delineation of health problems. Paradoxically, the university hospital with its tendency toward ultraspecialization and its lack of a geographically defined, encompassable patient population may inhibit such collaborative efforts unless unusual input is provided to make this feasible.

I look forward to the time when the non-psychiatrist appreciates the significance of his potential contribution to the assessment of normal behavior. Perhaps the day is not far off when psychiatric audiences will attend a symposium where the featured speakers are non-psychiatrists presenting data and opinions on normal behavior.

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