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Asian Indian Perceptions of Normality: A Qualitative Study

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ASIAN INDIAN PERCEPTIONS OF NORMALITY: A QUALITATIVE STUDY

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ABSTRACT

Normal mental health has always been defined from a Euro-centric worldview that excludes non-Western cultures. In fact, what is normal is biased against non-Western cultural ideals that influenced the definition of mental health. The difference between Eastern and Western cultural values suggest that the two cultures may also have differing views on the definition of normal mental health. The most commonly accepted definition of normality currently in use in the West is based on the models of health, utopia, average, transactional systems, and pragmatism. However, people from non-European cultures, such as Asian Indians, may not be represented by these current parameters of mental health and illness.

In this study, the construct of normality was investigated from an Asian Indian perspective. Specifically, interviews were conducted with Asian Indian graduate students in which participants were asked to discuss their perceptions of normal mental health. A Consensual Qualitative Research analysis strategy was then conducted. Five domains were created: Perceptions of Normal, Perceptions of Abnormal, Cause of Mental Illness, Criteria Used to Differentiate Normal from Abnormal, and Difficulties in Defining Normal. The categories within these domains were discussed as they related to psychological treatment services for international students such as well as implications for future research.

CHAPTER I

INTRODUCTION

Normality is defined by Webster (1959) as "the usual degree, condition; average or mean" (p. 552). However, a debate still exists as to how normality should be defined in terms of mental health (Mosak, 1967; Offer & Sabashin, 1991; Sinha, 1975; Steinbock, 1998). Some believe that normality, as defined to include mental functioning, does not exist and that we should move on to a new understanding of this concept (Buck, 1992; Buck, 1996, Vincent, 1990; Widiger, 1997). Despite the debate over the construct of normality, some agreement does exist as to its validity in helping the field of psychotherapy in its conceptualization of patient care (Offer & Sabshin, 1991). As Ursano and Fullerton (1991) pointed out, "psychotherapy per se, directed to the relief of pain and symptoms and the prevention of future illness, is very dependent on the concept of normal" (p. 41).

Given the present confusion about what is normal and what is abnormal in the mental health field, and given that this confusion has the potential to impair treatment, a better understanding of the construct is needed. Horton (1971) emphasized this point in his attempt at defining normality. He stated, "the term normal does not designate a valid construct, nor is there a relevant scientifically meaningful body of psychiatric knowledge from which to proceed in developing an empirically sound construct" (p. 54).

Several attempts have been made at defining normality as it relates to human mental functioning (Millon, 1983; Mosak, 1967; Offer & Sabshin, 1991). However, as noted above, there is substantial confusion about those definitions. This confusion is greatly increased when attempts are made to discuss normality as a meaningful construct across cultures. One view of normal mental health, the sociocultural perspective, is currently being used to help understand what is normal across cultures.

In the sociocultural perspective, normal mental health is viewed not only within the context of the individual and the individual's environment, but also within the individual's cultural context (Gray, 1994). According to Gray (1994),

> "The kinds of psychological distress that people experience, the ways in which they express that distress, and the ways in which other people respond to a distressed person vary greatly from culture to culture and over any given culture's history." (p. 608)

Culture-bound syndromes, which are abnormal expressions of mental health limited to specific cultures, provide evidence that these variations in normality exist across cultures.

Some examples of culture-bound syndromes include anorexia nervosa and bulimia nervosa, which are more prevalent in Western European and North American cultures in comparison to Asian cultures. Another example, koro, the belief that the penis will retract into the abdomen and cause death, is almost only existent in Southeast Asian males (Gray, 1994). In fact, the Diagnostic and Statistical Manual of Mental Disorders 4Th Edition Text-Revised (DSM-IV-TR) (American Psychiatric Association, 1999) includes a list of culture-bound syndromes in order to classify these disorders that are culturally distinct. These syndromes indicate that the differences between Asian, Western European, and other cultures may lead to differing views on what is normal, and that cultural context should be considered when determining what is normal.

Asian Cultural Context

Currently, Asian people comprise 4% of the U.S. population, or approximately 12 million people (Rajpoot, 2000). The term Asian has most commonly referred to those who hail from China, Japan, or are "Oriental" (Rajpoot, 2000). However, for the purposes of the current investigation, Asians will be referred as any number of people hailing from those aforementioned countries as well as those from the Philippines, Vietnam, Korea, India, Cambodia, Hmong, and Laos.

While the differences between Asian and American values have been investigated (Segal, as cited in Ponterotto, Casas, Suzuki, & Alexander, 1995), there is no current research indicating how these differing values may lead to different concepts of normality. Several researchers have found differences between U.S. and Asian cultural values, stating that most U.S. Asian groups focused on "collective needs, interdependency, and conformity" (p.146). White Americans tended to focus on a more "individualistic orientation . . . and on actualizing one's personal processes" (Sodowsky, Kwan, & Pannu, 1995, p. 146). Sodowsky et al. (1995) have shown that Asian concepts of normal personality and development are influenced by religions such as Buddhism, Islam, Hinduism, and Taoism as well as many others. These religions have emphasized personality traits such as "silence, nonconfrontation, and moderation in behavior, self-control, patience, humility, modesty, and simplicity" (p. 146). On the other hand, Americans have emphasized such traits as "extraversion, sociability, self-confidence, and dominance as healthy traits" (p. 146).

Given these differing cultural values one might suspect that differing views of normality exist across cultures. Several researchers have shown that normality, even in homogenous American populations, has been misunderstood, and that this misunderstanding has had a negative impact on those seeking psychological services (Jackson, 1963; Offer, Ostrov, & Howard, 1981; Rosenham, 1973). For example, Rosenham (1973) placed "normal" people into a mental health hospital and found that nurses and other staff members could not distinguish them from other in-patients. In their study of normality Hornstra, Lubin, Lewis, and Willis (1972) found that in mental health practices, patients and staff often had different views on what the therapeutic process and its goals were even about. These cases illustrate the lack of understanding by professionals of what is normal in mental health.

International Student Context

The experience of being an international graduate student may also have implications for perceptions of normality. According to recent data, there are 547,867 international students pursuing degree work in the U.S. (Yi, Lin, & Kishimoto, 2003). Evidence indicates that international students deal with the following mental health concerns: depression, time management, academic stress, homesickness, language barriers, problems adjusting to a new culture, and problems readjusting to their home culture (Yi, Lin, & Kishimoto, 2003; Komiya & Eells, 2001; Mori, 2000). International students are also viewed as having several intrapersonal dilemmas including: grief and loss, sense of inferiority, and a sense of uncertainty (Sandhu, 1994). However, despite these mental health issues, international students are reluctant to seek out psychological services (Arthur, 2004; Mori, 2000).

The lack of utilization of psychological services has been attributed to several factors. Arthur (2004) stated that international students are unfamiliar with the counseling process and that intrapersonal factors may keep them from seeking out services as well. Other researchers have indicated that international students are reluctant to self-refer for psychological services based on cultural stigmas as well as a lack of perceived support (Yi, Lin, Kishimoto, 2003; Sandhu, 1994).

The interpersonal and intrapersonal factors regarding international students' use of psychological services has led to a lack of services being provided to this population. In addition, there are variables in the counseling process that may also limit the utilization of psychotherapy within this population. Fernandez (1988) reported that the cultural differences between Asians and Americans have an impact on the counseling process as well. According to Fernandez (1988) therapy with Asian international students needs to be presented in a manner that does not focus on the Western models of counseling that emphasize self-exploration and personal growth. This may lead international students to feel vulnerable and thus impair the therapeutic process and discourage further help seeking (Fernandez, 1988).

It is suggested that models of therapy be grounded in a holistic or behavioral approach. The holistic approach adheres to the Asian cultural context in that it takes into account the interconnectedness between the individual and the larger social unit one ascribes to (Fernandez, 1988). Researchers have also indicated that the behavioral model may work well with this population because the focus is directive and emphasizes behaviors rather than feelings (Sandhu, 1994; Fernandez, 1988). Within these models, the need for the cultural context of international students' to be understood was highlighted.

Throughout the studies on international students and mental health, the awareness of the cultural context was viewed as essential in providing effective services (Komiya & Eells, 2001, Sandhu, 1994; Fernandez, 1988). Arthur (2004) stated that "international students have unique issues that require an understanding of the ways in which culture impacts the experiences of living and studying abroad" (p. 8). Despite the common issues shared by the context of international students, and the apparent solutions that can be utilized to increase their utilization of services, there are several factors that may vary across this international student group. For example, Mori's (2000) investigation into international student's mental health concerns resulted in the conclusion that data needs to be collected on variables such as religion, gender, linguistic backgrounds, and ethnicity in order for a meaningful therapeutic model to be developed. Therefore, research in the area of international students' mental health needs to examine both the commonalities and differences within this population. For the purpose of this study, only students of Asian Indian ethnicity were selected to participate.

Statement of Problem

The lack of a working definition of normality can be detrimental to psychotherapy. Furthermore, what definitions exist, often misunderstood themselves, are based on the Western cultural values from which they originated thus leaving out Asian, as well as other cultures. The intention of this research is to allow for perceptions of normality to emerge from a sample consisting of Asian Indian graduate students residing in the U.S. The goal is to then use these perceptions to increase the multicultural awareness of mental health providers regarding Asian Indian graduate students views on mental illness, with the ultimate goal of providing better psychotherapeutic services within that population.

Given the negative impact that may be experienced in therapy by applying Euro centric values in a deficiency model against other cultures, there is a need for a new exploration of what is normal and or pathological in these 'other' cultures. While several theories of normality exist, these have been used to define normality from the Euro centric point of view and were based on western cultural values (Millon, 1994; Mosak, 1967; Offer & Sabshin, 1991). Angel and Williams (2000) stated that in order to understand what is normal, or what defines mental illness, that "it is necessary to understand the culturally based schemas that give rise to explanatory models and illness labels" (p. 31). Therefore, it is not enough to have cultural knowledge in order to understand normality; people from those cultures must also be included to help us define what is normal. The meanings ascribed to the schemas used to describe what is normal within those cultures needs to be understood in order to construct a definition of normality that is truly representative.

Ursano and Fullerton (1991) stated that the construct of normality was essential to psychotherapy. Other researchers have also shown the value of the construct of normality in psychotherapy (Millon, 1983; Offer and Sabshin, 1991). While normality is viewed as vital to the process of psychotherapy, cultural value differences have influenced Asians to decline or dismiss mental health services (Laungani, 2004; Root, 1998). Given the importance of normality in psychotherapy, the lack of an Asian definition of this construct, and the rise of the Asian population in the United States, it would serve psychotherapy to find a working definition of normality for this population.

Purpose of the Study

In this study, I explored the perceptions of normality in an Asian Indian graduate student population. While the construct of normality has been cited as being useful and essential to the therapeutic process, there are no current definitions that are not based on the Euro centric worldview. The aim of this study was to provide the field of psychotherapy, and the Asian culture studied, with a culturally specific perception of normality that can be used to benefit psychotherapeutic assessment, intervention, and treatment within that population.

CHAPTER II

LITERATURE REVIEW

In the first section of this chapter, the literature on multiculturalism and Asian mental health is presented. Specifically, Asian mental health is discussed in terms of Asian mental health concerns, Asian perceptions of mental health, and Asian healing strategies.

In the second section of this chapter the various models of Normality are presented and critiqued. The models' application and limitation to the Asian Indian culture is discussed as well as possible solutions to the limitations presented. The use of Normality as a construct is also critiqued.

Definitions of Multiculturalism

The term multicultural has been defined by the American Heritage Dictionary of the English Language (2000) as "of, relating to, or including several cultures". With this as a working definition of what it means to be included in the categorization of those seeking multicultural counseling, there appears to be some recognition that this type of client differs from those who embrace a single cultural identity. Multicultural counseling was incorporated to meet the specific needs of this type of client, and provide individuals with a means of recognizing themselves in terms of their contextual/cultural relationship to the society in which they lived (Ivey, 1995). While the term multicultural incorporates many people, the focus of this paper will be on people of Asian descent. In order to provide therapy with the Asian population we then need to understand what it means to be Asian. Thus an understanding of cultural values from an Asian perspective and the interpretation of those values from a Euro centric (American) context are needed.

While as a group Asians are a diverse people with differing views and beliefs, several common values may be found (Sue, 1998). According to Sue (1998), these common values include being loyal towards parents and extended family, making family needs primary, hiding individual feelings that might cause conflict in the family, families being patriarchal in nature, having an obligation to listen to one's parents, and parents using guilt and shame to control their children. From a Euro centric viewpoint, these values are often misunderstood in the therapeutic context. Krause (1998) went so far as to state that when working with people in a multicultural setting, there is no common ground from which to build the therapeutic relationship. She also reported that she often questions whether or not she knows what is normal and what is pathological given both her own differing worldviews and the worldviews of different clients (Krause, 1998). This is an example of the cultural and institutional barriers that have been cited as one reason why Asians do not seek mental health services (Laungani, 2004).

According to Fernando (1991), "the perception of people in terms of culture is itself determined by the ways in which their culture(s) are perceived" (p. 32). From a Euro centric worldview then, certain biases are used when making determinations of normality and pathology based on differences in cultural values. Fernando cited three distinct Euro centric views of non-Western peoples during the development of models of mental illness during the 19th century. First, Rousseau's concept of the "noble savage" (as cited in Fernando, 1991) implied that "savages who lacked the civilizing influence of Western culture were free of mental disorder" (p. 33). Second, in Europe there was the viewpoint that non-westerners were mentally deficient because they lacked Western culture. Finally, in the U.S. there was the viewpoint that non-whites were mentally inferior. Here, one sees the beginning of the definitions of mental illness stemming from a Euro centric worldview whose biases remain present to this day. While this Euro centric view of mental illness exists, there is also an Asian perspective of mental illness that is in use by many non-Western cultures.

Asian Mental Health

The Asian perspective of mental health is discussed in terms of: Asian mental health concerns, perception of mental illness, and healing strategies. Asian mental health concerns have been addressed by the Chinese American Psychiatric Epidemiologic Study (CAPES) study which was conducted by the U.S. Surgeon General's Office (2001). While the CAPES study was aimed at gathering information about Chinese Americans, it provided data regarding the mental health concerns of other Asian populations as well. Asian perceptions of mental illness are discussed in terms of Asian psychological beliefs concerning the development of psychopathology and psychological well-being. Finally, Asian healing strategies are described. Specifically, meditation as a means of alleviating mental and emotional pain is discussed.

Asian Mental Health Concerns

While there are approximately 11 million Asians currently living in the U.S., very little is known about Asian mental health (Sue & Sue, 2003). However, there has been one study that investigated the mental health concerns of Asians; the CAPES study. This study, conducted by the Surgeon General's Office (2001), investigated the mental health concerns of the Asian population residing in the U.S.

The results of the CAPES study indicated that the prevalence rates of mental illness were similar to those of Caucasians. Asians were also found to have higher rates of experiencing depression in comparison to Caucasians. While depression was more prevalent among Asians, Filipino (3.5%), Chinese (8.1%), and Japanese (9.1%) populations had a significantly lower suicide rate than Caucasians (12.8%) (U.S. Surgeon General, 2001).

The CAPES study also found that there were several Asian populations that were at higher risk for severe disorders (U.S. Surgeon General, 2001). Many Southeast Asians are at risk for post-traumatic stress disorder (PTSD). Approximately 70% of Southeast Asians who were receiving mental health services met the criteria for PTSD due to trauma suffered both before and after entering the U.S. More specifically, 50% of Cambodians who fled Pol Pot's regime were found to be suffering from PTSD and approximately 41% were suffering from depression (U.S. Surgeon General, 2001). While this study focused on Asian mental health concerns it did not offer information about Asian perceptions of mental health or healing strategies, and represented a Western worldview of Asian mental health.

Asian Perceptions of Mental Health

Asian views on normal and abnormal mental health are best viewed from a developmental perspective (Walsh, 2000). From this point of view, psychopathology occurs when an individual fails to progress through both personal and transpersonal stages of development. Walsh (2000) described the personal, or conventional stage of development, as the time in ". . . which we establish a more coherent sense of self and largely accept the conventional cultural view of ourselves and the world" (p.409). Transpersonal development involves self-transcendence and allows one to have a broader experience with one's inner and outer world.

Development of Psychopathology

According to Asian psychological beliefs, while personal development is important to psychological health, it is believed that problems in transpersonal development are the most frequent cause of mental illness (Walsh, 2000). Asian beliefs about mental illness focus on delusions, cravings, and aversions as the factors involved in the hindrance of transpersonal development (Walsh, 2000). These factors are seen as being responsible for stunting the process of mental and spiritual development that leads to psychological well-being.

From the Asian psychological perspective, a delusion is considered to be a kind of "mental dullness or mindlessness that misperceives and misunderstands the true nature of mind and reality" (Walsh, 2000, p. 422). Delusions cause a transpersonal dilemma in that they do not allow one to truly experience the inner and outer world and therefore hinder self-transcendence. These misperceptions can lead to other psychological problems such as cravings and aversions.

According to Walsh (2000), cravings are viewed as the second factor involved in the development of psychopathology. Cravings occur when one is focused on possessing certain stimuli. When the stimuli are not possessed cravings lead one to experience emotions such as fear, anger, jealousy, and depression. Walsh indicated that the following process takes place when cravings are unmet:

> "We fear that we will not get what we crave, boil with anger toward whoever stand in our way, writhe with jealousy toward people who get what we lust after, and fall into depression when we lose hope." (p. 422)

When these cravings are unmet, and the process of emotions that leads to depression takes place, attachments are developed. These attachments are defined as a compulsive need to experience and possess the desired stimuli and produce aversions.

Aversions are the opposite of attachments. Walsh (2000) stated aversions create a "compulsive need to avoid or escape undesirable stimuli". When trying to avoid these undesirable stimuli, one could experience emotions such as anger, fear, and defensiveness.

Together, delusions, cravings, and aversions create a mental and emotional imbalance. This imbalance is the cause of psychological pain and results in psychopathology if dismissed. From an Asian psychological viewpoint, this pain is an opportunity for the individual to recognize the entrapment of cravings and aversions and make changes in their lives. While Asian psychologies have defined the path to mental illness, they have also described the methods one can use to maintain psychological health.

Psychological Well-being

From an Asian perspective, psychopathology exists when one falls prey to the trappings of material existence and fails to emphasize the transpersonal. Therefore, psychological well-being depends upon the development of the transpersonal self. The psychologically healthy person is described as one whom: steers clear of delusions, cravings, and aversions; develops particular fit mental traits and capacities; and matures to a transpersonal level of development (Walsh, 2000).

Given the variety in Asian psychology, i.e. from Buddhist teachings to Hindu texts, there are several different sets of fit mental traits that one should strive towards in order to reach transpersonal maturity. However, there are seven qualities that appear to be agreed upon as the basic tenets of achieving transpersonal maturity (Walsh, 2000). These qualities include: ethics, emotional transformation, redirecting motivation, training attention, refining awareness, wisdom, and altruism and service (Walsh, 1999).

Ethics. From an Asian psychological perspective, ethics comprise a set of beliefs and actions that allow one to bring joy to others, and allow the self to heal. By performing ethical acts such as kindness, generosity, and compassion the self counteracts the effects of unethical behaviors (Walsh, 1999). These ethical actions heal the mind and soul by creating a positive psychological imprint on one's soul.

This concept of determining the state of one's soul based on past behaviors is *karma*. By creating good *karma,* ethical behaviors contribute to one's ability to reach the transpersonal level of existence. Therefore, psychological well-being is achieved by eliminating the toxic effects on one's soul that would be caused by an unethical existence, where one causes harm to self and others.

Emotional transformation. The second quality that one must possess in order to reach the transpersonal level of development is emotional transformation. An emotional transformation involves the process of reducing painful feelings (i.e. hate, jealousy), cultivating positive feelings (i.e. love, happiness), and developing equanimity (Walsh, 1999). The belief here is that feelings play an important role in how we think and act.

By reducing painful feelings and promoting positive feelings, one views the world as a nurturing rather than intimidating environment. One must develop equanimity then in order to maintain positive emotions despite the negative situations that one will inevitably be exposed to. When this type of worldview is achieved, one where love and hope are present, psychological well-being is promoted.

Redirecting motivation. The third quality needed to achieve transpersonal maturity is redirecting motivation. In the quest for true happiness and love people often are mistaken as to what will bring about these states. People often choose to attach themselves to others and material possessions in order to find happiness. However, these external motivations lead to cravings and attachments which are primary contributors to mental illness (Walsh, 2000).

According to Asian psychology, in order to find true happiness and achieve transpersonal growth one must change motivation. One needs to cease finding happiness through attachments and giving into cravings, and find inner motives towards achieving this goal. Through the use of mediation, and utilization of the principles of an ethical existence and emotional transformation, one can begin the process of redirecting these motivations. The goal is to shift from external motives to internal ones such as self-transcendence and self-actualization in order to become closer to the transpersonal (Walsh, 2000).

Training attention. The fourth quality of transpersonal maturity, training attention involves the process of learning how to concentrate and focus one's mind. Asian psychology posits that the uncontrolled mind can lead to mental illness while the attentive mind can promote psychological well-being. This conviction stems from the belief that the mind takes on the qualities of whatever stimuli one attends to.

Based on this belief, if one attended to anger or violence one's mind would be saturated with anger. Conversely, if one's mind attended to a caring individual the mind would be filled with love. The ability to train one's attention then could determine the psychological state one was in. According to Walsh (2000), "The person who can control attention can therefore control and cultivate specific emotions and motives" (p. 425). The ability to control one's mind allows one to focus attention on positive stimuli such as love and happiness which, in turn, allows one to become psychologically healthy.

Refining awareness. The fifth quality involved in Asian psychological well-being is refining awareness. Asian psychologies believe that mental illness can occur because one's inner and external perceptions are not functioning at their true potential. Perceptions are considered to be driven by one's thoughts and desires. Therefore, one can create an illusion of reality based on one's faulty inner perceptions.

According to Asian psychologies, faulty perceptions caused by a lack of awareness lead to the states of absentmindedness, self-alienation, and automaticity (Walsh, 1999). Absentmindedness includes those moments where one is caught up in one's own thoughts and unaware of the situation at hand. Self-alienation involves a sense of loss of identity and a depersonalization of the self into object form. Automaticity takes place as one wanders robotically, or automatically, through life.

Together, these states of absentmindedness, self-alienation, and automaticity contribute to a veiled existence. This type of existence impairs one's ability to be present in the world by creating a distortion of reality. Asian psychologies posit that being mindful will allow one to bring enough awareness to the self so as to combat these distortions and live a psychologically healthy life. So how does one become mindful?

Mindfulness involves the process of being attentive to each moment in the present. Along with being attentive, mindfulness also involves the process of being more aware of one's activities. According to Walsh (1999), mindfulness has five benefits that lead one to closer to the transpersonal level of existence. These include: interpersonal sensitivity, refining the senses, knowing one's mind, freedom from automaticity, and the healing power of awareness.

Interpersonal sensitivity takes place when one is mindful because one is more present in social interactions. This allows one to be more sensitive in these situations and pick up on social cues that would otherwise be ignored. By doing so, one is able to reflect empathy which in turn allows one to develop healthier relationships with the self and others.

Refining one's senses is made possible by mindfulness as one is challenged to bring each sensory experience to a level of awareness. Refining the senses brings about psychological well being in three different manners. First, it allows one to experience enhanced pleasure and appreciation of each moment. Second, cravings are reduced because each moment is more satisfying. Finally, beneficial exercises such as concentration and calm are brought about through the process of refining the senses, which further enhances the ability to be mindful.

Mindfulness also enhances one's ability to know one's own mind. Knowing one's mind involves the process of delving into the unconscious in order to bring about greater awareness in the conscious. In Asian psychologies this is done through the practice of meditation.

There are two types of meditations, *concentration* and *awareness* (Walsh, 1999 Others view meditation as a combination of concentration and mindfulness, which is the end result of increased awareness (Goleman & Epstein, 1983). Concentration meditations focus one's mental and emotional energy on one thought or object. This type of meditation may also focus on breathing or on mantras, sacred verbal formulas that are repeated, in order to help train one's mind. Awareness meditations allow one to focus and shift attention from one object to another. Meditation as a therapeutic method is discussed in detail in the section on Asian healing strategies.

These two meditative practices allow one to examine the unconsciousness and free oneself from unconscious motives. Once free, the mind is able to increase awareness in the conscious thus allowing the self to be less driven by unconscious motivating forces.

This increased awareness can lead to psychological well-being as one is no longer functioning automatically, but rather making conscious, aware, decisions.

As awareness increases, one can escape the cycle of stimulus-response that creates a state of automaticity. Asian psychologies believe that one is motivated by the stimulus-response mechanism. In this mechanism, stimuli create feelings, which then give rise to cravings and aversions. In this sense, one responds automatically to any given stimulus.

While the cycle of stimulus-response is automatic, it can be stopped (Walsh, 1999). According to Asian psychologies, utilizing awareness at the moment stimuli are presented can allow one to take conscious control over the feelings that arise. This awareness can reduce cravings and aversions and eliminate the conditioning process that takes place. By stopping the automatic responses, awareness leads one to live a less automatic life and increases personal freedom.

Increased awareness can also be beneficial in that it increases mindfulness (Walsh, 1999). Mindfulness allows one to recognize choices that lead to emotions such as anger, fear, and frustration. Together with awareness, mindfulness works to stop these emotions from strengthening in the unconscious by bringing them into our conscious thought processes. According to Buddhist philosophy, one of the major contributors to Asian psychology, mindfulness has three major advantageous properties that lead to the *healing power of awareness*. Walsh (1999) stated that these properties include:

> "inhibiting unhealthy qualities such as greed and anger, cultivating and strengthening healthy qualities such as joy and love, and promoting the optimal balance of healthy qualities." (p. 183)

Refining awareness can be healing and is an essential component of maintaining mental health. Through the practice of meditation, one can begin to reap the benefits of mindfulness by becoming more self-aware of the decisions one is making in life. The goal of refining awareness is met when one can utilize meditation in order to reduce harmful feelings such as anger and frustration by allowing oneself to become aware of where these feelings arise from and to gain more self control in decision making.

Once self control is established, and the processes of absentmindedness, self-alienation, and automaticity cease, one can strive towards self-transcendence which leads to psychological well-being. While the knowledge of self is important, one must also be able to have a deep understanding of the meaning of life's other questions. This type of awareness is cultivated through wisdom.

Wisdom. Wisdom is the sixth quality one must possess in order to achieve and maintain psychological well-being. Asian psychologies posit that one must be able to have a profound understanding of existential issues in order to be psychologically healthy. The ability to understand these existential issues is considered wisdom. These existential concerns include: freedom, isolation, meaninglessness, and death (Yalom, 1980).

Wisdom is composed of two individual, but coupled pieces. The two pieces of wisdom include a visionary or understanding aspect, and a practical or applied aspect (Walsh, 1999). One must develop each of these pieces in order to achieve wisdom.

The visionary aspect of wisdom involves the process of understanding what lies beneath the surface of things. Typically, one can have knowledge of something through simple observation and categorization. However, wisdom is not achieved until the underlying meaning is found. Vision in this sense allows one to develop a clear concise view of what things are, which then leads into understanding.

According to Walsh (1999), understanding goes beyond vision in that it "involves the process of analyzing and investigating the way things are" (p.217). Through the use of analysis and investigation, wisdom identifies means of living a psychologically and spiritually healthy existence. One is able to use vision to identify stimulus-response dynamics as well as develop insights as to why these dynamics exist. So what exactly does one need to investigate in order to develop wisdom?

The visionary aspect of wisdom explores three areas: life, mind, and the nature of reality (Walsh, 1999). The exploration of life consists of an investigation into the causes of happiness and suffering. Wisdom allows one to recognize that life is full of strife and pain when one operates from greed and envy. On the other hand, wisdom also allows one to know that psychological and spiritual well-being can be achieved by living an ethical and generous life. With the knowledge of what causes happiness and suffering, wisdom guides the individual towards a better way of life.

Wisdom also comes about through the examination of the mind. The mind is viewed as the most powerful force in determining the way one thinks, feels, and acts. Wisdom allows one to respect this power and thus forces one to learn how the mind works. Wisdom is enhanced by both the knowledge and the subsequent training of the mind that the individual embarks upon to improve one's life.

Wisdom is also utilized to gain a deeper understanding of the nature of reality. The exploration of reality through wisdom allows one to delve deeper into nature than the average person, and thus many otherwise unknown meanings become clear. However, one also learns that knowledge only advances the mind to a certain limit and the recognition of this further develops wisdom (Walsh, 1999).

The practical or applied aspect of wisdom is developed from the visionary aspect. Practical wisdom comes from living one's life according to what one has learned through visionary wisdom. The knowledge gained from exploring the mind, life, and nature of reality are applied to daily living. This type of life is typified by living harmoniously with others and following ethics and morals, and brings one closer to all of nature. According to Asian psychologies, this connection with nature allows one to transcend personal goals and focus on collective ones. Through this transformation of individualism to collectivism one begins to operate on a more transpersonal level which increases psychological health.

Altruism and service. Wisdom guides one towards the practice of altruism and service, the seventh quality of Asian psychological well-being. The focus now is on providing for others vs. the self. The act of giving creates happiness in others and strengthens one's own feelings of providing pleasure to others. This process also combats negative thoughts and emotions such as greed, anger, frustration, and envy.

The seven qualities agreed upon by Asian psychologies as essential to promoting psychological well being -- ethics, emotional transformation, redirecting motivation, training attention, refining awareness, wisdom, and altruism and service -- work in tandem to instigate a change in the self. Asian psychologies posit that this change is needed because people must strive towards an ideal state and away from the flawed state most are in. Once this ideal state is reached within the individual, one will be able to live a more psychologically healthy life. However, not all are capable of reaching this ideal state. What do Asian psychologies suggest for those who are not able to develop these qualities and therefore develop mental illness?

Healing Strategies

Asian philosophy and psychology converge in their thoughts regarding the cause of mental illness. In both Asian philosophy and psychology mental illness is primarily believed to develop from a lack of balance between unhealthy and healthy mental qualities (Goleman & Epstein, 1983; Walsh, 2000). According to Asian psychology, the mental qualities described in the previous section including: ethics, emotional transformation, redirecting motivation, training attention, refining awareness, wisdom, and altruism must outweigh negative factors such as delusions, cravings and aversions, in order to achieve a state of mental and emotional balance that leads to mental health.

The primary means to achieve balance is through use of meditation. The use of meditation as a healing strategy stems primarily from Buddhist philosophy. The main goal of Buddhism is the reduction of human suffering, and currently 350 million Buddhists are practicing throughout the world. While meditation is widely used as a healing strategy, other healing strategies are utilized amongst different Asian populations. The following therapies are introduced, along with meditation, as examples of other Asian healing strategies: Demonological Therapies, Ayurvedic Therapies, Ayurvedic Dietary Prohibitions and Prescription, Yoga Therapy, and Religious Counseling.

Healing through Meditation

Meditation is the practice of training and maintaining attention (Goleman & Epstein, 1983). The purpose of meditation is to allow the mind to become more aware of both the positive and negative emotive states one may be experiencing at any given time. Once the mind is aware of the status of these emotional, mental, and physical states, the mind can adjust thoughts and behaviors to maintain balance and increase psychological well-being. This balance is achieved through the process of replacing a negative factor with its' opposing positive factor (Goleman & Epstein, 1983). Once the positive factor is present, the negative factor is inhibited and the result is psychological health. The two meditative strategies that are applied to reach this balance include: concentration and mindfulness.

Concentration. According to Goleman and Epstein (1983), the goal of concentration is to focus one's awareness on a single target. However, this is a difficult process because the mind tends to lack the ability to stay focused on single target for extended periods of time. Intrusive thoughts, feelings, and desires, and perceptions enter the process of concentration and cause one to lose focus (Goleman & Epstein, 1983). Therefore, one must repeatedly work on developing the skill of concentration in order to achieve mental health.

There are several factors, also known as the Five Hindrances, that contribute to difficulties in concentration including: lust, ill will, sloth and torpor, agitation and worry, and doubt (Goleman & Epstein, 1983). These factors hinder the ability to concentrate in that they interfere with one's ability to focus on the target and redirect the mind to these distractions. While these factors exist, there are also complementary positive factors that can be developed as concentration increases. These positive factors include: resolution, energy, willingness, attention, joy, rapture, and one-pointedness (Goleman & Epstein, 1983). These positive factors need to simultaneously work together to combat the negative factors.

Goleman and Epstein (1983) stated that each of the positive factors contribute to concentration through their ability to counteract negative factors (See Table 1). While resolution and willingness do not play a specific role in counteracting negative factors, they still provide resources in the effort to achieve concentration. The purpose of resolution is to provide the necessary energy required of long periods of concentration. Willingness directs the mind to the focus of a single target.

Table 1. The Five Hindrances and Complementing Factors of Absorption.

Five Hindrances	Factors of Absorption
Sloth and Torpor	Applied Attention
Doubt	Sustained Attention
Agitation and Worry	Joy
Ill will	Rapture
Greed and Lust	One-pointedness

Goleman and Epstein (1983) stated applied attention allows one to focus on the target and keep it there, and combats the effects of sloth and torpor which attempts to make the target seem unwelcome. Sustained attention keeps one's mind on the target of concentration and minimizes the impact of doubt, which influences one to be indecisive and move from target to target. Joy allows one to take pleasure in the target and combats the effects of agitation which is characterized by worry and restlessness. Rapture allows one to become fascinated with the target, and diminishes the effects of ill will which makes the target appear unpleasant in the mind.

The purpose of one-pointedness is to provide fixation of the target in the mind, and counteracts the effects of greed and lust which constantly seek out other forms of pleasure to distract the mind. The factors of applied and sustained attention, joy, rapture, and one-pointedness, also known as the Factors of Absorption, counteract the negative aspects of the Five Hindrances and allow one to maintain a focus on a single target. Once these positive factors diminish the impact of the Five Hindrances, the meditative strategy of concentration is initiated (Goleman & Epstein, 1983).

The meditative strategy of concentration progresses through several stages. These stages include access concentration and Jhana. These stages are characterized by their frailty in that the benefits of concentration will dissipate rapidly unless one continues to practice.

Access concentration is the 1st stage of concentration. This stage is the first point where one experiences the ability to remain focused on a target (Goleman & Epstein, 1983). However, this stage is short-lived due to the propensity of the mind to wander. Here, the factors of absorption are not developed well enough to keep one's concentration focused for a long period of time. Despite this lack of full concentration, this stage marks the beginning of one's ability to attain and remain focused on a target. With continued practice one advances to the next stage of concentration, Jhana.

Jhana is identified as a trance state in which one becomes fully consumed with the focus of the target. This stage involves a split from consciousness into a trance like state. Here, the negative factors are diminished by the positive factors and the mind is able to concentrate fully. According to Goleman and Epstein (1983), this first experience with jhana is also short-lived, but with practice can become a state of concentration that one can enter when one chooses to do so.

Once jhana is perfected, other benefits include the development of the four "illimitables" or measureless states (Goleman & Epstein, 1983). These four states include: compassion, joy, all-embracing kindness, and equanimity. The purpose would then be to practice concentration exercises that allow one to express these "illimitables" to others.

While proficiency in concentration has many benefits, there remain some limitations as to its effectiveness as a complete healing strategy. Concentration is effective in weakening the negative factors only as long as the meditator remains in the jhana state. It is inevitable that the meditator will leave the jhana state and at that point the negative factors will reemerge. This is due to the nature of the negative factors.

Goleman and Epstein (1983) stated the negative factors function at three different levels. These levels include:

"Transgression in deeds or in speech, transgression in internal thought processes (where, for instance, hatred will be felt towards a person, but not acted upon), and a latent potential for such factors to arise if the appropriate situation occurs." (p. 243)

In order for psychological growth to occur, it is not enough that transgressions in deed or speech and in internal thought processes be eliminated. The latent potential of these factors must also be addressed. While concentration allows one to momentarily curb negative factors, it does not address the latency issue. In order to achieve psychological well-being, the root cause of the problem must be taken into account. This is done through the process of mindfulness.

Mindfulness. One can achieve psychological health through the meditative strategy of mindfulness. Mindfulness eliminates the latent nature of negative factors through the development of insight. Asian philosophy and psychology believe that the use of insight can lead to Nirvana. Nirvana is considered the highest state of being one can achieve and at this point all negative factors that could influence the mind cease to exist (Goleman & Epstein, 1983).

Mindfulness and insight are separate, but connected. Mindfulness involves the recognition of several occasions of consciousness. Insight involves the analysis of those occasions (Goleman & Epstein, 1983). The development from mindfulness to insight occurs when the meditator can remain attentive to the constantly changing aspect of one's consciousness without giving in to any diversions.

The meditator can utilize many skills in order to refrain from giving in to diversions. When practicing mindfulness, the meditator initially focuses on what is most distinct in one's consciousness (Goleman & Epstein, 1983). The meditator may focus on a primary object such as a Mantra, but still pays attention to other sensations and thoughts that surface in one's awareness. According to Goleman and Epstein (1983) the goal is not to condense awareness to a solitary target, but to pay attention to the variability of the consciousness. With practice, the meditator can pay attention to the variance present in the mind from the beginning of meditation without becoming too distracted by them. The goal is to then gain some meaning from these distractions in order to strengthen the mind. From this process, the mind develops positive factors that facilitate one's ability to achieve balance and mental health.

Goleman and Epstein (1983) stated that five faculties arise when one can master mindfulness. These include: faith, energy, wisdom, mindfulness, and concentration. These factors provide the meditator with the vigor, proficiency, and self-assurance needed to progress towards insight. If these factors are not developed in a balanced relationship to one another, the result is a lack of progress. Mindfulness is utilized as the balancing force that is required to keep these factors properly aligned in order to achieve insight.

The development of insight transpires through four stages. These stages include: observation of the distinct, purification of the mind, purification of the view, and overcoming of doubt. One progresses through the various stages of insight as one develops the skills required of each preceding stage.

The first stage of insight involves the observation of the distinct. This initial stage allows one to become aware of objects in the mind. Once this initial awareness can be mastered, one can progress to the next stage of insight.

In the second stage of insight, purification of the mind, mindfulness is further enhanced. At this stage, one can instantly recognize any off course thoughts, and achieve a momentary respite from negative factors. One's progress to the next stage of insight is determined by the ability to recognize each and every instance of awareness in order without any deviations (Goleman & Epstein, 1983).

The third stage of insight is known as purification of view. According to Goleman and Epstein (1983) this stage is marked by the meditators ability to:

> "perceive consciousness and its object as clearly distinct phenomena arising and passing away together in each moment." (p. 245)

Here, the meditator realizes that there is no "self" and that there is only the "voidness of self" (Goleman & Epstein, 1983). This realization allows the meditator to utilize insight as a means of understanding the consciousness.

The fourth and final stage of insight, overcoming of doubt, occurs when insight has reached a state of fervor. Here, the meditator is able to determine how each thought enters one's mind. As insight is developed further, the meditator understands the three traits that are intrinsic features of all events: impermanency, insubstantiality, and suffering (Goleman & Epstein, 1983). Once the meditator achieves an understanding of these concepts, a level of confidence permeates within that allows one to eliminate feelings of doubt related to how much one knows about the workings of the mind.

The ability to eliminate doubt allows one to hamper the three primary negative factors of cravings, delusions, and aversions. When the meditator can do this, insight is further enhanced. With the weakening of the negative factors and increased insight one can potentially reach the ideal state of Nirvana, or enlightenment (Goleman & Epstein, 1983). This stage of being is considered the ultimate goal of Asian psychological health, and stems largely from Buddhist philosophy. While the stage of enlightenment is considered the ideal, and meditation is viewed as the primary means to achieve that state, there are strategies that provide healing through other means and have different goals.

Demonological Therapies

The use of shamans as a healing method is one option available to Asians. Shamans are traditional healers who utilize various techniques to help free people's minds from possession. According to Laungani (2004) the main goal of demonological therapies is to

> "Cure a person of any serious psychological or psychotic disorder, the underlying basis of which may be possession of the afflicted person by a devil, a malevolent, demonic spirit or *shaitaan*." (p. 142)

Some Asians believe that possession by these devils or demons is caused by several factors. The factors that have been attributed to possession include excess wealth or health, greedy behaviors, inappropriate sexual conduct, poor family dynamics, and addictions (Laungani, 2004).

There are several illnesses and symptoms that are seen as the consequence of having this type of demonic possession. According to Laungani (2004), some Asians believe that the presence of unexplained illnesses, depression, impotence, rashes, raging temperatures, and smallpox can be explained by demonic possession. However, while the patient may have displayed behaviors that were counter to the Asian philosophy of psychological well-being (i.e. giving in to cravings) the patient is seen as an innocent victim of these demons that have taken over the mind.

Indigenous Ayurvedic Therapies

Ayurveda is considered the traditional model of medicinal healing utilized in India. According to Laungani (2004) the goal is to maintain one's mental, emotional, physical, and spiritual balance. Indians believe that this method of healing is based on the interconnectedness between nature and life. Illness occurs when there is an imbalance of humoral factors in one's life (Laungani, 2004). The emphasis of treatment then is to understand the person and the illness in order to help them achieve balance once again.

Ayurvedic therapies primarily focus on purification as the means to achieve balance. In the past, Indian's utilized techniques such as purges, emetics, enemas, and bleeding to purify. The present state of Ayurvedic medicine consists of utilizing herbal remedies (Laungani, 2004).

The goal of Ayurvedic therapy is to achieve balance. Since there are so many facets of a person that may be out of balance, there are a wide variety of prescriptions that one is recommended to follow. According to Laungani (2004), patients are encouraged to practice breathing exercises and physical exercise. Patients are also prescribed personal and social goals which train one on how to maintain balance with the self and others. These prescriptions may include a mandate such as refraining from self abuse by not living a life of overindulgence. Considerable importance is also placed on diet which is based on the Asian belief that some foods possess certain characteristics (both negative and positive), and should therefore only be consumed at prescribed times.

Ayurvedic Dietary Therapies

Asian Indians seeking therapy will often ask for therapeutic guidance in relation to their diet (Laungani, 2004). In India, Hindu's adhere to strict dietary restrictions based on the belief that certain foods posses certain qualities that can impact a person. According to Laungani (2004) Hindus categorize food based on pollution, cold, hot, sour, and those that have distinct associations with mental and emotional states.

Hindus' conception of polluted food is broken down into a matter of varying degrees. Laungani (2004) stated food that has been cooked is considered more of a pollutant that fresh food. Also, foods that have been cooked by a member of a lower caste and offered to a higher caste are polluted since any contact with a lower caste member is considered polluting.

Hindus also adhere to social rules which guide their concepts of pollution. According to Laungani (2004) Hindu's will not touch food eaten by others, eat off a plate shared by others, or share a glass with another. Another social rule to avoid pollution is to wash one's hands before eating, and not washing the hands after eating is seen as polluting. The degree to which food is polluted is of utmost importance in the Hindu belief system as to how one can maintain psychological, physical, and spiritual health.

Hindus also categorize food into cold, hot, and sour. According to Laungani (2004) Hindu's believe the following:

> "Cold foods, such as rice, yoghurt, oranges, buttermilk etc. are considered to have a cooling effect on the body; hot foods, such as meat, eggs, mangoes and certain vegetables are considered to have a heating effect on the body; and sour foods

such as lemons and tamarind, tend to create gases and stomach upsets in the body." (p. 147)

The healer can utilize these various beliefs in order to prescribe a diet that counteracts the patient's current illness. For example, if the patient complains of an upset stomach the healer can prescribe a diet that eliminates foods that are sour.

Hindus also believe that some foods impart their characteristics upon the consumer. Laungani (2004) stated that foods known as *rajas* are believed to increase compassion and lust. Consumption of meat was believed to cause dullness of the mind and body and is considered *tamas*. Other foods, referred to as *sattvic*, which include rice, wheat, and most vegetables are believed to produce accord and balance and are deemed the most useful in achieving psychological well-being.

Hindus who adhere to traditional beliefs feel that any deviation from proscribed diet could lead to mental illness. Therefore, the healer should be able to recognize this belief system and address it with Indian's seeking psychological services. In order to remove the illness, dietary consumption and restriction may be prescribed that will enable the client to achieve balance once again.

Yoga

Asian Indians often turn to the practice of yoga in order to treat their psychological disorders. In fact, it is the most popular form of treatment for psychological disorders in India (Laungani, 2004). The practice of yoga is based on the principle of detachment. At the base of yoga philosophy is the idea that one should reject a lifestyle that focuses on possessions.

Yoga is used to control one's thoughts and feelings in order to achieve a higher state of consciousness. Laungani (2004) stated that yoga is:

> ". . . a discipline of asceticism, renunciation, and meditation, which through sustained practice leads to spiritual experience and enlightenment into the nature of existence." (p. 151)

In order to achieve this higher level of existence, one needs to master the eight aspects of the yogic path, which include: yama (moral restraint), pranayama (breath control), prayahara (sense withdrawal), asanas (bodily postures), niyama (practice of virtues), dharana (concentration), dhyana (meditation), and samadhi (state of trance) (Laungani, 2004). Yogic healing theory posits that when these eight aspects are developed one diminishes the causes of mental illness.

Religious Healing

Yoga and meditation are used throughout Asia as a means of treating mental illness. However, these practices are useful when one believes that one is responsible for his or her current psychological state. As in the case with demonological theories, religious healing strategies place the cause of illness on some higher being or deity.

When seeking religious healing for mental illness, Indians seek out Hindu shrines or Muslim dargas. At these locations, gurus are empowered to provide spiritual guidance to the afflicted in order to relieve symptoms of illness (Laungani, 2004). Gurus are given complete control and may prescribe prayers, pilgrimages to holy sites, meditation, and the performance of religious rites in order to achieve psychological health.

The guru and the afflicted utilize the relationship as the primary means of therapy. The guru takes a teaching approach and instructs the afflicted with how to proceed. The guru guides the afflicted through all his or her symptoms of illness and offers prayers in order to instill hope. The afflicted then must follow all of the guru's instructions in order to be healed.

The guru must also possess certain qualities that will ensure the success of the therapeutic venture. Afflicted people must view the guru as learned and astute. The guru must also be perceived as someone who has no materialistic needs and also has no desire to achieve financial gain in the healing process.

Asian mental health has been discussed in terms of mental health concerns, development of psychopathology, psychological well-being, and healing strategies. Throughout Asian psychology, there is an emphasis on achieving mental, emotional, and spiritual balance in order to maintain psychological health (Laungani, 2004; Walsh, 2000). The Asian model of mental health emphasizes control of the mind as the primary means of minimizing the potentially harmful effects of various thoughts and actions that may contribute to an imbalanced state. Although these models focus on balance and indicate that the lack of balance contributes to psychological illness, these models do not specifically address the issue of normality. Yet, there may be parallels between the Asian perceptions of balance and Western perceptions of normality. The next section of the literature review discusses models of normality from a Western cultural viewpoint.

Models of Normality

Offer and Sabshin (1991) stated "No concise knowledge of the variations of normality or healthy functioning has yet been developed" (p. xii). While the construct of normality is imperative to psychotherapy, there is still much confusion as to what this construct means. Despite this confusion, several definitions of normality have been proposed, including those of: Offer and Sabshin (1966), Jeger and Slotnick (1982), Mosak (1967), Millon and Davis (1994), and Husserl (as cited in Steinbock, 1998) (see Table 2). The remainder of this chapter will describe each of these models, examine their strengths and weaknesses, and assess their application for Asian populations.

Offer and Sabshin's Model of Normality

Offer and Sabshin (1991) based their definition of normality on five perspectives. These included: normality as health, normality as utopia, normality as average, normality as transactional systems, and normality as pragmatism. According to Strack and Lorr (1994), Offer and Sabshin's (1991) definition of normality is one that most broadly covers the range of definitions present in the field of psychology, and appears to be the definition that is the most accepted in the literature today.

Offer and Sabshin (1966) identified these five perspectives of normality through a synthesis of the various disciplines that discussed normal behaviors. Therefore, this was not an empirical approach to defining normality. Rather, it was more an attempt to compare and contrast differences about what constituted normal behavior in the disciplines of medicine, psychiatry, psychology, psychoanalysis, anthropology, sociology, and biology (Offer & Sabshin, 1974).

The goal was to develop a working definition of normality based on the theories of normality within each of these disciplines. According to Offer and Sabshin (1974), it was emphasized at the conclusion of the synthesis that ". . . at the present stage of knowledge, the distinctions between normal and healthy states of behavior are based on hypotheses rather than on empirical evidence" (p. xvi). The following definitions of normality lack empirical support; health, utopia, and transactional system, but have sufficient theoretical cross-discipline support to validate normality as a construct (Offer & Sabshin, 1991). Empirical evidence for the normality as average perspective is provided in a single study.

Normality as health is a perspective that defines what is normal based on the absence of symptomatology. This is consistent with the medical model of normal health, in which one is normal if free of symptoms of disease. From this perspective health is described as a reasonable state rather than an optimal state. Physicians favored and most frequently used this definition of normality (Offer & Sabshin, 1991).

The normality as health perspective is observed across several disciplines. The medical model viewed the normal person as someone who is free of undue pain, discomfort, and disability (Barton, 1958; Spitzer & Endicott, 1978). From the psychoanalytic perspective, Alexander (1963) believed that the normal psyche was one that was analogous to a democratic government and neurosis was caused by an autocratic government. Alexander (1963) stated, a normal person had ego functioning that allowed one to remain free of coercion and anxiety (freedom from disease) caused by the autocratic state. Support from an anthropological perspective is found as normality is viewed as the ability to maintain positive interpersonal relationships, which is a reasonable state given that most people achieve this, and keeps one free of symptoms of illness (Hsu, 1961; Linton, 1956). Normality as health is also supported by the biological perspective postulated by Kallmann (1959). Classical genetic theory, which Kalmann (1959) subscribed to, proposed that abnormality was caused by genetics and not the environment. Therefore, people are normal if they show a lack of genetic inherited symptomatology.

The normality as utopia perspective is based on an ideal state of existence that few people ever achieve. Kendell (1975) stated that this perspective has been criticized because of its dependence on a state that cannot be achieved. The ideal state is considered the optimal level of functioning and is described as self-actualization.

This utopian perspective of normality is favored by some psychoanalysts and fits well with other theories of personality including Rogers and Maslow (Offer & Sabshin, 1991). Most psychoanalysts believed that all egos suffered from trauma. Therefore, no perfect ego could exist, and normality was viewed as a utopian state that could never be achieved (Freud, 1962; Hartmann, 1958; Money-Kyrle, 1955). The psychological theories of Rogers (1959) and Maslow and Mittleman (1951) describe the healthy person as someone who strives toward an ideal or optimal state of functioning (i.e. through self-actualization) that is rarely achieved. These theories utilize a psychological ideal that is not achieved by most people and shares similarities with the utopian model of normality.

Normality as a transactional system is based on a more developmental, rather than static concept of normal. Offer and Sabshin (1991) stated that this idea of normality incorporated both adjustment and adaptation over time into its definition. From this definition, normal individuals are those who adjust and adapt to the changes in their environment while those who are abnormal fail to do so effectively. The important difference here, in comparison to other definitions of normality, is that normal functioning is examined and determined across time.

Table 2. Authors, Method of Model Development, and Definitions Generated.

Authors	Method	Definitions of Normality
Offer and Sabshin (1966, 1974)	Synthesis	Health Utopia Average Transactional System Pragmatism
Jeger and Slotnick (1982)	Synthesis	Biological/Medical Psychodynamic Behavioral/Learning Humanistic Social/Sociocultural
Mosak (1967)	Clinical Observation	Frequency Other-as-Referent Therapist-as-Referent Self-as-Referent Pre-Morbidity Conformity Mediocrity Boredom Perfection Absence of Symptoms
Millon and Davis (1994)	Synthesis	Aims of Existence Modes of Adaptation Strategies of Replication
Husserl (1917-1921)	Clinical Observation	Concordance/Discordance Optimality/Non-Optimality

The transactional definition of normality is found across disciplines of biology and psychology. Biologists such as Friedman and Roe (1958), and Fiebelman (1961) emphasize that abnormality is an evolutionary necessity on the biological path towards higher functioning. The biological support for this model is emphasized in the evolutionary model of normality proposed by Millon and Davis (1994) which is described in detail later in this chapter. Psychologists that adhere to developmental perspectives of normal personality growth such as Eriskon, Freud, and Piaget also subscribe to the transactional model of normality.

Normality as pragmatism defines normality as "the conditions and behaviors that, rarely, if ever, bring people to clinicians" (Offer & Sabshin, 1991, p. xiv). Therefore, those people with conditions that require treatment are defined as abnormal. Offer and Sabshin (1991) stated that this model was atheoretical in that it was based on practical clinical experience. According to Offer and Sabshin (1991), this definition of normality is circular in reasoning. This definition of normality does not stem from Offer and Sabshin's (1966) original synthesis, and thus does not have the cross-disciplinary support of previous definitions of normality.

Normality as average defines normality as the mean or statistical average. Offer and Sabshin (1974) stated that this model is "based on the Bell-shaped curve and its applicability to physical, psychological, and sociological data" (p. 105). Normality is determined statistically by comparison of group data on the Bell-shaped curve with the middle range (68.2%) considered normal and the extremes (15.6% on either side) considered abnormal.

In their synthesis of normality, Offer and Sabshin (1974) found that the statistical model of normality was supported by the biological, medical, psychological, and sociological perspectives. The biological and medical models utilize normality as average through their use of measurement and classification (Offer & Sabshin, 1974). For example, clinical laboratory tests (i.e. blood pressure, cholesterol, hemoglobin counts, etc.) allow for clinicians to determine illness based on whether or not measurements are within a "normal" range. With this type of testing, illness is believed to exist if one's measurements fall outside of this statistical average. Psychologists also utilize this model of normality through the use of intelligence tests, projective tests, and any other scale or measurement that incorporates data that can be measured under the Bell-shaped curve (Offer & Sabshin, 1974).

The sociological perspective also incorporates the normality as average model. Sociologists such as Kardiner and DuBois conceptualize normality as average. DuBois' concept of the "modal personality" (as cited in Offer & Sabshin, 1974) attempts to describe the "range of functioning of an average member of the culture" (p. 107). Kardiner's concept of "basic personality structure" (as cited in Offer & Sabshin, 1974) "describe people in a culture in terms of the degree of approximation to its basic personality structure" (p.107). Sociologists thus attempt to differentiate normal from abnormal by classifying individual thoughts and behaviors against the average norms of the given society. The further one is from the societal norm the more deviant the individual. Offer and Sabshin (1991) noted that this model is culturally dependent in that what is considered normal in one culture could be considered abnormal in another.

The statistical model was supported in part by Horton's (1971) experiment on normality. While other experiments on what is normal have been conducted (i.e. Offer and Sabshin's (1963) experiment of what typifies a "normal" adolescent), this experiment explicitly contributes to the construct of normality.

Horton (1971) asked 47 psychiatric residents to evaluate how a typical normal person would respond to a variety of situations that dealt with anxiety, hostility, generosity, satisfaction, and candor. Subjects were asked to rate their responses according to how angry they felt a typical person would respond and how angry they themselves would respond. The scale of possible anger responses included: "not at all", "annoyed, but decides to forget", "mildly angry and voices anger", "much anger and quits job", and "murders the boss".

The results indicated that the majority of residents had an idea of what constituted "normal" behavior, and that they were in close agreement. The majority of subjects (66%) responded with a range of responses which included "annoyed, but decides to forget" up to "much anger and quits job". This indicated that normality was viewed as a hybrid of normality as average and normality as utopia perspectives. The importance of this study was that it indicated a possible hybrid view of normality which was not present in the literature (Horton, 1971).

While Horton's (1971) experiment was valuable, there were several weaknesses to this study. No demographic information about the hypothetical person was given to the residents. Perhaps if the "normal" person in this case were viewed as someone from a minority race the results would have been different. For example, the subjects may have thought that persons who were African American, uneducated, or of lower socioeconomic status may have responded more angrily than the subjects themselves due to cultural biases.

Another weakness in this study was that it was not stated whether or not there were any minority subjects in the sample which may have reduced some of the sampling bias if any were present. Although Horton (1971) did not attend to racial or ethnic status, he supported the possibility that racial difference would impact perceptions of normality. Horton stated that what was normal can only be understood from the context of the sample it was derived from.

While Offer and Sabshin (1991) stated that the statistical average as normal model had the least amount of bias, and was the one most widely used in research, there are still inherent problems when viewed from a multi-cultural perspective. Foulks (1991) stated that people from non-Western cultures might not even comprehend the very concepts of normal and abnormal. So even with our most widely accepted definition of normality some cultures may not be adequately represented.

Jeger and Slotnick's Model of Normality

Offer and Sabshin (1991) have developed the most widely accepted definition of normality. However, other researchers have developed models as well. Jeger and Slotnick (1982) stated that there were five models of psychopathology that have informed us about what is normal. These included: biological/medical, psychodynamic, behavioral/learning, humanistic, and social/sociocultural. This model of normality has not been empirically examined. Similar to Offer and Sabshin's (1966) synthesis of normality, Jeger and

Slotnick reviewed theoretical concepts of normality across several different perspectives in developing their own model of normality.

According to Jeger and Slotnick's (1982) biological/medical perspective, normal behavior is differentiated from abnormal behavior by the presence or absence of disease. This definition of mental health can then be seen as one in which mental disorders are caused by physiological problems, which then lead to physical diseases. Another definition of mental health from the biological/medical perspective holds that physical diseases are in fact analogous to mental disorders (Jeger & Slotnick, 1982). In this latter case, diseases are believed to occur within the individual, but no physiological evidence is present that can be traced to these disturbed thoughts or emotions (Gray, 1994). The biological/medical model is currently the most widely adhered to by psychiatrists, and is similar to Offer and Sabshin's (1974) definition of normality as health.

From their psychodynamic perspective, Jeger and Slotnick (1982) viewed inner psychological factors as the determinants of mental health. According to Gray (1994), abnormality occurs when there is a conflict between these inner psychological factors. In Freud's theory, the conflict would occur in the mind between the id, ego, and superego. From this Euro-centric perspective, mental disorders are manifested and normal functioning compromised when a sufficient amount of anxiety results from these conflicts.

Jeger and Slotnick (1982) stated that the behavioral/ learning model of normality is one that views mental health in terms of maladaptive behaviors. Here, normality is compromised through learned maladaptive responses experienced within the environment. Both normal and maladaptive behaviors are learned through the same mechanisms, which include: classical conditioning, operant conditioning, observational learning, and cognitive learning (Jeger & Slotnick, 1982). From this perspective, normality is a construct that is external to the self and is learned.

The humanistic perspective views abnormality in terms of alienation from the self. The conflict here occurs between one's actual and ideal self, and hinders one's ability to achieve self-actualization. When this conflict is unresolved normal functioning is compromised (Jeger & Slotnick, 1982). For example, in his humanistic theory Rogers (as cited in Gray, 1994) believed that people became abnormal when "they look to others as guides to how to feel and act, and at the same time rebel inside or feel resentful about living according to others' preferences" (p. 662). This process stagnates the strive towards self-actualization and can lead to abnormality.

Finally, in the sociocultural perspective, normality is viewed in terms of the social context from which an individual operates (Jeger & Slotnick, 1982). This is another example of a view of normality that is seen as external from the self. According to Gray (1994), "the kinds of psychological distress that people experience, the ways in which they express that distress, and the ways in which people respond to a distressed person vary from culture to culture" (p. 608). Here we see further evidence for the need to develop a working model of normality that allows for these unique sociocultural factors to be accurately represented.

The model of normality proposed by Jeger and Slotnick (1982) oversimplifies the criteria used to distinguish normality from abnormality. For example, the biological/medical model by Jeger and Slotnick viewed the concept of health in a restricted manner. According to Offer and Sabshin (1966), the biological model oversimplifies the process of determining what is or is not normal. The biological model of normality is based on the late nineteenth century work of Robert Koch who found that the presence of bacteria within an organism caused illness (as cited in Offer & Sabshin, 1966). This model of health and pathology has been accepted and adhered to by physicians over the past two centuries (Offer & Sabshin, 1974).

While the biological/medical model was, and still is, widely accepted, it does not consider other factors that may lead to mental illness. Other clinicians believed that non-clinical factors played a role in the development of disease. Cannon (1929) posited that an imbalance or lack of homeostasis of physiological functions could cause illness and result in abnormality. Ryle (1947) stated that human functioning was constantly changing over time. According to Ryle (1947), the biological/medical model of normality was inadequate in that it did not take into account the adaptive nature of humans. From this new perspective of illness, the concept of normality as presence or absence of disease is non-inclusive. Factors such as emotional, physical, and mental states are not taken into consideration. Also, other factors such as finances, housing, and relationships are also ignored. Offer and Sabshin (1991) stated that while the biological/medical model has been at the forefront in the diagnosis of people with illness, it provides little service in defining normality or healthy persons.

Mosak's Clinically Based Model of Normality

Mosak (1967) constructed a definition of normality based on clinical interviews with his patients. From these interviews normality was defined by: frequency, other-as-referent, therapist-as-referent, self-as-referent, pre-morbidity, conformity, mediocrity, boredom, perfection, and absence of symptoms. This model of normality has not been empirically tested, and is simply based on Mosak's interviews with patients. Mosak's model is vague and does not provide any detailed information about his subjects, the type of interviews he utilized, or under what conditions patients were interviewed.

Frequency of a behavior or symptom was seen as a statistical measure of normal. That is, if other people were operating in a similar manner than one was thought to be normal. However, if one is acting in the statistical minority then one is said to be abnormal (Mosak, 1967). This is the English language definition of normal (Webster, 1959). This is similar to Offer and Sabshin's (1966) definition of normality as average.

The other-as-referent criterion was a non-statistical measure of normality. Here, Mosak (1967) stated that our construct of what is normal is based on individual perceptions of others' behaviors. This is in contrast to the frequency criterion in that these behaviors cannot objectively be observed, but rather are making an inference. For example, a person might think that people always shake hands when introducing themselves, so the person makes an inference about what is normal and abnormal on this thought. If the person does not shake hands with someone then the person makes the inference that he or she is not like others and is therefore not normal. People who utilize this model of normality are often those who believe that they would like to be like everyone else (Mosak, 1967). With this criterion, patients were unable to even define what the 'other' people were like despite the fact that they were defining their own behavior as normal or abnormal based on this concept.

The therapist-as-referent criterion was based on patient reports that they saw the therapist as the ideal of what constituted normal (Mosak, 1967). Here, patients measured the discrepancy from their own behaviors to that of their therapists as the difference between abnormal and normal. The therapists' behaviors then were a reference point for patients to use in their determination of what constituted normality (Mosak, 1967).

The self-as-referent criterion consists of those rare patients that see themselves as the basis for normal. According to Mosak (1967) "only should others' behavior coincide with his or her is their behavior normal" (p. 160). This concept of normality is static and does not fit under other models of normality that are more dynamic in nature (Tishelman & Sachs, 1998).

The pre-morbid criterion was based upon the patient's adjustment in the absence of symptoms. As in the biological/medical model cited earlier (Jeger & Slotnick, 1982; Offer & Sabshin, 1974), this type of normality is based on physiological symptoms present in the patient that were not present in the normal state. Here, the concept of normal is referenced as a state that was present with the absence of symptoms (Mosak, 1967). The patients stated that they would like to be the way they used to be (Mosak, 1967). This definition of normality differs from previous definitions in that the patients believed that what was normal was their level of functioning before symptoms presented themselves.

Normality equaling conformity as a criterion was defined from the viewpoint that conforming behaviors are normal. From this point of view, abnormality was defined as acting out (i.e. misbehaving). In this criterion, the other-as-referent is seen as irrelevant because the basis for normality is constructed from a moral concept of acting in an acceptable manner despite others' behaviors (Mosak, 1967).

Normality as mediocrity is based on the concept of average. Mosak (1967) found that extremism was considered abnormal. So from a statistical perspective any behavior that varied too much from the average (i.e. laughing too loudly or eating too much) is seen as a manifestation of abnormality. This perspective is once again similar to the statistical definition of normality.

The normality equals boredom criterion is defined from patients' views that being normal constituted being boring. This definition of normal is based on extremism and statistics. Here, the concept of normal is based upon the idea that the range of behaviors is limited when one is normal, and that when those ranges are exceeded (i.e. by those who seek to have a more "hip" lifestyle) the behaviors are seen to be abnormal (Mosak, 1967).

Normality as perfection is defined as a state in which one could meet and solve every problem one faced. This is seen as an ideal state where the patient, in Mosak's (1967) interviews, does everything right. Here, a perfect balance between emotions and behaviors exists and everyone loves them.

Based on his clinical interviews, Mosak (1967) believed that the following criteria of normality: frequency, other-as-referent, therapist-as-referent, self-as-referent, pre-morbid criterion, conformity, mediocrity, boredom, perfection, and the presence or absence of symptoms were all relevant models of normality. However, this study cannot be empirically tested as Mosak failed to provide details of his subjects and his methodology. Once again, this is a model of normality simply based on observation.

In comparison to Offer and Sabshin's (1974) model, Mosak's (1967) model of normality appears more inclusive. Similar to Offer and Sabshin, Mosak views normality in terms of a comparison to a standard. Both Offer and Sabshin, and Mosak, with his Frequency and Mediocrity criteria, specifically cite the use of the mathematical concept of average in their models. Offer and Sabshin (1991) summarized their critique of the statistical method as follows:

> "Whereas any alert observer can count behavioral acts and thus correctly label typicalities, identification of normal behavior seems to require knowledge less about the act and its frequency than about the meanings and significances attached to it." (p. 218)

Mosak (1967) also uses other non-statistical comparisons to the mean when defining normal that move beyond the objective measures found in the Frequency criterion.

From clinical observations of clients, Mosak (1967) developed several concepts of normality that did not emerge in the models that were developed through a synthesis of the literature. The criterions of the Other-as-referent, Self-as-referent, Boredom, and Conformity are comparisons to a subjective standard in which one is allowed to determine normality based on personal experience. This use of the subjective allows for a more inclusive model of normality in that it utilizes both cultural and individual variability when determining normality.

Millon and Davis' Evolutionary Model of Normality

Millon and Davis (1994) stated that the structure and make-up of a person's personality determines whether or not the person can operate in a normal way in terms of mental health. The authors hypothesized

> "when an individual displays an ability to cope with the environment in a flexible manner, and when his or her typical perceptions and behavior foster increments in personal satisfaction, then the person may be said to possess a normal, healthy personality." (p. 81)

From this concept of normality, Millon and Davis proposed a construct of normality based on evolutionary and ecological theory. The evolutionary model of normality is similar to Offer and Sabshin's (1966) definition of normality as a transactional system. This evolutionary model of normality has not been empirically tested. Millon and Davis developed this model through a synthesis of literature in the fields of biology, chemistry, physics, and with a focus on the principles of evolution and ecology. Their goal was to connect the concept of normality with the core sciences in order to develop a theoretical framework from which normality could be better understood.

Millon and Davis (1994) stated that the primary purpose for adaptation was to increase the chances of survival and ensure reproduction. The authors then argued that abnormality results from people's inability to adaptively respond to changes in their environment. Millon and Davis stated that pathology occurs when Darwin's concept of "fitness" is not achieved. "Fitness" involved the process of the development of traits that would contribute to reproductive success and survival.

The constructs of adaptation and strategy in evolutionary ecology were seen as analogous to psychological constructs that make up personality styles and structures (Millon & Davis, 1994). This analogy was based on the idea that people have personality styles and structures that allow them to survive in their environment. Those that have the structures and styles that allow for them to adapt and change were seen as having a higher chance of survival meaning that they would not develop a mental illness.

The evolutionary and ecological theory of normality was based on three distinct areas in which evolutionary and ecological principles were applied to the concept of normality (Millon & Davis, 1994). These three areas included aims of existence, modes of adaptation, and strategies of replication. Within each of these areas, polarities exist which are used to make a continuum on which normal and abnormal mental health are based on.

The three-polarity model of normal human processes has its foundations in Freud's (1925) work "The Instincts and their Vicissitudes" (as cited in Offer & Sabshin, 1991). In these works, Freud (1925) proposed that mental functioning is governed by three polarities which included: subject-object, pleasure-pain, and active-passive. From this foundation, several other scientists (Buss & Plomin, 1984; Cloninger, 1987; Gray, 1973; Russell, 1980; Tellegen, 1985) have developed three polarity models of functioning that Millon and Davis (1994) cite as laying the framework for their model.

Aims of existence are seen as a strategy that involves both achieving existence and preserving it. This sphere incorporates the concepts of life enhancement, defined as seeking pleasure, and life preservation defined as avoiding danger and pain. Here, the authors argue for a concept of normal that incorporates a drive to seek enrichment in one's life. This differed from Freud's view of normality, which stated that our primary motivation was to reduce tension or avoid pain. Millon and Davis (1994) stated that abnormal states of mental health such as schizoid and avoidant personality disorders could be manifested due to the inability to meet this pleasure drive.

Modes of adaptation involve the processes used to sustain survival, which are seen as ecologic accommodation and ecologic modification. Accommodation involves a passive response to the environment by simply fitting into one's surrounding with a dependence on this to survive. The more active mode involved ecologic modification. In this mode, one changes the environment to adapt or shows some variability in behavior as the environment changes in order to survive. The authors stated that utilizing a flexible balance between both of these processes leads to normal mental health (Millon & Davis, 1994).

Finally, strategies of replication referred to reproductive styles that optimized the "diversification and selection of ecologically effective attributes" (p. 91). In this sphere, the continuum of normality is based upon reproductive nurturance, which consisted of the ability and desire to care for and love others, and reproductive propagation, which consisted of individuating and actualizing the self. The authors argued that abnormal personalities such as narcissistic and antisocial develop from one being unable to love others. They also argued that dependent personalities might develop from an inability to actualize the self (Millon & Davis, 1994).

Based on these spheres and their corresponding polarities the authors suggested that an ecological evolutionary definition of normality could be constructed. Millon and Davis (1994) stated that what constituted normal human personality was analogous to the evolutionary model of survival in other organisms in the natural world. They concluded that the ability to balance one's life along each of the spheres was what determined if one was normal or not and that extremes on either ends of any one of polarities mentioned would potentially lead to abnormal functioning (Millon and Davis, 1994).

The evolutionary model of normality developed by Millon and Davis (1994) is useful in that it does not depend on bodily mechanisms in determining normality. Unlike the biological/medical model developed by Jeger and Slotnick (1982) and the criterion of absence of symptoms proposed by Mosak (1967), which utilize internal biological malfunctions in determining normality, the evolutionary model is focused on the utility of mechanisms. This focus allows for a determination of normality that is open to the dynamic nature of human beings. An evolutionary model of normality is useful in that it allows one to make distinctions of normality and abnormality across time. Examples of this can be seen in the practice of psychiatry as the diagnostic criteria for both alcoholism and homosexuality which have either been changed, in the former, or eliminated, in the latter, over time.

An examination of the consequences of failing to meet the aims of existence and modes of adaptation also lend support to Millon and Davis' (1994) evolutionary model. Offer and Sabshin (1991) stated that the evolutionary model was comprised of concepts that related to Maslow's (1968) hierarchy of needs. In this example, Maslow's basic needs of health and safety are seen as analogous to Millon and Davis' (1994) concepts of evolution that emphasize self-preservation. Offer and Sabshin stated that if health needs such as food and sleep are not met the organism could develop pathologies that would deem them abnormal. Also, several personality disorders exist in which one does not attend to safety needs. For example, antisocial and borderline personalities often put themselves at risk of harm. This comparison is used to emphasize that abnormality exists when basic safety, and therefore evolutionary, needs are not met (Offer & Sabshin, 1991).

Similar to Offer and Sabshin's (1974) transactional system model of normality, Millon and Davis' (1994) evolutionary model also has inherent problems. According to Offer and Sabshin (1991), evolutionary models of normality are too dependent on the system under investigation. That is, the evolutionary model minimizes the observation of the individual when determining what is normal. Subsequently, evolutionary models are cited as not being useful in clinical, social, and forensic decisions, which are dependent on the observation of the individual, pertaining to normality (Offer & Sabshin, 1991).

A Genetic Phenomenological Model of Normality

Steinbock (1998) described Edmund Husserl's (1917-1921) unpublished work on the definition of normality. From Husserl's perspective, normality is based on "how something becomes meaningful or takes on sense within experience" (Steinbock, 1998, p. 12). This experiential perspective provides an opportunity for the subjective experience to define normality.

Husserl viewed the subjective construction of normality as a developmental process that was dynamic rather than static. Husserl (as cited in Steinbock, 1998) stated that there were four modalities of normality and abnormality. These included: concordance/discordance, optimality/non-optimality, typicality/a-typicality, and familiarity/non-familiarity. According to Steinbock (1998), the first two modalities are essential in determining normality. This model of normality has not been empirically tested. Husserl's model was based on his perspective of how he believed normality could be viewed outside the realm of empiricism.

From the experiential perspective, concordance occurs when a person's experience with an object is both pleasant and familiar. Abnormality is experienced when this concordance is disturbed for any number of reasons. For example, if one were to drive to a location that one had been to before using the same roads, the experience would be normal in that it is consistent with the experience one has had driving down that road in the past. However, if one were to take that same road and see a detour, new building, or even an accident the experience would be abnormal.

Situational optimality, or normality, occurs when "a system of appearances . . . presents the most of the same thing with the greatest richness and differentiation" (p.13). Abnormality was then viewed as an experience that was interpreted as being less than "better" and "richer" and was thus "diminished" or "worse". Here, normality is based on the argument that one attempts to optimize experience by transcending norms and creating new ones (Steinbock, 1998). This relates to previous conceptions of normality as a utopian ideal where transcendence is viewed as central to achieving normal mental health (Offer & Sabshin, 1974).

Husserl's definition of normality based on the experiential process appears to be useful in that it allows for all people to be included. We all experience the world in our own way and Husserl's theory allows for each of us to be unique in our idea of normality based on our own subjective experience.

The optimality/non-optimality model of normality proposed by Husserl would define most people as abnormal. Similar to Offer and Sabshin's (1974) utopian model of normality, the optimality/non-optimality model maintains that one strives towards some higher level of functioning. However, since the majority of people fail to reach this higher level more people fall into the category of abnormal (Offer & Sabshin, 1991). This could be problematic in defining abnormality and normality in that there is a far greater potential for non-optimality to begin with.

Application to Asians

The models of normality described above are hypothetical propositions as to how we can conceptualize normality. However, despite the vast number of disciplines that have been synthesized, few have approached normality from a multicultural perspective. The following section critiques the application of the previous models to an Asian population.

Jeger and Slotnick's model. Of the models described by Jeger and Slotnick (1982), only two would seem to fit under Asian cultural definitions of what normal mental health might be; the biological/medical model and the sociocultural model. The biological/medical model may be appropriate in describing what normality is to Asian's in that it uses a medical definition describing normality as the absence of physiological symptoms.

Atkinson et al. (1998) stated that Asians tended to view their mental or emotional distress as stemming from biological causes rather than attributing them to mental illness. Therefore, the Asian population may utilize a biological/medical model more when defining normality. Also, since Asians tend to be focused more on bodily complaints, those models that focus more on psychological constructs such as the humanistic and psychodynamic models might not relate to that population.

Asians also utilize biological treatment methodologies such as yoga and dietary prescriptions which lends support to their use of the biological/medical model of normality (Laungani, 2004). The biological/medical model is analogous to the definition of normality as health proposed by Offer and Sabshin (1974). Therefore, it appears that Offer and Sabshin's definition of normality as health would be applicable to Asian populations as well.

Asians might also prescribe to the sociocultural model proposed by Jeger and Slotnick (1982). This is similar to a postmodern perspective of normality. Sophie Freud (1999) defined normality as ever changing and ambiguous. She stated that from a postmodern perspective, the construct of normality is based on many possible truths and realities that have all been, to a more or less extent, humanely constructed.

Freud (1999) believed that normality was value based and depended on the sociopolitical economic (cultural) context in which it was defined. Atkinson et al. (1998) stated that due to the cultural values placed on honor and pride in some Asian societies in the family unit, mental illness might not even be reported while in other instances more traditional methods of healing may be incorporated such as using will power. Thus, the sociocultural method allows for a definition of normal given the context of the people under investigation. This flexibility is important given the dynamic nature and differences present amongst Asians.

Mosak's model. While the frequency of behavior definition is used widely in psychology today, it is not inclusive of an Asian perspective of normality (Foulks, 1991). The statistical model was already biased against non-Western people based on the way normality was defined in the first place. Therefore, this measure is not inclusive enough to be used with non-Western populations such as Asians. Offer and Sabshin (1974) also proposed a definition of normality based on the statistical average that would not be useful in an application to Asian populations.

The other-as-referent criteria would not seem to be useful to a population, such as Asians, that is dependent on context. The fact that assumptions are being made about other people's behaviors without any knowledge of their situation seems to conflict with basic Asian principles of knowledge and understanding that contribute to mental health (Walsh, 2000). The other-as-referent criteria also conflicts with the postmodern viewpoint described earlier that requires us to take into account the person's cultural context which was viewed as beneficial for Asians.

Asians would not utilize the therapist-as-referent criteria because they do not equate their illnesses with psychological or behavioral problems (Atkinson et al., 1998). Therefore, the behaviors that are modeled by the therapist may go unnoticed or misinterpreted. Also, Asians tend to seek out people of similar cultures when they do seek mental health needs, and thus the modeling would only be appropriate if someone relayed it from their own cultural background. However, this would be rare given the number of Asian psychologists in practice.

Since Asian cultures are more collectively rather than individualistically based, the self-as-referent definition of normality would not seem an appropriate fit (Atkinson et al., 1998). However, the pre-morbid definition would be a model that Asians might prescribe to given their tendency to ascribe mental or emotional problems as stemming from physical illness (Atkinson et al., 1998). Again, this is supported by Asian healing strategies that focus on healing the body such as yoga and dietary prescriptions (Laungani, 2004). Similarly, the presence or absence of symptoms criterion would seem to fit with this model of attributing mental or emotional difficulties with physical illness. Another definition based on Mosak's (1967) model that appears consistent with Asian cultural values is the definition of normality as conformity. Sodowsky, Kwan, and Pannu (1995) stated that U.S. Asians tended to value conformity and interdependency, which would suggest that they would relate to this definition of normality.

The definition of normality as mediocrity would not seem appropriate in use with Asians. In fact, some Asian cultures do not distinguish between what is abnormal and normal (Foulks, 1991). This definition is based on the statistical model similar to that of Offer and Sabshin's (1974) definition of normality as average which has been shown to be ineffective when applied to Asians.

Normality as boredom is based on the principle that one is normal if one does not present with extreme behaviors. The definition of normality as boredom would seem to fit with Asians because it coincides with their values of conformity and collectivism and on modesty in both behavior and thought (Walsh, 2000). Finally, normality as perfection would apply to Asian populations. This definition appears to fit well in that it is an attempt to reach an ideal state, which is what Asians believe will lead to healthy psychological functioning (Walsh, 2000). Since Asians tend to utilize the healing strategy of meditation, which attempts to help one reach an ideal state, the normality as perfection model would seem to fit (Laungani, 2004). This definition of normality as perfection is similar to Offer and Sabshin's (1974) definition of normality as utopia, and Husserl's (1917-1921) concept of normality as optimality/non-optimality.

While Mosak's (1967) client demographics are unknown, five out of the nine models proposed seemed to fit with what Asians might define normality as described above. Given that the definition of normality plays an important role in psychological treatment, it would be imperative then to determine whether or not these definitions of normality apply to Asians or not.

Millon and Davis' model. Millon and Davis' (1994) evolutionary theory of normality does not seem useful in terms of multicultural awareness particularly with Asians. Millon and Davis' mode of aims of existence does not fit with Asian cultural values of modesty and placing the needs of the family before ones own (Atkinson et al., 1998; Walsh, 1999). Asians operating from a traditional Asian value set would not be considered normal then because they did not seek individual pleasure. Millon and Davis' strategies of replication also did not appear useful in that they were based around constructs such as self-propagation and individuating the self, both of which conflict with Asian cultural values (Walsh, 1999).

While the modes of existence and replication did not fit an Asian model of mental health, the mode of adaptation seems more useful. With this definition of normal, the cultural context of one's actions may be taken into consideration as it relates to surviving in one's environment. This appears to be a good fit with the postmodern/ sociocultural perspective described earlier.

While Millon and Davis (1994) have an interesting theory of normality, it is not entirely useful to Asians. As an evolutionary theory, Millon and Davis are attempting to describe normality in terms of its intrinsic nature in humanity, but they fall short in that their model does not account for non-Western cultural ideals that conflict with more individualistic goals. Perhaps an evolutionary perspective is too broad and a focus on more culturally specific models of normality is needed.

Husserl's model. Husserl's (1917-1921) model of normality would be useful for Asians in that they have been left out of previous definitions of normality that did not include this contextual perspective. Husserl's emphasis on recognizing experiential processes would appear to fit with Asian concepts of introspection and contribute to the meditative process. Husserl's model of normality also focused on a developmental process, similar to the normality as a transactional system model proposed by Offer and Sabshin (1974), where one views the process of normality over time.

The developmental process is supported by Asian's use of meditation as a healing strategy. In meditation, one develops a set of skills and then applies them in order to reach the next developmental phase with the end goal being the ideal state (Laungani, 2004). The developmental process coincides with Asian psychological ideals of transforming and refining the self over time in order to achieve a healthy psychological state (Walsh, 2000).

Limitations of Normality as a Construct

The concept of normality has been utilized by most of the fields in science. The models of normality presented previously were developed out of a synthesis of various fields including: psychology, medicine, sociology, biology, anthropology, and from an evolutionary perspective. However, despite its widespread use across these fields of science, normality has been criticized on several fronts including: normality's limited view on human capabilities and its inherent bias.

Buck (1992) argued that normality continues to be confused with health. She warned, "normality as construed by psychological theory and diagnostic practice does not exist" (p. 251). The author suggested that by attempting to normalize people, psychology might actually be depriving people of their unique strengths (Buck, 1990). Buck also stated that normality, as it requires adjustment and conformity, does not allow for the freedom of behaviors that humans are capable of operating from in a healthy manner. Buck (1992) argued that "the limited autonomy permitted by normality promotes caution leading to an avoidance of risk; failure is minimized compared to the healthy, but so is fulfillment." (p. 253)

Finally, normality is characterized by the motivation to simply maintain one's current state. Buck (1992) believed that this allowed for "moderate satisfaction and unhappiness, but the fight against deterioration leaves one overwhelmed by the impending disaster" (p. 254).

Jenkins (1993) stated that there is an inherent bias in defining normality. Jenkins (1993) argued that the people who determine what is normal are not only influenced by their own values and interests, but also by biomedical/institutional interests. Still, others believe that there is no clear distinction between what is normal and abnormal on a given continuum.

Widiger (1997) stated that while the validity of normality was not in question, what was in question was if a qualitative distinction of normality could be deemed valid. According to Widiger, a psychological disorder involves some kind of uncontrolled impairment in psychological functioning. Widiger noted that despite the criteria for a mental disorder there is often no distinction between mental and physical functioning. Widiger cited several disorders where the distinction between mental and physical causes for impairment could not be determined. These disorders included: organic mental disorder, pain disorder, pre-menstrual dysphoric disorder, and breathing-related sleep disorder. Thus, while normality appears to be a concept that can be defined there appears to be some doubt as to whether or not these various definitions are distinctive enough to be considered valid in their own right.

Limitations of Normality as Applied to Asian Cultures

From these early definitions of normality, one can see that an inherent bias existed against non-white people. From a Euro centric worldview, Asian values are often contradictory to a healthy model of mental functioning (Sodowsky et al, 1995). Fernando (1991) stated that these attitudes were derived from "a racist perception of culture which supposed that European culture alone, associated with white races, was civilized" (p.33). The early definition of normality in the U.S., in terms of mental health, was seen as absences of illness or average (Sabshin, 1967). However, this definition was developed in the context of the Western worldview mentioned earlier. With these racial biases present, it is imperative to gain a better understanding of what normality is from a non-western viewpoint in order to provide better treatment. This can be accomplished by learning about the impact this concept has on psychotherapy.

It has been argued that the construct of normality has an impact on psychotherapy and that the definition of what is normal has been biased against non-whites. Foulks (1991) stated that the idea of normality is unique to the Western European scientific viewpoint. Foulks also stated that the dichotomy of normal and abnormal was a foreign idea in most non-Western societies. While Foulks' argument implies that an Asian model of normality may not be valid, normality is utilized by mental health professionals. Mental health professionals must ask if a disservice to people of non-white cultures is occurring when biased definitions of what is normal are used for people who were not included in the original model of what normal meant.

Possible Solutions

Chin (Chin, De La Cancela, & Jenkins, 1993) cited three principles that would be useful in minimizing the impacts these inherent biases, world views, and cultural values between both the therapist and the client may have on therapy. The first principle is that there needs to be a shift from the deficit model to a difference model of multicultural counseling. The second principle is the need to incorporate cultural variables into therapy. Chin (Chin et al. 1993) suggested this could be accomplished by increasing the awareness of ethnocentric bias amongst counselors. Another suggestion was to acknowledge that cultural differences exist and to examine the theories used in therapy to see if biases exist within them. It was also suggested that cultural behaviors must also be seen as adaptive as they have been present over centuries and have served a function for that particular group. Finally, the third principle is that cultural variables were not to be taken as "good or bad, but as to whether they facilitate achieving psychotherapeutic outcomes" (p. 71).

Carter (1995) stated "racial barriers exist in psychotherapy and counseling in large part because traditional theories have not considered race in human and personality development" (p. 11). Perhaps, if concepts of normality from other races and cultures are included, these barriers and biases may begin to be broken down. Then, by examining the differences between Euro centric and Asian worldviews in terms of mental health, ideas can be developed that would minimize these inherent biases that exist from the earlier definitions of normal.

While there is hope that models of cultural awareness will improve the field of multicultural counseling there are foundational errors upon which non-Western peoples are being evaluated upon in terms of what is normal. The history surrounding the foundations of normality cited by Fernando (1991) earlier in this chapter depicts a concept of normality that is racially biased against non-whites. With the knowledge of the bias that was, and still is inherent, in concepts of what constitutes normal mental health work must be done to develop a new construct of what is normal that is more inclusive of people from non-Western cultures.

Summary

Asian psychological health is based upon the concept that one should work physically, mentally, and spiritually towards an ideal state of being. Asian psychologies posit that when one does not follow the developmental path towards transcendence, and remains mired in any given stage, the result is psychopathology (Walsh, 2000). Through the use of meditation and self-awareness, Asian psychological thought, rooted in Buddhist philosophy, posits that the ideal transcendental state can be achieved. The Asian model of normality may involve a developmental process towards this ideal state.

The models of normality cited in this study provide a context from which the construct of normality can be examined. The definitions of normality presented by Offer and Sabshin (1974), Jeger and Slotnick (1982), Mosak (1967), Millon and Davis (1994), and Husserl (1917-1921) were based on a synthesis of the viewpoints about normality from different scientific fields, and in some instances from atheoretical clinical observation. Normality as a construct has not been empirically examined. Rather, theories of normality have been developed through connecting hypotheses across disciplines. Of these various syntheses, Offer and Sabshin's (1974) model of normality, which defined normality as: health, utopia, average, transactional system, and pragmatism, has been the most widely accepted. However, despite the acceptance of this and other models of normality, criticisms as to its applicability as a construct remain.

Normality has been criticized for being too narrow in its view of humanity. Normality also has been criticized for having an inherent bias by those who determine its definition. This bias is criticized for producing, and subsequently perpetuating, a model of normality that has not taken into account non-Western European ways of psychological being.

Still, no studies have been done utilizing Asian populations to define the construct of normality. Since Western European values were the basis for the most widely accepted concepts of normality, Asians have been left out from the beginning and are not represented by this construct to a certain degree. Therefore, studies that incorporate a non-Western cultural ideal may lend some insight as to where current models are deficient as well as where they are efficient in their definitions of normality as it relates to all people. The purpose of the current study is to allow for the possible creation of an alternative perspective on normality from a non-Western cultural context.

CHAPTER III

METHOD

In this study, I examined perceptions of normality from an Asian Indian cultural perspective. Consensual Qualitative Research (CQR) (Hill, Thompson, & Williams, 1997) was used to allow Asian Indian graduate students to give a broad description of what normality means to them given their cultural context. Based on the methodology of Chaves et al. (2004), categories were developed from participant's responses during an oral interview. Once categories were developed, the research team we analyzed how often certain responses occurred and gained an understanding about participant's thoughts and feelings. First, a pilot study was conducted to develop the questions used during the oral interviews. These questions were given to the auditor and were revised for use in the main study. A more detailed description of the CQR process is provided in the procedure section.

Participants

Pilot study. The pilot study involved 5 Asian Indian graduate students. This sample consisted of 4 Asian Indian males and 1 Asian Indian female who were selected from a medium-sized southeastern United States public university. Participants were recruited utilizing a selective sampling technique. Possible participants were identified on campus at a large international student housing complex that primarily housed Asian

Indian students. Students were approached as they exited and entered their residences and asked if they would like to participate in the study. Participants were allowed to complete the study based on having met inclusion criteria, which included being a citizen of India, completing a graduate degree in the U.S., having spent a maximum of 2 years living in the U.S., and having lived in India for all other portions of their lives.

Principal study. The main study involved 10 Asian Indian graduate students. This sample consisted of 6 Asian Indian males and 4 Asian Indian females, and utilized the same selective sampling technique as in the pilot sample, with participants recruited from the same university. This sample consisted of subjects originally from India who were students completing their M.S. degrees. Four subjects were completing degrees in Computer Science, 2 in Computer Science and Engineering, 2 in Mechanical Engineering, 1 in Mechanical Engineering and Computer Science, and 1 in Electrical Engineering.

Subjects hailed from three different Indian states: Tamil Nadu (n = 2), Andra Pradesh (n = 7) and Delhi (n = 1). The mean age of subjects was 23.5 years with a standard deviation of 1.18. The mean amount of time spent in the U.S. in months was 20.6 with a standard deviation of 3.95. All subjects were unmarried. The primary language of subjects was Telugu (n = 7) while 2 subjects spoke Tamil and 1 subject spoke Hindi. All subjects communicated in English during the interviews.

Instruments

Demographic information. Demographic information was gathered at the beginning of each interview. The participants were asked the following questions: (a)

What is your name? (b) What is your age? (c) What is your education level? (d) What is your major in school? (e) What is your marital status? (f) What is your primary language spoken at home? (g) How long have you been living in the U.S.? (h) What is your primary occupation? (i) What is your country of origin and state? These questions helped establish whether or not the participant was included in the study, as only Asian Indians of Indian citizenship met study participant selection criteria. These questions also served as a warm-up for the oral interview process.

Data collection instrument. Questions were developed for the oral interview in order to gain an understanding about how Asian Indians defined the construct of normality. The pilot study was conducted to determine how participants would respond to these questions. The pilot study consisted of the following questions: (a) How would you define normal from a mental health perspective? (b) How does someone become mentally ill? (c) How do you know someone is having problems mentally? (d) What are these people doing differently from you or from others? (e) Can you describe someone who is psychologically normal? (f) Can you describe someone who is not normal? (g) Now that we have talked about this for a while, can you define normal from an Indian perspective of mental health?

The pilot questions were revised after the auditor reviewed these initial interviews. Based on both the auditor and pilot subjects' suggestions the following questions were used in the main study: (a) How would you define normal? (b) How does someone become mentally ill? (c) How do you know someone is having problems mentally? (d) What are these people doing differently from you or from others? (e) Can you describe someone who is psychologically normal? (f) Can you describe someone who is not normal? (g) Now that we have talked about this for a while, can you define normal again? (h) What protocol or criteria are you using to determine if someone is normal or abnormal? Adding this last question allowed for a more precise response in terms of how participants defined normal and abnormal.

Procedure

Data collection. Oral interviews were completed with each participant in individual meetings, for both the pilot and main study data. The primary researcher conducted all interviews. The interviews were semi-structured which allowed for participants to engage in a dialogue with the interviewer. This format allowed participants to ask for clarifications or any other questions they had, and ensured that the interview process reached the depth necessary to have useful and meaningful data. Data were collected by tape-recording all interviews. The interviews were then transcribed, checked for accuracy, and analyzed by the research team.

Research team. The research team consisted of three judges and one auditor. The three judges were all doctoral level psychology students completing their 4th year. Two judges were from clinical psychology programs and one from a counseling psychology program. The judges consisted of one Asian Indian male doctoral student, one African American female doctoral student, and one Caucasian female doctoral student. The judges had significant training and experience in working with diverse cultures. Also, all three judges had a desire to reduce the impact of cultural bias in the analysis process and discussed these thoughts and feelings with one another. The auditor was a Caucasian female and professor of counseling psychology.

Data analysis. There are three primary steps in the CQR process. These include qualitatively categorizing participants' responses to open-ended questions into domains, using the domains to create core ideas for each case, and finally, conducting a cross-analysis to define categories of core ideas amongst all cases within domains (Hill, et al., 1997). The following sections describe how CQR was used in completing the analysis of this study.

Within case analysis. The first step in CQR involves creating domain names for the data. In this process, team members analyzed the literature to find initial domain headings that were used to group data derived from the interview transcripts. From the literature, initial domains included normal mental health as defined by: average, an ideal, a lack of illness, being like everyone else, the mean (statistical), definitions of abnormal, lack of adjustment or adaptation, lack of psychological stress, being at peace with oneself, frequency of behaviors as compared to others, behaving, being perfect, and no such thing as normal.

With these initial domains in mind, individual members of the research team analyzed transcripts on a case-by-case basis. They placed the individual statements (any number of sentences relating to the domain) made by participants into one of the domains if applicable. Once these cases were analyzed individually, the team as a group then analyzed the placement of these statements into their domains and attempted to come up with a consensus as to whether or not a certain statement fit within that domain. The team also developed new domains and deleted others in this step as needed. After the team agreed that statements were in their proper domains, the team then moved on to develop core ideas within each case.

Once statements had been categorized into domains, the next step of the CQR process involved the development of core ideas. Core ideas were summaries of the statements that were within each domain. In this step, team members individually summarized each domain within each case. Here, the process involved creating a short summary of all the statements within a domain that described those statements within the context of that particular domain. For example, this study had 48 different statements or sentences which described how someone became mentally ill, which was under the domain of "cause of mental illness", these statements had common themes such as "lack of mental flexibility" and "genetics". These themes became the core ideas for that particular domain. The analysis team reviewed each others' core ideas and came to a consensus as to whether or not these core ideas were representative of the data and made changes to core ideas if needed. Once a consensus was reached at this step, both domains and core ideas were sent to the auditor for review.

Auditing core ideas and domains. An auditor was used in the CQR process to provide a measure of validity to the analysis team. The function of the auditor was to provide an objective voice to the review process. Once the analysis team had agreed upon core ideas and domains, the auditor began the review process. The auditor analyzed the transcripts and determined whether or not the statements were in their proper domains, that all the relevant data had been analyzed, and that core ideas were good summaries of the statements within each domain. The auditor then made revision recommendations about core ideas and domains to the analysis team. The analysis team consensually agreed about what revisions were necessary based on the auditor's recommendations, made changes where needed, and began the cross analysis of data.

For example, once domains were created and core ideas emerged, there were several participant responses that the team was unable to assign relevant meaning to. This group of data was labeled as "Other" by the analysis team. These responses included such statements from participants such as Subject 2 who reported "A kind of humor a kind of anger a kind of tension", and from Subject 4 who stated "My mom always says she is not normal". The analysis team submitted all domains and core ideas to the auditor including the "Other" responses. The auditor was able to provide additional insight to the analysis team regarding this "Other" domain which included suggestions as to how to examine this data differently in order to ensure that the data was included in existing domains, thus minimizing the risk of eliminating relevant data. This process was also completed during the audit of the cross analysis phase in which categories were developed.

Cross analysis. At this level of analysis the team analyzed data across cases. The team analyzed the core ideas within each domain across cases and attempted to find similarities. The process involved taking the core ideas and finding how they related to one another. Once the team examined the core ideas within each domain and determined how the core ideas fit with one another they created categories to assign meaning to the data.

The categories were used to determine the level of variance within the sample. The categories that encompassed all participants were considered general, those that applied to more than half were considered typical, and those that applied to less than half or just to two or three were variant, and those that applied to two or less were dropped (Hill et al., 1997). However, these "dropped" categories were re-examined to determine if their core ideas were to be placed in other categories so that data would not be lost. This final process was not forced it was more a measure to ensure that all data had been analyzed thoroughly.

Audit of cross analysis. Once core ideas were categorized, the auditor reviewed the cross analysis. In this process the auditor reviewed the data to ensure that the core ideas had been placed in their proper categories. The auditor also re-checked to ensure that the categories were descriptive of the core ideas and determined whether or not categories were added or deleted. Once the auditor's recommendations were made, the analysis team once again discussed the auditor's comments and arrived at a consensus as to what changes were made. This last review was the final level of data analysis.

CHAPTER IV

RESULTS

The results of this study were based on participants' responses to questions regarding the concept of normality. Five domains emerged: Perceptions of Normal, Perceptions of Abnormal, Cause of Mental Illness, Criteria Used to Differentiate Normal from Abnormal, and Difficulties in Defining Normal. Within each of these domains, categories were established that describe participants' responses (see Table 3).

Examples of participants' responses are included to provide detail to the categories developed. Participants often produced responses that were coded across several categories within a single domain. Therefore, the number of responses in a given domain may exceed the overall number of participants (n = 10). According to the guidelines established by Hill et al. (1997), categories are labeled as: (a) general, (b) typical, and (c) variant. A category was labeled general if it applied to all cases. Typical categories were those that included half or more cases. Finally, variant categories applied to less than half, or three to four cases. Categories that were supported by two or fewer participants were dropped.

Perceptions of Normal

Participants in this study were initially asked three questions which addressed the following: definition of normal, description of normal, and discuss behaviors associated with the concept of "normal" mental health. Originally, three domains were developed from these initial questions which included: (a) Definitions of Normal, (b) Description of Normal, and (c) Behaviors Associated with Normal. However, results from the development of core ideas indicated that there was an overlap in concepts of "normal" across the initial domains. Therefore, the initial domains were condensed into one single domain, Perceptions of Normal. The participants' perceptions of "normal" resulted in the following categories: (a) Normal is having one's emotions in a state of balance, (b) Normal involves rate of recurrence, (c) Normal involves adherence to cultural standard, (d) Normal involves connection to others, (e) Normal involves the directive of inflicting no pain, (f) Normal involves the ability to utilize multiple points of view, (g) Normal involves the ability to mentally and emotionally move on, and (h) Normal involves the ability to complete objectives despite circumstances (see Table 4).

Normal is having one's emotions in a state of balance. This was a typical category, as the majority of participants (n = 6) indicated that "normal" mental health involved the process of maintaining a balanced emotional and mental state. For example, Participant 2 stated, "Normalcy I would define as keeping your emotions and tendencies to moderate, I mean, within moderate defined limits, and not letting it go to extremes." Participant 3 responded in a similar manner and reported that, " . . . most of the time you need to be in equilibrium . . .", and ". . . mentally stable." Participant 5 also echoed these ideas and stated that, "You can say someone who is not too excited much about anything."

Table 3. Domains and Categories Developed.

Domain	Category	Frequency
Perceptions of Normal	Having one's emotions in a state of balance	Typical
	Rate of recurrence	Variant
	Adherence to cultural standard	Variant
	Connection to others	Variant
	Directive of inflicting no pain	Variant
	Ability to utilize multiple points of view	Variant
	Ability to mentally and emotionally move on	Variant
	Ability to complete objectives despite circumstances	Variant
Perceptions of Abnormal	Presence of erratic thoughts and behaviors	Typical
	Inability to achieve an emotionally balanced state	Typical
	Inability to move on	Variant
	Perpetuate actions that instigate pain	Variant
	Inability to maintain social function	Variant
	Inability to follow and recognize cultural standards	Variant
	Deviation from expected pattern	Variant

Table 3 (continued)

Domain	Category	Frequency
Cause of mental illness	Reactions to environmental stress	Typical
	Unmet expectations	Variant
	Uncontrollable factors	Variant
Criteria used to differentiate	Comparison to recognized standards	Typical
Normal from abnormal	Observations of emotional and behavioral expression	Typical
	Ability to move on	Variant
	Deviation from expected pattern	Variant
Difficulties in defining normal	Normal is difficult to define because of its' subjective nature	Typical
	No previous experience with concept of "normal"	Variant

Participants also indicated that this emotionally balanced state involved self regulation. Referring to normal people, Participant 4 stated that "They also take things easy; they don't get out of control whatever happens, bad or good." Participant 10 also recognized this component of self regulation in maintaining emotional balance and said ". . . something like you'd be having control over you senses . . . I mean you need to control your senses, and anything you do without controlling them becomes abnormal for me."

In these examples, participants are indicating that being normal involves two processes. The first is that one's thoughts, feelings, and emotions must remain in a moderate state. Second, one must utilize self-control in order to achieve this moderate state.

Table 4. Perceptions of Normal.

Category	Frequency
Normal is having one's emotions in a state of balance	6
Normal involves rate of recurrence	4
Normal involves adherence to cultural standard	4
Normal involves connection to others	4
Normal involves the directive of inflicting no pain	3
Normal involves the ability to utilize multiple points of view	3
Normal involves the ability to mentally and emotionally move on	3
Normal involves the ability to complete objectives despite circumstances	3

Normal involves rate of recurrence. In this variant category, four Participants perceived that a thought or behavior was "normal" if it occurred often enough to become expected. For example, Participant 5 stated ". . . if any action or event occur frequently then it would become normal," and Participant 9 reported "Something like customs you are used to."

Along the same lines as expectedness, normal was also perceived as having an aspect of routine and familiarity. For example, Participant 7 stated "They are still doing things they are supposed to do: they are working, and when they hungry they are also looking for food." Participant 8 stated that normal involved ". . . doing your regular routine . . .", and ". . . carrying out your regular activities." In these examples, participants conclude that when something happens often enough to be considered a custom or becomes predictable then it is considered normal.

Normal involves adherence to cultural standard. The third category, also variant, involved a definition of normal that was based on following cultural rules (n = 4). For example, Participant 6 stated "There might also be a particular standard for India, about being normal or not, I guess there are four Ashrams, the phases of life," and "Everyone has to go through the four phases of life." Similarly, Participant 7 said ". . . society has set standards . . . of day-to-day life," and "If we follow those standards than you are not bothering anybody, you are doing your work your way, and you are letting others do the work their way."

Participant 10 reported that " . . normal is doing all the things that other people think are normal," and that one must ". . . stick to society's rules . . . ." in order to be considered normal. In this category, participants are viewing someone as normal if they are abiding by the standards set by the culture they are residing in. Also, participants noted that the basic standard is to not cause harm to another.

Normal involves connection to others. In this variant category, several participants indicated that being normal involved maintaining the social aspect of one's life (n = 4).

For example, Participant 8 stated that being normal involved ". . . mixing up with people, being social," and "It just means I don't restrict myself from doing anything and I am social." Participant 10 also adhered to this social description of normal and stated that a normal person was someone who ". . . calls his parents frequently . . . " and "You keep in touch with your friends." Similarly, Participant 3 stated ". . . he would be happy just joying around, mixing with everyone." In these examples, participants are indicating that one is normal if one maintains social relationships.

Normal involves the directive of inflicting no pain. Participants responded variantly that normal people were those who did not cause harm or inflict pain upon others (n = 3). For example, Participant 7 reported "Basically you should not harm or bother others." Other participants echoed similar thoughts as Participant 9 stated that a normal person was one that ". . . doesn't consider to be harmful . . .", and Participant 10 said ". . . you don't hurt any other person's feelings." Here, one is normal if one does not cause mental, emotional, or physical suffering to another.

Normal involves the ability to utilize multiple points of view. The sixth category developed from the domain *Perceptions of Normal* involved the ability to incorporate other perspectives. Less than half of the participants (n = 3) supported the variant category that normal meant being able to avoid single mindedness. For example, Participant 1 stated "Whatever they do, it will not just be one voice in their head," and "I mean, it's someone who doesn't just go along with what goes on in his mind, but also considers the situations and circumstances around him, and maintains a balance between these two." Similarly, Participant 4 described the normal person as ". . . having a perspective when looking at a situation." Here, participants are indicating that being mentally flexible enough to incorporate multiple perspectives contributes to being normal.

Normal involves the ability to mentally and emotionally move on. In this variant category, Participants viewed people to be normal if they were able to mentally and emotionally let go of negative thoughts and feelings caused by environmental stress (n = 3). For example, Participant 2 described this concept as ". . . being able to bounce back from extreme emotions within a set period of time." Participant 3 added the notion of acceptance and said "They are able to accept what has happened . . . able to bounce back down to earth." Participant 10 described this process as one in which ". . . you keep constantly evolving in your behavioral patterns." In these examples, participants are stating that one must be capable of recovering from a stressful stimulus within a given amount of time in order to be considered normal.

Normal involves the ability to complete objectives despite circumstances. The final category, which was also variant, developed from *Perceptions of Normal* involved the ability to complete one's goals (n = 3). Participant 4 stated "Keep smiling; do your job, whatever you are supposed to do." Two other participants shared similar concepts of normal. Participant 6 said "Any given situation; you need to work," and "Any situation; complete it." Likewise, Participant 8 stated "I think my responsibilities are my first concern," and responded to elaboration requests by stating "I think my answer would be the same as I told you before; that you just need to do your duty." Here, participants are viewing people as normal if they can keep working on their everyday jobs.

Perceptions of Abnormal

The second question of the study asked participants to conceptualize the meaning of abnormality. The goal was to add depth to the overall meaning of normality by allowing participants to approach normality from a different perspective. Initially, two domains were developed: *Behaviors associated with abnormal,* and *Description of abnormal.* However, the data once again revealed that there was enough overlap in content between the two domains to condense the data into one domain *Perceptions of Abnormal.* The following categories were developed: Presence of erratic thoughts and behaviors, Inability to achieve an emotionally balanced state, Inability to move on, Perpetuate actions that instigate pain, Inability to maintain social function, Inability to follow and recognize cultural standards, and Deviation from expected pattern (see Table 5).

Table 5. Perceptions of Abnormal.

Category	Frequency
Presence of erratic thoughts and behaviors	7
Inability to achieve an emotionally balanced state	5
Inability to move on	4
Perpetuate actions that instigate pain	3
Inability to maintain social function	3
Inability to follow and recognize cultural standards	4
Deviation from expected pattern	3

Presence of erratic thoughts and behaviors. Participants typically stated that abnormality involved the presence of volatile reactions, peculiar behaviors, and florid symptoms (n = 7). For example, when referring to abnormal people, Participant 1 stated "I heard that they do some crazy stuff like throwing stuff and shouting at people," and "I saw people who would mumble to themselves too much and they would not bother with what is going on around them, and they go crazy at times."

Participant 7 reported that "I would rather say that they are also in their own world, but they don't have any control over their particular sense of behavior." Similarly, Participant 9 stated "They are out of track, their speak [sic], you know, they are thinking something else out of this world, and behaviors; they get violent sometimes." In these examples, participants are indicating that capricious behaviors are indicative of abnormality.

Inability to achieve an emotionally balanced state. Participants also typically believed that being abnormal involved the inability to achieve mental and emotional balance (n = 5). Participant 3 reported that a person would be considered abnormal if he or she was "Dwelling on either of the extremes, either being too dull or being too, you know, excited." Also, Participant 5 stated "He reacts too much," and "With excitedness comes all this going out of the way things."

This lack of balance was also expressed in turns of an obsessive state of mind. For example, Participant 6 stated "Take for example an addicted person, guy who smokes cigarettes a lot he starts out with a little bit then gets addicted to it, that is abnormality." Similarly, Participant 2 said "That kind of obsessive liking or dislike." In these examples, participants are signifying that abnormality consists of any extreme state of thought or emotion, and being fixated on an object.

Inability to move on. In this variant category, participants (n=4) perceived people to be abnormal if they were not able to overcome emotional or mental stress in a given time frame. For example, Participant 3 stated "Not if it just stays a while, but if it stays for a long period I guess that is not normal," and "Well, if you say something might make you angry or excited, but if you are going to stay that way for a long time, that is not really healthy." Along these same lines, Participant 9 stated "If they are not normal for a lot of time, then maybe I will consider them not normal," and "He's probably going through something, and if you give him time he would probably go back and adjust and act normally, but if he doesn't do that after a period of time, you would start thinking that something is wrong with that guy." Here, participants are stating that abnormality occurs if one fails to return to a previous level of functioning after being exposed to a stressor within a given amount of time.

Perpetuate actions that instigate pain. Causing harm to another as a sign of abnormality was a variant category that was supported by a small number of participants (n = 3). Participant 5 stated "Mostly some sort of crime, like killing someone, harassment, assault, any kind of assault." Participant 7 said "Abnormal is guys who create trouble," and "It could be any harm, which could disturb you or bother you." Also, Participant 9 stated "One thing I think of is if that person was going to harm me in some sense, either physically or even verbally." In these examples, participants are indicating that causing injury to another would make one abnormal.

Inability to maintain social function. A moderate number of participants (n = 3) stated that the variant category of disengaging oneself from the environment or others was a sign of abnormality. For example, Participant 8 said "He is not socializing he is not moving well with other people." Also, Participant 10 stated "Well, like I said, he may not be mixing up well with his friend like he was doing before." Here, participants are stating that the inability to sustain social relationships contributes to abnormality.

Inability to follow and recognize cultural standards. The inability to adhere to society's rules was variantly supported by four participants as an indication of abnormality. Participant 5 stated "Abnormality I think, they go out of the way of from the social norms," and "The social behavior, whatever they do, is not acceptable according to the social norms for the place where we stay, our locality." Participant 9 added "Mentally ill . . . if you are not acting the normal way, to a certain extent that it is not acceptable to the surroundings that you are in." Participant 10 cited examples of non-adherence "Say they are perverts, they break the rules, they desecrate something, at least the desecration the majority of society believes that activity is a desecration, maybe it is not desecration for that guy." In these examples, participants are summarizing abnormality as a departure from the rules of behavior that has been established by society.

Deviation from expected pattern. Finally, the last category developed in *Perception of Abnormal* involved a change in behavioral pattern and was supported by a variant number of participants (n = 3). As an example of this variant category, Participant 9 said "So you think is not taking things the way he usually does and he is not taking things properly." Participant 10 reported that "There may be some patterns, some impressions in my mind, o.k. this guy usually does this sort of things when he is among us; now suddenly, those patterns are not seen that were generated before, and I will think there is something wrong." In these examples, participants are indicating that when what is expected does not occur is abnormal.

Cause of Mental Illness

The third question in this study addressed participants' ideas about how someone becomes mentally ill. This question was designed to allow participants to add depth to the concept of normal mental health. The following categories were developed: Reactions to environmental stress, Unmet expectations, and Uncontrollable factors (see Table 6).

Table 6. Cause of Mental Illness.

Category	Frequency
Reactions to environmental stress	8
Unmet expectations	3
Uncontrollable factors	4

Reactions to environmental stress. Participants typically determined that mental illness was caused by environmental stress (n = 8). For example, Participant 1 stated "Maybe too much of stress or everyone has a breaking point they could reach." Also, Participant 2 added "Some kind of psychological impact, through experiences through . . . should be the principal reasons."

Participant 3 said "Some event like that causes some kind of strong emotions that makes it so that they are out of their equilibrium and that they cannot recover." Similarly, Participant 10 stated "The majority it may be due to the environment in which the individual, the subject, is growing up, or some events in his life, some events which he does not have the capability to handle that properly so he may become mentally ill at that point in time." Also, Participant 6 reported that becoming mentally ill depends on "How the person deals with anger, sadness, love, affection."

In these examples, participants are indicating that mental illness is caused primarily by the environment. Participants believed that mental or emotional trauma was the main factor. Participants also added that when these traumas occur, mental illness may develop as a result due to one's lack of mental or emotional fortitude.

Unmet expectations. In this variant category, participants stated that mental illness was caused by unmet expectations or desires (n = 3). Participant 1 stated "Maybe they are deprived of something they want very dearly . . . .", and Participant 5 added "or if he is expecting too much of anything and he can't get it." Also, Participant 4 said "usually maybe it is because they want to get something badly, or they are continually thinking about something, then they might end up with some sort of illness." Here, participants are suggesting that mental illness occurs when one feels that one's needs and wants are not met.

Uncontrollable factors. Participants cited factors such as genetics and fate as contributing to mental illness. Since four participants responded in this manner this was a variant category. For example, Participant 6 stated "So in the mental sense, any disability has been predetermined." Participant 7 said "It could be from birth also like children get some disorder by birth." Also, Participant 10 stated "Mentally ill, I believe maybe it's there in the genes and it's triggered at some point in time." Participant 9 reported "Very sure my parental guidance."

In these examples, participants are indicating that mental illness occurs due to factors outside of the individual. Participants believed that destiny or fate could be the reason why mental illness occurs. Other participants felt that genetics and parenting also played a role in determining mental illness.

Criteria used to Differentiate Normal from Abnormal

Participants were also asked to define and describe criteria that they used to distinguish between abnormal and normal behaviors. Once again, this question was designed to allow participants to describe normal by different means. From this question, the following categories were developed: Comparison to recognized standards, Observations of emotional and behavioral expression, Ability to move on, and Deviation from expected pattern (see Table 7).

Table 7. Criteria used to Differentiate Normal from Abnormal.

Category	Frequency
Comparison to recognized standards	7
Observations of emotional and behavioral expression	5
Ability to move on	3
Deviation from expected pattern	3

Comparison to recognized standards. The majority of participants typically distinguished normal from abnormal through the use of some comparative method (n = 7). Participants compared behaviors of others against their own, an ideal, and others when making a determination on what was considered normal. For example, Participant 4 stated "Usually like um . . . I think I am a normal person so I tend to compare it to . . . I don't exactly expect someone to be similar to me, but at least on the same lines," and Participant 5 said "When I see a person doing something, I would place myself in that situation and see if I would react the same way." Also, Participant 8 added "I just think I am normal." These examples are representative of the standard of comparison to the self.

Other participants compared individual behaviors to that of a group of others. For example, Participant 3 stated "I mean, not talking like any normal person would do." Similarly, Participant 9 stated "The . . . group of friends you're in; what is accepted by them is normal for me."

Participants also compared individuals to an ideal and societal standard. For example, Participant 4 reported "Or sometimes I tend to think of if I have an image of someone as being ideal, or close to ideal then I try to compare with them." Participant 7 addressed the comparison to societal standards and stated "Lets take a particular state of mind where a person is there as part of a society, but he is doing certain things which are harmful, disturbing, or which are bothering others," and "Over time, there is a certain code of conduct for the smooth functioning of society."

In these examples, participants are indicating that the criterion used to distinguish normal from abnormal involves a comparison to some subjective standard. Participants reported that they utilized comparisons to self, others, society, and the ideal when differentiating between normal and abnormal. If the observed met the subjective standards of normal for the comparison group then one would be considered normal.

Observations of emotional and behavioral expression. In this typical category, participants reported that they used observations of emotional expressions and responses to environmental stimuli to distinguish between normal and abnormal (n = 5). For example, Participant 2 stated "How you react to circumstances and what affects you more should get you into the extremes of emotions." Participant 4 echoed similar thoughts "Well, maybe the way they react like 'Oh my God!' I mean, like it they are continually, once in a while everyone goes into every kind of mode and every kind of behavior, but if something is recurring regularly then maybe something is wrong with that person." Participant 6 added "You keep on looking at people, the way they behave, and you will be told that this guy is good or this guy is bad because of their actions." These examples are representative of participants' beliefs that abnormality and normality are distinguished by an observation of certain behaviors.

Ability to move on. A variant number of participants believed that a normal person would be able to mentally and emotionally move on (n = 3). For example, Participant 2 stated "If that time is getting to be too long and you sense that is affecting that person a little more than what it typically occurs." Likewise, Participant 3 said "Well, like I told you before, any extreme emotion for a long time, for very small things," and "I would be kind of surprised that the person is feeling that way for that long I would say that person is not normal." Here, participants are indicating that they observe how long it takes someone to mentally and emotionally recover from some stressor as a criterion for determining normal or abnormal.

Deviation from expected pattern. In this variant category, participants (n = 3) stated that they used the distinction between what thoughts or behaviors were expected and what a person actually did to distinguish between normal and abnormal. For example, Participant 9 stated "We know what he'll do if he is angry or in a usual mood we know everything more or less since the day you've known him until now, you know what he'll do and suddenly something happens and you expect him to act one way, you expect a certain thing, and suddenly he is violent." Similarly, Participant 10 stated "There may be some patterns, some impressions in my mind, o.k. this guy usually does this sort of things when he is among us, now suddenly those patterns are not seen that were generated before and I will think there is something wrong."

In these examples, participants are indicating that they utilize the criterion of familiarity as a means of determining abnormal and normal. That is, if something occurs that is familiar then that is deemed normal. On the other hand, if something occurs that is unfamiliar or unexpected that is considered abnormal.

Difficulties in Defining Normal

Several participants had difficulty addressing the concept of normal. In fact, all 10 participants responded with uncertainty at some point in time during the interview process. The following categories were developed to describe the nature of problems participants had in defining normal. These categories included: Normal is difficult to define because of its' subjective nature, and No previous experience with concept of normal (see Table 8).

Normal is difficult to define because of its subjective nature. Participants typically stated that it was difficult to define normal due to its subjective properties (n = 8). For example, Participant 2 stated "It would vary from a case to case basis," and Participant 4 stated "So it depends on just how you look at it." Similarly, Participant 5 sated "We can't really say for sure if the person is normal or abnormal," and "You really can't give a definition . . . it all depends on the locality . . . it depends on the situation actually . . . It's all a contextual thing." Also, Participant 6 stated "It all depends on the context, on the domain you are targeting."

Table 8. Difficulties in Defining Normal.

Category	Frequency
Normal is difficult to define because of its' subjective nature	8
No previous experience with concept of "normal"	3

Other participants reported that despite the evidence of observable behaviors one can still not be sure about determining what is normal. For example, Participant 9 stated "Any heuristic or measurement I could say that he is normal I mean, that could be his normal behavior because some people are very ill, some people are very outspoken and he could be offending me, but it could be that is normal for him." Participant 10 reported "If you are saying for mentally abnormal things, I mean it is inside and then again we may not be able to know his activities outside . . . . We may not be able to know if he is abnormal really."

In these examples, participants are indicating that defining normal is fraught with difficulties due to its subjective nature. Participants stated that what is normal could vary across situations and people. Participants also reported that what is observed in making the distinction between normal and abnormal can not always be trusted.

Finally, a variant number of participants (n = 3) reported that they had difficulty in defining normal due to a lack of experience with abnormal people for comparison and a lack of thought dedicated to the concept of normal. For example, Participant 1 stated "I use that word so frequently I never really thought about it." Participant 8 stated "I don't have much experience with this type of thing." Similarly, Participant 9 reported "I've not had people who are not normal," and "I have not had such an experience." Here, participants are suggesting that normal is difficult to define because they had never thought about the concept before.

Summary of the Findings

Participants' views on normality indicate that maintaining mental and emotional balance is the primary facet of being normal. When extreme states of emotion or thought are observed, participants attributed these to an abnormal state. Also, participants felt that environmental stress was the leading cause of positioning one in this unbalanced state. If one was unable to reduce the erratic thoughts and behaviors, within a given time frame, that were often the result of these stressors, one was viewed as abnormal. The criteria used to make the distinction between what constituted abnormal or normal was based on the subjective comparison to oneself, others, society, or an ideal.

While participants were able to provide descriptions of normal and abnormal they also stated that there was a problem in defining these constructs. Almost all participants (80%) stated that the subjective nature of normality created difficulty as they attempted to provide a definition. Participants stated that normality was a dynamic construct that could shift meanings across any given situation, time, or place. Participants also reported that observers may truly not know what is going on inside the mind of the observed. Therefore, without intimate knowledge of what someone is thinking or feeling one might make a mistake in determining what is or is not normal. This could result in negative consequences for both the person making the judgment and those being perceived as abnormal.

CHAPTER V

DISCUSSION

The purpose of this research was to present a description of normality from a multi-cultural perspective. Specifically, Asian Indian graduate students were asked to describe normality in order to provide an insight into possible psychotherapeutic implications with this group. According to the Asian Indian graduate student sample in this study, normality, or normal mental health, was thought to be a state in which one achieved mental, physical, and emotional balance. From an analysis of the domain content, participants believed that deviation from this balance, observed as extreme emotional or behavioral responses, was an indication of abnormality.

Based on participant responses, the following domains emerged: Perceptions of Normal, Perceptions of Abnormal, Cause of Mental Illness, Criteria Used to Differentiate Normal from Abnormal, and Difficulties in Defining Normal. These domains represented the multiple techniques participants discussed as part of their working conceptualization construct of normality. Because perceptions of normality were generated from many different domains, a multifaceted approach to defining this construct may be needed. When analyzed individually, domains generated unique descriptions of normality. However, domains were also related across several categories.

Domains were interpreted by the research team to be related in terms of how normality was viewed as an amalgamation of controlled behavior and thought that led to normal mental health. These domains also shared the notion that normality was based on some cultural standard that was relative to the place one was residing. From these cultural standards, participants developed perceptions of normality that shared similar traits across all domains. While the domains and categories that emerged may indicate that a clear demarcation point can be made when describing normality, or abnormality, such as the presence or absence of balance in one's life, normality may also be described in terms of a range of behaviors. The data in this particular sample appears to have generated perceptions of normality that could be considered extreme. The exploration of the full range of normality is discussed in the implications and future research section.

From the participants responses, it was interpreted that the cultural standard that may have been employed was one of Asian Indian graduate students who had lived their entire lives in India and had spent less than two years in the United States. Based on participants' cultural viewpoints, the perception of normality that emerged was one that incorporated both Asian and Western cultural values. However, it should be made explicit that participants were not directly asked what cultural value system they were operating from, and that this is an interpretation of the results. This point is discussed further in the limitation section. The means by which one could deviate from these values and thus deviate from this normal state were also interrelated among the domains. For example, an environmental dimension, which primarily included family upbringing, was given as a possible explanation as to why one might deviate from normality.

There were several behavioral, mental, and emotional criteria used by participants to describe normality across domains. For example, participants viewed a normal person as someone who refrained from injuring another person. In this example, injury was referred to as any action that caused mental, emotional, or physical harm to oneself or another. Participants also stated that behaviors and thoughts needed to be predictable. That is, given a particular situation a person needed to act in a similar manner as they had before, or act in a manner that was consistent with cultural guidelines in order to be considered normal. These standards included: not harming oneself or others, sustaining social relationships, carrying out one's everyday jobs, and moving on from emotional and mental stressors. It appeared that an inability to adhere to cultural guidelines was viewed as abnormal and that deviation from the balanced state was equated with abnormality. This is similar to Mosak's (1967) definition of normality as conformity where individuals are seen as normal if they abide by societal rules.

These findings were consistent with Asian models of mental health that emphasized balance as a means of achieving psychological health (Laungani, 2004; Walsh, 2000). The findings were also consistent with Western cultural models of normality that defined normal mental health as the absence of symptoms (Jeger & Slotnick, 1982; Mosak, 1967; Offer & Sabshin, 1966). That is, participants were interpreted to have identified with the Asian psychological belief regarding balance as normal, and also adhered to guidelines of distinguishing normal from abnormal established by Western models of normality. What is proposed then is an Asian Indian model of normality that incorporates both Western and Asian psychological concepts regarding normality.

In the following discussion section I will propose an Asian Indian graduate student model of normality, grounded in the data of this study, which represents a possible hybrid of Western and Asian psychological thought regarding normality. This model will then be discussed in terms of its' application to therapy with Asian Indians. The limitations and possible future research related to the findings of this study will be addressed at the conclusion of this section.

Proposed Asian Indian Model of Normality

This particular sample of Asian Indians endorsed a model of normality that was based on cultural criteria and personal beliefs. The model that emerged was based on the concept of homeostasis. From the data, it was interpreted that participants viewed normality as the process of maintaining balance, or equilibrium, throughout all aspects of the self. The necessity for balance was viewed as the foundation of the participants' model of normality. However, while the aspect of balance is consistent with Asian psychological thought regarding psychological well-being, the participants in this study also responded in a manner that suggests they incorporated other world views in their definition of normality.

In their attempt to define normality, participants failed to incorporate the concept of transpersonal development. Transpersonal development was viewed as fundamental to Asian psychological thought regarding mental health (Walsh, 2000). The lack of a transpersonal factor also deviates from current models of normality, such as Mosak (1967) and Offer and Sabshin (1966), which suggest the ideal or utopian state as normal.

Since participants did not address the notion of self-transcendence, as a factor in normality, it suggests that influences other than the Asian theory of mental health influenced their responses. This seems appropriate given that both Asian and Western cultural factors may have been utilized in determining participants' definition of normality. However, it could be that the Asian model of mental health was not an appropriate fit for this population because they reside in America. Also, based on the sociocultural perspective of mental health, it would seem to fit that these participants would incorporate a bi-cultural view of normality. This viewpoint agrees with the sociocultural idea that normal mental health is defined by both one's individual and current cultural context, and is supported by the sociocultural model of normality (Gray, 1994; Jeger & Slotnick, 1982). Due to the influences of both their individual (Asian) and cultural (Western) contexts, the participants' responses in this sample may be indicative of a hybrid model of normality that incorporates both Western and Asian values.

In stating that normality consisted of being social and completing one's goals, participants in this study utilized may have utilized a Western value set. This is supported by literature that indicates that Americans tend to value such traits as extraversion, sociability, and individualism (Sodowsky et al., 1995). The participants in this study also may have utilized an Asian value set as they indicated that normality was based on maintaining balance in emotions and behaviors. This is consistent with literature findings that indicate Asian values include moderation in behavior and self-control (Sodowsky et al., 1995).

Taking into account that both Western and Asian values may have been utilized, the model of normality that is proposed is essentially a hybrid model. The hybrid description of normality that emerged can be summarized as follows: mental and emotional balance must be maintained through self-control, social relationships must remain intact, and work tasks need to be completed. Normality as Balance is supported by the Western model of normality that utilizes the normality as health perspective, which views normality as a reasonable state rather than an ideal sate (Offer & Sabshin, 1991), as well as Asian philosophical ideas that one must achieve mental, physical, and spiritual balance if one is to reach the ideal state (Walsh, 2000).

Normality perceived as the maintenance of social relationships is supported by a Western model of normality. The field of anthropology viewed the ability to maintain interpersonal relationships as central to maintaining mental and emotional health (Hsu, 1961; Linton, 1956). The anthropological perspective supported the hypothesis of normality as health, which postulated that normality was equivalent to an absence of symptoms that contributed to illness (Offer and Sabshin, 1974). In this perspective it was considered reasonable to strive towards maintaining relationships, and that these relationships could minimize illness.

Participants also supported the idea that normality involved consistency. That is, behaviors were normal if they had been accepted by society and were considered familiar. For example, one participant indicated that in America, if one were to display fireworks on a day other than the Fourth of July, it would be deemed unfamiliar and therefore considered abnormal. However, in India there are many festivals that involve fireworks throughout the year. Thus, if Indians were to celebrate these festivals with fireworks here in America they might be considered abnormal at first, but over time people would become accustomed to them and regard them as normal. This view of normality is consistent with the view of normality as concordance (Steinbock, 1998).

One of the benefits of this qualitative study was that it allowed participants to describe their experience of normal from the perspective of abnormality. This generated additional responses that added depth to the definition of normal. Participants described abnormality as an inability to adapt to situations which may have been caused by a lack of mental and emotional strength. This inability to adapt was the basis of the Western model of normality that was based on evolutionary principles (Millon, 1994).

Abnormality was also perceived as any observable deviation from balance usually indicated by extreme emotional or behavioral responses including: self-injury, injury to others, unpredictability, prolonged anger, and other florid symptoms associated with mental illness. In this study, participants explained that mental illness, or abnormality, could occur if one was mentally and emotionally inflexible, lacking in fortitude, and could not recover from a negative stimulus. The use of mental and emotional robustness as a means of staving off abnormality is supported by Western models of normality. According to the literature, the inability to move on or adjust is supported by Millon's (1994) definition of normality as adaptation. This inability to utilize one's mental strength to proceed back to a state of balance when faced with a negative environmental stress was viewed as a sign of abnormality.

Finally, from Jeger and Slotnick's (1982) psychodynamic perspective of normality, abnormality existed when inner psychological conflicts were caused by anxiety. It would make sense to argue then that these participants would view one's inability to effectively deal with stress as a model for abnormality as it could lead to physical, mental, and emotional imbalance.

In sum, it is proposed that the Asian Indian graduate students in this study utilized both Western and Asian values in describing normality. The description of normality that emerged was a hybrid model that incorporated Western models of normality and drew upon Asian psychological principles of psychological well-being. Foremost, normality was defined as an ability to maintain mental, emotional, and physical balance. This portion of the hybrid model is similar to Asian psychological beliefs and values that emphasized moderation and self-control (Sodowsky et al., 1995; Walsh, 2000). It is suggested that participants also drew upon physical signs of mental illness such as the presence of erratic behaviors or florid symptoms as an indicator of abnormality. The utilization of somatic criteria agrees with the Asian view of attributing mental illness to biological factors (Atkinson et al., 1998). Participants may also have agreed with Western models of normality that stressed socialization, adaptation, and familiarity or frequency.

Implications for Practice

Given the importance of the concept of normal in psychotherapy, these findings suggest that a hybrid model of treatment may be useful in treating Asian Indian graduate students living in America. The literature suggests that treatment is inherently impacted by the construct of normality, and that clinicians use this construct in their conceptualization of patient care (Offer & Sabshin, 1991; Ursano & Fullerton, 1991). Therefore, it is suggested that the hybrid model of normality, suggested to have been utilized by these participants, be reflected in the psychotherapeutic treatment they receive.

By incorporating both Western and Asian values, the participants have suggested that a bi-cultural model of therapy may be most useful in alleviating their psychological stress. In fact, a lack of ethnically specific models of therapy has been viewed as a primary reason for the underutilization of mental health services by minorities (Atkinson et al., 1998). Ethnically specific models of therapy can also be useful in treating mental illness (Atkinson et al., 1998). For example, therapy that is tailored to meet the specific needs of a particular ethnic group has shown: increased use of services, increased return rates, and attendance in a higher number of sessions (Atkinson et al., 1998). Therefore, a bi-cultural model of therapy that incorporates this sample of Asian Indians' ethnically specific beliefs on normal mental health would seem appropriate.

A culturally specific therapeutic approach with this population could address both the return to balance and maintenance of social and work roles. This can be accomplished by utilizing treatment methods that meet both the Western and Asian values that were perceived by this population to be pertinent to normality. The primary ethnically specific model of therapy incorporated by Asian Indians would involve some form of meditation or yoga.

The use of meditation and yoga would allow clients to develop the mental and emotional strength needed to recover from stressors that lead to imbalance. This ability to recover within an acceptable amount of time was seen as essential in determining normal vs. abnormal behavior. While meditation and yoga are primarily utilized to meet transpersonal goals, the participants in this study indicated that they did not view this aspect of Asian psychological thought as central to their concept of maintaining psychological well-being. However, meditation and yoga can be used to reduce painful feelings, and effectively deal with the delusions, cravings, and aversions which may lead to mental illness (Goleman & Epstein, 1983; Laungani, 2004; Walsh, 1999).

This non-European approach may also allow for more congruence between therapist and client, which would lead to a more effective therapeutic relationship. Also, Laungani (2004) has argued that the relationship needs to be hierarchical and the process of therapy directive in order to be effective with Asian Indian clients. While this differs with the non-directive approach espoused by many Western therapists, the relationship would be enhanced in that Asian Indian clients and Asian clients in general, view the therapist much like they would gurus, and require a level of formality. That is, Asian Indian clients would continue to seek treatment from a therapist that they recognized as having some high status. This status can be achieved by connecting with clients' thoughts and feelings regarding the cause of mental illness (Atkinson et al., 1998; Laungani, 2004). Therefore, an approach to therapy that recognizes the importance of achieving balance through mental and emotional training might be most useful for establishing relationships with Asian Indian clients.

As noted above, Asian Indian participants in this sample were understood to recognize abnormality by the presence of somatic problems. Consequently, therapists who recognized that balance could be achieved by alternative methods such as Ayurvedic and dietary therapies may also be better prepared to work with this population. The use of these therapies would also assist in returning the client back to a balanced state (Laungani, 2004, Goleman & Epstein, 1983; Walsh, 1999). Through the use of Ayurvedic therapies, the Asian Indian's in this sample may be treated more effectively in that balance is achieved without the emphasis on transpersonal development. In their review of counseling ethnic minorities, Atkinson et al., (1998) emphasized this point of utilizing indigenous therapies by stating "Counselors may be able to best serve their minority clientele by attempting to facilitate rather than discourage the use of indigenous support systems" (p.313).

By using ethnically based techniques in conjunction with the recognition that this population may be utilizing a multi-cultural model of normality, therapists can provide the most effective treatment. That is, by acknowledging both cultural systems that define normality the therapist can avoid the entrapment of believing that all Asians wish to seek Nirvana. Instead, it is proposed that the competent therapist recognizes that Asian Indian graduate students may value Western ideals as well, and use ethnically based techniques to help them achieve a normality that is rooted across cultures.

Limitations and Future Research

In this study I attempted to describe what the construct of normal meant to a non-Western sample. Specifically, I wanted to investigate how an Asian cultural sample, such as Asian Indian graduate students, perceived normality in comparison to the Western cultural models that are currently accepted. There are several factors which could be considered confounds in this study.

First, while the attempt was to describe normality from an Asian Indian graduate student perspective, the logistics of the study may have impaired this primary directive. That is, the fact that the sample consisted of Asian Indian graduate students who were residing in the U.S. may have produced results that were biased by the effects of acculturation. The entire sample consisted of 10 Asian Indian students who were attending graduate school and had been in the U.S. for approximately 24 months. These participants may have responded differently to the research questions had the mean amount of time residing in the U.S. been greater or lower.

Also, while it was proposed that this sample incorporated a hybrid view of normality, they were never explicitly asked what cultural context they were incorporating, if any, into their descriptions of normality. Future research may involve studies of normality that can account for the effects of acculturation, and be more explicit regarding queries into the cultural context that may be in use. Future studies could be conducted in the country of origin in order to minimize the impact of acculturation.

Second, there are inherent limits to generalization. The participants may not have accurately represented the vast majority of Asian Indians, approximately 75% (of 1.2 Billion) of whom reside in rural areas and are mostly uneducated and impoverished. One could assume that the Asian Indians in the sample might have a different view of normality from those sampled. Perhaps the "rural" Asian Indian might prescribe more to transpersonal development because of a lack of job and educational opportunities. Thus the focus would be on achieving spiritual rather than work goals, which differs from the results in this study. Studies could be conducted with subjects who were more diverse in terms of their age, and economic status.

Another limitation of the sample was in its' lack of diversity in terms of occupation. All of the students in the sample were earning advanced degrees in a scientific discipline. It could be that concepts such as balance and dedication to completing goals, that were used to describe normality, were a result of this particular sample's educational and career choices. Broader descriptions of normality may emerge if future studies are conducted that seek a wider range of educational and career backgrounds.

It has also been proposed that Asian psychology is a combination of both religion and philosophy (Walsh, 2000). Given this connection between religion and philosophy in the development of Asian psychology, it could be argued that participants' religious identification could impact their perceptions of normality. Therefore, future studies may also incorporate some questions regarding religious affiliation and the degree to which religion may be playing a role in one's perceptions of normal mental health.

The interview questions in this study may also have contributed to a confound. By asking questions such as "How does someone become mentally ill?" results may have been generated that led to extreme views of normality. It could be that participants had an emotional response to questions that inquired about mental illness and their personal history with the topic. Future studies could incorporate questions that limit the possible emotional response and generate perceptions of normality that may better describe the full range of the construct.

In addition to studying a more diverse Indian sample, the long term goal of additional studies may be to develop models of normality that are representative in general. That is, models of normality could be broken down across many different cultures such as China, Japan, Mexico, Saudi Arabia, Tanzania, or Canada. The goal would be to examine models of normality across a wide geographical, political, sociocultural, religious, and economical sphere in order to find both differences and similarities in how we globally define what is or is not normal. My future research goals include the continued study of an Indian model of normality as well as other Asian cultures. The purpose would be to collect data that could be compared to the Western models of normality in order to improve, where needed, the psychotherapeutic treatment of clients from these cultures. Also, this leads to the question of how both those in the professional and non-professional fields view normality. That is, how do those who pursue and provide psychotherapy in the West view normality, and how does that compare to non-Western viewpoints?

Finally, the participants in this study also indicated that normality may not be a valid construct. Normality was viewed as being too subjective of a construct to define by 8 out of 10 participants. The difficulty in defining normality lends support to arguments that normality may not be a valid construct (Buck, 1992; Jenkins, 1993; Widiger, 1997).

Despite the number of responses that cited the subjective nature of normality, results indicate that clients were able to define normality when prompted with a diverse enough question set. In fact, participants adhered to the Asian belief of maintaining balance in one's life, and as a whole, did not subscribe to all aspects of Asian psychological thought regarding normality. The participants did not cite transpersonal development or the attainment of an ideal state as their concept of normality. This differs from the Asian psychological concept of normal as the pursuit of an idyllic state of existence as the ultimate goal in one's life, when one follows traditional Buddhist philosophy (Walsh, 2000).

Given the subjective nature of normality, how does one explain the consistency of responses regarding the definition across participants? It could be that normality is at times instantly recognizable and at other times ambiguous. Perhaps participants overemphasized the subjective nature of normality when they had difficulty articulating their thoughts on the definition, which occurred during several of the interviews. Normality may also be present in the subconscious and one might have problems accessing that information when asked to do so. Maybe normality operates under the same principles as stereotypes. That is, maybe our mind utilizes various definitions of normality that work on the subconscious level in order to help us maintain our ability to make quick judgments about situations. This would seem to agree with Millon's (1994) assertion that normality is based on evolutionary principles.

Conclusion

It has been argued that normality is a construct that has an impact on therapy. It has also been argued that the current definitions of normality fail to recognize the myriad of multicultural perspectives regarding this construct. Studies have indicated that the therapist client relationship is positively impacted when both are in agreement as to what is normal or abnormal, and when culturally or ethnically specific models of treatment are utilized (Atkinson et al., 1998; Laungani, 2004).Thus, it seems that a valid description of normality that is developed from a culturally or ethnically specific approach would benefit both practitioners of mental health services and consumers.

Finally, the American Psychological Association (APA) (2002) has made an implicit call to practitioners and researchers to follow certain ethical guidelines in regards to multiculturalism. In an examination of the first five APA guidelines one can find the purpose to continue studies on the diversity of normality. The guidelines can be summarized as follows: psychologists should know that their cultural background may have a negative impact on the relationship they have with others who do not share the same background; given that there is a potential that one's cultural values and beliefs may lead to misperceptions about those who come from a different cultural system, psychologists should strive towards gaining more knowledge about different cultures and value the need for multicultural sensitivity; psychologists should teach others about the value of utilizing multicultural principles; psychologists should conduct "culture-centered" and ethical research with subjects from minority populations; psychologists should make every effort to use "culturally-appropriate skills" in their work with clients (APA, 2002).

Given the emphasis on incorporating a multicultural perspective across all facets of psychology, it can be argued that the continued study of a more diverse view of what is normal is imperative. The proposed hybrid model of an Asian Indian graduate student construct of normality was an attempt to meet several of the ethical criteria previously mentioned. The current study employed the principle of culture-centered research and attempted to challenge some of the potentially harmful misperceptions that may have been held regarding this population's concept of mental health. In addition to challenging misperceptions, the purpose of this research was to increase multicultural awareness and ultimately make a contribution that could be utilized in an applied setting. Thus, one way psychologists can continue to meet the APA (2002) ethical guidelines regarding multiculturalism would be the continued research of normality in the hopes of developing progressively more culturally-relevant models of mental health.

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