THE MYTH OF NORMALITY

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Again and again, psychiatrists, psychologists, and others concerned with mental health are called upon to decide how "sick" a person is. Their ability to arrive at anything that resembles a sound judgment is hampered because there is no standard of psychological "normality" or "good health."

In somatic medicine, physicians know that the normal systolic blood pressure will range from 110 to 130. When the reading is 160, the physician can readily label it deviant and recommend treatment for high blood pressure. But researchers in the mental health fields have been so engrossed with the study and treatment of people who are labeled "sick," they have had neither the opportunity nor the interest to study people who are "well."

One tragic result of the failure to develop a reliable yardstick is the appalling hit-or-miss process by which people are sent to mental institutions. A sociologist recently evaluated one hundred and sixty cases in a state know for relatively high standards in its mental hospitals. The psychiatric interviews to determine sanity were sometimes as brief as one and a half minutes and averaged only nine minutes each. A direct observer of twenty-five of them rated the persons interviewed as follows: seven met the criteria of insanity as postulated by the law; eleven might have done so in time; seven definitely did not. Yet the psychiatrist recommended freedom for only two. It appeared obvious to the observer that the psychiatrist tended to search for error or pathology. For example, there was a patient who answered a number of very difficult questions,

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including complicated arithmetical problems, but on the basis of a single wrong answer was adjudged suitable for commitment. One psychiatrist stated,

Originally published in *Medical Opinion and Review* vol. 3, no..5, pp. 28-33 (1967). Reprinted with permission.

"if the patient's own family wants to get rid of him, you know there has to be something wrong." It brings to mind a jingle that might fit most state hospitals: "When in doubt, don't leave them out."

The myth of normality has an insidious influence, not only for those unfortunates who are judged insane, but on the lives and attitudes of us all. Both the experts and the public are trapped by propaganda and by historical and psychological forces (fear being one of the most paralyzing) that lead to the dichotomization of mankind in the normal and the abnormal. We now live in an era of classification in which labels are sought for all human activities. This kind of classification is part of our attempt to simplify life and build reassuring fences around the perimeters of experience. The more common the experience, the more comfortable it makes us; it is easy to classify and can thus be called a know fact.

Anything occurring outside common experience stimulates fear is labeled "freak," "accidental," "miraculous," "crazy," lest we need admit *we simply don't understand*. People are most anxious to classify behavior and observations about the human personality because the unknown forces operating inside each man, and among men, are the most frightening of all—hence the most uncontrollable. However, the few extreme cases at the end of the mental health continuum, those which are fairly obvious and more readily classifiable, represent only a small portion of mankind; the bulk falls somewhere in the "normal" range. How crazy a particular

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person appears to you depends on your own frame of reference and the limits of your own experience.

Since pre-Biblical days, classifications have been used to support ethno-political ideas of racial or national superiority. The Nazi belief that a super race could be evolved through control of heredity differs only in degree from the attribution of mass personality traits to entire nationalities, as the “hot-blooded” Spanish or the “emotional” Italians. These meaningless generalizations serve to maintain the comfortable fiction of our own national personality traits, which are, of course, admirable in our eyes.

Such reductionist thinking is common even among expert and well-educated professionals. For instance, the discovery in medicine that traumas cause disease was picked up rather uncritically by psychiatrists. On the one hand, psychic traumas are alleged to cause neuroses and psychoses; on the other, the absence of obvious trauma (especially in childhood) in a mentally disturbed person is assumed to mean that he has a weak constitution. A trauma, moreover, is seen as some kind of horrendous occurrence, such as rape, severe beating, the death of a mother while a child is very young, and so on, so that the complexities and subtleties of human interaction are lost. One could postulate that lesser traumas too insidious and too constant to be noticed are far more damaging to the human personality than are the more dramatic occurrences that are easier to label and to understand.

Just as psychiatrists lifted the trauma theory from physical medicine as a piece, they also base assumptions about the human personality and its relation to heredity on the results of animal experiments. The leap from animal to human is made with astonishing ease by some theorists who ignore the greater subtlety and complexity of human experience.

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One of the most deeply entrenched belief systems in our culture today holds that the measure of man's intelligence is directly related to inheritance and brain-cell functioning, and that intelligence tests can produce a valid estimate of a human being's total potential. Although *no* personality trait has been established as hereditarily determined, and although behavioral scientists agree little on which aspects of personality they would label as traits, the intelligence quotient model as applied to personality still remains very much in vogue.

The differentiation of normal and abnormal personalities, which reflects in the rigid notion that individual limitations are fixed or inherent, is expedient for mankind and is used unabashedly for the most mercenary, cruel, and inhuman purposes. If one assumes that the truly abnormal is produced by pathological cells, one need have little guilt about man's inhumanity to man. In the South, those who support inferior schools for Negroes frequently defend their economics by stating that Negroes are unable to learn as rapidly as Caucasians, so better facilities would be wasted. Similarly, if the mentally ill are completely different from all the rest of us, it makes sense for us to isolate them miles from town in stone and brick mausoleums euphemistically called state hospitals. It makes things nice and tidy to have the two groups: one that is crazy and belongs in isolation, and one that is sane and is free.

Most psychiatrists, however, will admit that hospitalization generally depends much more on the family's attitudes than it does on the patient's. Recent statistical evidence comes form a follow-up study of all Canadian war veterans who suffered schizophrenia during World War II. There was little difference in the symptoms (including hallucinations and delusions) displayed by those who were in and those who were out of the hospital, but a great deal of difference was

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found between the families of the two groups. Those veterans who were not hospitalized had families that were more optimistic and supportive.

It has been assumed that a certain percentage of people suffer nervous breakdowns or are admitted each year to state hospitals, and that this constitutes the mentally abnormal group. The rest of us are considered to be in quite a different category. However, a recent study of a midtown section of New York City yielded some staggering statistics. A carefully selected representative sample of sixteen hundred persons was interviewed. According to the ratings of several experienced psychiatrists, 81.5 percent of the sample suffered from some type of emotional disorder: 2.7 percent were incapacitated by their symptoms; 7.5 percent had severe, 13.2 percent had marked, 21.8 percent had moderate, and 36.3 percent had mild psychiatric symptoms. Only 18.5 percent were considered well. Many persons outside hospitals, perhaps even the majority, make their way through life with symptoms (especially during particular periods) that would be labeled pathological if diagnosed by a psychiatrist. Fortunately, most of these persons cannot afford psychiatrists, so do not get labeled.

The importance of such block-by-block surveys of “normal” persons can hardly be overestimated. When the relatives of a patient in a mental hospital are interviewed, or course, a certain degree of emotional disturbance can be found; this is the foundation for the belief that psychiatric disorders are hereditary. But such conclusions about heredity become meaningless if the incidence of emotional disorder in the general population is high, as indicated by the New York City study. One could begin equally well with the patient’s psychiatrist, or with the hospital staff, and come up with a sizable degree of emotional disorder.

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If one reviews the few studies available on ordinary people, there is little safety in clinging to a normal-abnormal dichotomy. In one study, psychiatrists interviewed a hundred men whose functioning could be considered above average by most standards. Of these men, three-fourth had childhoods affected by appreciable tension and conflict between their parents and often by parental separation and divorce. Ten men claimed that their parents lived blissfully together, yet gave family histories of serious psychosomatic disorder, the amount of psychic trauma that they reported occurring in their childhood would have been considered sufficient to account for their symptoms. Instead, this was a group of symptom-free successful men.

It is a well-know fact that five of our Nobel laureates in literature were very friendly with the bottle, and several had psychotic relatives. Many of the most important contributors of original scientific ideas have had nervous breakdowns, and the incidence of psychosomatic disorders in gifted actors and artists is impressive. Case histories, biographies, and autobiographies of outstanding persons demonstrate repeatedly that “out of the mud grows the lotus.”

If someone overcomes a particularly sordid, squalid background, geneticists attribute his achievement to superior genes rather than to the accidents of rearing that abound in most of our lives. That is, they ignore the adult friend, the school teacher, or the lucky break that may represent the turning point in a person’s life and help produce a Superior Court Justice rather than a criminal. Many studies have been made of gifted children, comparing noncreative and extremely creative children with comparable IQs. It has been found repeatedly that the families of the creative children were generally less happy and evidenced greater conflict and tension. IN short, it took anxiety plus IQ to make the child superior.

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Genetic theories about what is normal and what is not normal rely on the assumption of the "thingness" of pathology, labeling human traits or characteristics as if they were tangible realities, when, in fact, such "traits" are only ideals and remain undefined and unobserved in any scientific sense. As a student of the family for many years, I think it is safe to say that there is no such thing as a normal family any more than there is a normal individual. There are parents who appear to live in extreme harmony together but have nervous children, and parents who get along miserably but whose children appear to be functioning well. When one hears the expression, "Gee, they're a normal family," the speaker is usually referring to some facet of family living and not to the total familial interaction, which is unknown to the casual observer. Such statements are usually made by persons who value conformity and see this family as one that lives up to all the ideals of the ladies' magazines, including the cardinal principle of "togetherness." Truly, such behavior has little to do with mental health. There are cultures and families within our culture, in which the family structure is very different from what is commonly considered normal. Yet the individuals therein are creative and productive.

It should be clear by now that I strongly believe psychologists and psychiatrists should stop asking, "What is normality?" IT seems to me that for purposes of scientific theory formulation, and also for practical clinical purposes, a different and more fruitful approach can be taken. One that would incorporate the views the human beings possess a variety of potentialities, that the achievement of certain potentialities may entail certain limitations, and that achievement and limitation vary with conditions. Thomas Szasz says the mental illness is a myth, whose function is to disguise, and thus render more palatable, the bitter pill of the moral

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conflicts in human relations. He states that we have are problems in living together, and not poor mental health. These problems are biological, economic, political and sociopsychological.

What can replace the concept of normality? Obviously, for purposes of scientific study, we need to categorize in some fashion. It is possible to rate the members of a family, for example, on their level of ability to function in various areas of living. Thus, a man who earns ten thousand dollars a year has a certain degree of economic functioning: whether he has any friends or any sex life will be judged separately. This rating does not imply good or bad, since a high level of functioning does not necessarily indicate happiness or good moral character, or vice versa. There is also no implication that a person *should* function well in all areas. It is unlikely or impossible that he will, yet he can be compared with other persons in those areas in which he appears to function well or poorly. The advantage to be gained is that of evaluating each person in a wide variety of activities and contexts; our bias, while not eliminated, is apt to be less blinding than it is within the current concept of mental health.

An illustration will clarify this conceptualization. During World War II psychiatrists examined thousands of draftees and rejected many of them on the grounds of emotional instability. In recent years, the Army has come to reject virtually no one for emotional disorders. Even those who have had a schizophrenic breakdown are not necessarily rejected. The reason is quite simple. There are all kinds of jobs in the Army and many can be adequately performed by soldiers who don't impress interviewers as potential heroes. The liberal (compared to World War II) attitude toward selection during the Korean campaign did not result in increased psychiatric casualties among combat heroes. As a matter of record, casualties were reduced by putting

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psychiatrists to work on combat troop morale instead of letting them sit back at a General Hospital waiting for patients.

I submit that there is no such animal as the normal person. Instead there is a wide variance in adaptive patterns and behavioral repertoires. How a person acts varies with the culture, the subculture, the ethnic group, and the family group in which he lives. We tend to forget that values change, because we are so often uplifting the new and forgetting the old. At one point in our history, blushing was considered to be ladylike and was rewarded socially. Later it was considered cause for treatment by a psychoanalyst. Today the art of blushing seems virtually to have disappeared—is it, or was it, normal or abnormal?

If we recognize that normality is a myth that carries with it false genetic implications and dubious judgments about who is better than whom, we might be in a better position to undertake research about various kinds of functioning and techniques of problem-solving. We might also be in a better position to recognize that *most* people contribute something to the human condition and that man is fantastically adaptable. Those people or nations unlike ourselves are *not* inferior—just different. It is time to give up the false security born of labeling what we are doing as "right" or "normal" instead of using the more accurate but less reassuring term "conventional." It is going to be tough on some physicians to not label their unusual, anxious, or irritating patients—but think of the challenge!

As mentioned already, the idea that behavior depends on communication and interaction is not new. In addition to its occasional scientific recognition, it is the stuff of everyday experience. But such common knowledge or specific insight has remained limited and is

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especially rare where layman and specialist alike would most need it; that is, in looking at and dealing with unusually difficult behavior—badness and madness.

The next article offers a case in point. In it John H. Weakland considers sociocultural investigations of schizophrenia—the epitome of madness. It has been in science "a significant difference is a difference that makes a difference" This article illustrates how significantly different the evaluation of past studies and the planning of future ones becomes, if one takes a thoroughly interactional viewpoint, rather than one which, even while aiming to relate them, views schizophrenia and social living quite separately and in disparate frameworks.

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