

## NORMALITY AND PATHOLOGY – A FINE LINE THAT CONNECT AND DIVIDE

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### **Abstract:**

**How we conceptualise the nature and cause of abnormal behaviour has important implications for how we conceptualise treatment, the clinician's role, and the client's role. To a certain extent each concept captures a different aspect of the meaning of abnormality. When we talk about abnormality we inevitably invoke one or more of these definitions, either explicitly or implicitly, but we do use some definition. It is unavoidable and it is necessary.**

**When we choose a definition, we do so in part based on feelings, emotions, convenience, custom, appeal and ethics and it is a value judgment in the final moment. There is an inherent non-scientific arbitrariness in this choice. The potential result is that psychologist A and psychologist B could be talking about very different things when using the word "abnormal". Confusion and controversy exist, especially if the definitions remain implicit.**

**One alternative orientation is to use a difference model. The basic assumptions are changed. The question is no longer what is wrong with the person, but what are the strengths of this person and how can they be used. The goal changes from rehabilitating the person, to finding a setting into which the person could fit and use his/her abilities, and where he/she could develop new abilities. It could be called a psychology of strengths rather than weaknesses.**

Modernity's 'problem of pathology' manifested itself in the era's preoccupation both with the rehabilitation of various practices and ideals or normality, and with a relentless fascination concerning the identity and nature of the deviant, maladjusted, monstrous or 'otherly'. In fact, the 20th Century has seen varieties and manifestations of abnormality and pathology, and concurrently, the rise of social and medical disciplines intent on the classification of such transforming behaviours and identities.

The idea that there are normal and abnormal ways for people to be and to behave is a very familiar one. So also is the idea that abnormality or deviance is something regrettable, deplorable, and even, in some cases, punishable. Here, however, our main concern would be to consider what might be meant by the claim that a person is, in some respect, normal. There is, no doubt, an unsophisticated usage according to which what is normal is what is familiar, and the unfamiliar is feared or condemned as abnormal.

The terms normal, abnormal, benign and malignant are established clichés of modern medicine, and pathology. These terms necessarily express an opinion and hence a judgment. While the lay and the learned, patients and the doctors, have come to accept these terms as some kind of norm, a critical analysis reveals them to be judgmental jargon, relevant to semantic and scientific basis.

Normality is the range and not the average and hence inapplicable to an individual reading of any parameter. (Ardrey, 1970)

In examining the implications of defining one act as abnormal compared to another there are a multitude of ethical and practical problems. Firstly, (assuming judgments are necessary at all) who judges? And secondly, who judges the judges? Someone initially decides who is able to give an objective definition of normality; and must then decide the judges are indeed objective. In this context the judges are legal and medical experts who judge themselves. In attributing values to behaviour there is a considerable grey area. Statistically abnormal behaviour (Goertzel, Fashing, 1981) occurs infrequently; otherwise it would not be statistically abnormal. No value judgment is made between the rare behaviours of a serial killer who uses an unusual weapon and a unique pioneering experimental surgeon. They are both abnormal so far as the numbers go. Deviation from statistical norms allows acceptability, but is still based around morality.

One approach is to identify normality first. According to wide literature (Busfield, 1986), normality is about:

- The absence of mental illness - pretty tautological! What are mental illness-but being 'not normal'?
- Being capable of introspection - not useful, as any mental activity, however "deranged" could be introspection
- Growth, development and "self-actualisation" - this is too idealistic; few individuals achieve such heights of development; the famed psychologist Maslow admitted, "there are no perfect human beings"
- Integration of all aspects of self - again an ideal, failure to achieve this would not indicate mental impairment, as the vast majority of us aren't 'there' yet (if ever).
- Ability to cope with stress - negative coping mechanisms such as alcoholism would not be a healthy way to cope, but are acceptable under this explanation, despite their pathology.
- Autonomy and control over own life- again a matter of degree and subjective perceptions.
- Seeing the world as it really is - who judges reality?
- Environmental mastery: capacity to cope and adjust perfectly in interpersonal relationships -again, an ideal for many.

The majority of mankind is abnormal compared to the above, but as already stated, majorities cannot be abnormal, statistically.

Social class also affects definition: "eccentricity" in one class may be decried in a lower class. The context of behaviour is important; a child playing with toys in the home is normal; an adult playing alone with children's toys may be labelled abnormal; doubly so if this took place in the middle of a busy street, as the situation would also be inappropriate.

The great psychiatry-reform crusader Szasz (1961) believed health should only be judged biologically, pointing out that moral philosophy is not brought to bear on physical illnesses, such as blame for catching flu and so should not be aimed at "mental illness" either. Psychiatric diagnosis was often a relative moral-cultural process, not a medical one and it has a stigma as if there were some personal blame attached. A life-threatening heart attack prompts no shame, not so mental illness.

The patient becomes a bad marriage, job and credit risk; facing a double blow: disease and social stigma. Labelling is impersonal; a patient will be labelled as 'a manic depressive' - an object; rather than "a person with manic depression", which is dehumanising. Reinforcement of the label on a regular basis may be sufficient to create or prolong health problems (Kelly, 1955).

It has been suggested that personal distress (Oltmanns, Emery, 2000) at one's own behaviour could indicate abnormality, however not all subjects show distress, i.e. psychotic patients without insight into feelings, or manic patients, whose grandiose behaviour may be pleasurable to them. Those considered being dangerous to themselves and/or others are liable to physical removal to secure hospitals for psychiatric evaluation and/or treatment. Other patients arrive voluntarily, but the means of initial assessment (Treatment Protocol, 2000) seem rather subjective. A visual appraisal of clothing is made, covering suitability, cleanliness, "appropriate fashion" and state of repair, plus general physical hygiene. This imposes discrimination: a patient with any illness may be unemployed, perhaps also be homeless and unable to afford clothes or washing facilities, but be mentally well. And one thought that 'fashion police' was a metaphor....

In DSM-IV (1994), each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (i.e., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. Neither deviant behaviour (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual.

A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more readily, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."

A key point of the psychiatric view is that a legitimate "mental illness" requires underlying "behavioural, psychological, or biological dysfunction in the individual" (DSM-IV, 1994). According to The Concise Oxford Dictionary (1996), dysfunction is an abnormality or impairment of function.

So, there must be an abnormality or impairment of behaviour, biology or psychology that manifests from the mental illness (which is never observed, and completely assumed). Strangely, the entire field has never, not once, defined what normal or ideal functioning would mean in these areas! What would be an ideal condition for the psychological function known as attention? Memory? Imagination? Or intention? How might we strive to achieve these states? The raw truth is that the field has never examined these things, much less with an interest in ascertaining how these operate, and how these things could be improved and strengthened - an obvious desirable goal for any group tending to deal with the mind.

A basic and very large error in psychiatry's fundamental approach to this subject is obvious in the above line, "the term mental disorder unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionistic anachronism of mind/body dualism." (DSM-IV, 1994) The attitude contained in psychiatry is that "we have advanced past the old and over simplistic notion of man having a mind and a body, and that these two things are different." (ibid). Actually and factually the mind and the body are two different things, according to them, with observably different functions and following quite different laws. They do affect each other, and there are observable interrelations between the mind, body, and the environment, but they are fundamentally unique and different phenomena. Psychiatry would like us to believe mental disorders are all physical

because this fits in nicely with their theories of genetic and chemical-biophysiological causes for all mental illness. This ideological slant has led to a very incomplete picture of Man and society. Modern psychiatry ignores the entire realm of mind except as a category used in diagnosing mental illness, does not directly address the mind in any attempt to cure or empower a mind, and instead observes and attempts to manipulate behaviour and symptoms exclusively.

Yet, while ignoring the mind and refusing to address it directly, the modern subjects of psychiatry and psychology pretend to deal with mental health, mental hygiene, mental illness and mental disorders. What can these terms possibly mean when the subject itself has abandoned the mind? There are no clear definitions of these terms anywhere in the related psychiatric literatures, because the truth is that these terms are surrounded by vagueness and based upon very faulty notions.

Moreover, although the DSM (1994) provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of mental disorder. The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction - for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and aetiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, disadvantage, disability, inflexibility, irrationality, syndrome pattern, aetiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Psychiatry, as with many other modern fields, attempts to attack and destroy the negative and unwanted conditions, assuming that doing so somewhere leaves a positive and desirable condition. This is not so. Destroying the unwanted does not and is not the same thing as creating the positive.

Psychiatry uses mental concepts (ideas concerned with a mind) largely as an excuse to label people (Kelly, 1955) with mental illnesses. Examples: he has moderate

attention dysfunction (his mind wanders); she has mild memory impairment (she has trouble recalling some things); he has fixated attention on sexual imaginings (fantasies). These things are used only to justify a diagnosis of illness.

Normal is the common denominator of average acceptable behaviour. There is nothing desirable about it. Psychiatry has developed an entire science dependent upon labelling people abnormal or impaired because people deviate from their extremely biased concepts of what is acceptable and normal. What are termed mental disorders and illnesses often envelope what more accurately fall under the umbrella of individual differences, personal uniqueness, eccentricity and individuality (Oltmanns, Emery, 2000). Unusual sometimes? Yes. Strange? Maybe. A "mental illness"? No! For conditions that do have obviously harmful aspects to the person, the true cause lies in the mind which psychiatry pays no attention to as a thing to be addressed and corrected in it.

Psychiatry would have us accept and believe we "have" depression or anxiety disorder like we "have" a wart, a pimple or a stomach ache. While depression, as one example of many, may have certain characteristics and even similar repeated behaviours, statements such as factually characterize the actual state of depression:

I "feel" despondent

My "thoughts" are always negative and I can't control them

I "want" to kill myself

Life has no value or meaning for me

Each of these almost exclusively has to do with the realm of emotion and thought, but depression and hundreds of other supposed mental disorders are never dealt with addressing the realm of emotions or the mind.

Where else (DSM-IV, 1994) would one find "coffee drinking" (292.9 Caffeine-Related Disorder) turned into a mental illness! Smoking is now classified as a mental illness also! You'll find it under category 305.10 Nicotine Dependence, and 292.0 Nicotine Withdrawal. Yes, smoking does have an addictive aspect. No, drug addiction is not a mental illness! It's simply drug addiction - the reaction physically and mentally to drug

taking. "Withdrawal" is a physiological reaction to stopping the taking of a drug. It is not a mental illness either!

The dominant model today (at least within psychiatry) is the medical model of psychopathology (Treatment Protocol, 2000). The basic assumption is that psychological disorders are diseases. The nature of onset, distribution of cases, development and course, treatment response, and associated features seen in psychological disorders are seen to be parallel to what occurs in physical diseases. This model assumes diseases of any sort to be fully understood in terms of abnormal biological variables, thus, a psychological disorder can be explained in terms of (and actually is) a disorder of underlying physical mechanisms. Of the aetiological factors that we have examined, the biological realm is primary. To understand psychopathology, we do not need to look beyond the biological level. This approach embraces reductionism (Bickle, 1991): a philosophical view that complex phenomena (such as thoughts, behaviours, emotions) can be completely understood and explained in terms of a more basic level. That is, in this case, thoughts, behaviours and emotions can be reduced to the more basic level of biological processes. A thought is a neurological event in the brain. Psychopathology is a biological phenomenon (ibid).

This model has been criticized as being insufficient for truly understanding psychopathology. Biology simply can't account for psychological disorders. A model of psychological phenomena must be based on other levels of data, levels that involve psychological processes at cognitive and social levels. At the very least, to truly understand a psychological disorder, we need to integrate knowledge from these various levels with the biological level. We need to recognize that each level has its own strengths, but also its own limitations. Biological levels do pretty good at providing explanations of form, that is, it answers "how" questions - how a particular disease process occurs and what its mechanisms are. Biological explanations do not, however, provide explanations of the function of the disorder. That is, biology does not address the "why" questions. Why did this disorder occur, what is its meaning, purpose or function? Both sets of questions are important in understanding a phenomenon. Both approaches need to be assimilated.

Historically, medicine hoped that biological causes (Berrios, Porter, 2001) would be found for all psychological problems. But as we will see, there is a growing body of evidence that certain abnormal behaviours cannot be fully explained without looking at the psychology of the problem. Conversion hysteria results from a person's attempt to unconsciously cope with strong unwanted emotions such as anxiety. The definition implies health as absence of disease. According to the World Health Organization (Treatment Protocol, 2000), health is "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity." In other words, the absence of X doesn't necessarily mean the presence of Y.

Using a definition is unavoidable and it is necessary. But choosing one is a value judgment in the final moment. When we choose a definition, we do so in part based on feelings, emotions, convenience, custom, appeal and ethics. There is an inherent non-scientific arbitrariness in this choice. The potential result is that psychologist/therapist A and psychologist/therapist B could be talking about very different things when using the word abnormal. Confusion and controversy exist, especially if the definitions remain implicit. However, as professionals, we ideally make our definitions explicit and then attempt to clarify and modify these definitions through scientific/methodological rigor, with an eye always open to the exception and alternative explanations.

What is abnormal ("norm violating") in one society (Oltmanns, Emery, 2000) may be perfectly normal ("norm consistent") in another. The raw behaviour has not changed, but the society has. Each culture is different from the other. By which culture's standards do we judge behaviour to be abnormal? In addition, even in a single, small society such as New Zealand, there are a myriad of subcultures. Add to this the fact that norms change through the years so that what is normative in one generation, may not be in another. This definitional stance implies that normality is the same as conformity to the mainstream, when in fact there are many streams. The term abnormality thus loses any firm referent.

What critics claim is that the shift from the medical model to the biopsychosocial model (Engel, 1980) really made no fundamental change in orientation. The

underlying nature of these two models is the same: the deficit model. The victim blaming (Ryan, 1976), meta-messages and self-fulfilling prophecies that the two imply are just the same. They both are models that conceptualise the "patient" as defective or deficient in some way. One alternative orientation is to use a difference model (Rappaport, 1977). The basic assumptions are changed. The question is no longer what is wrong with the person, but what are the strengths of this person and how can they be used. The goal changes from rehabilitating the person, to finding a setting into which the person can fit and use his/her abilities, and where he/she can develop new abilities. These critics are calling for a psychology of strengths rather than weaknesses.

From this perspective, we would approach the schizophrenic person, for example, in a very different manner than we did in the other models. The focus now emphasize an individual rather than a patient status, treat person as responsible human being, rather than providing treatment (so person can fit back into society), restructure society so there are more opportunities and resources available for the person and what skills s/he does have, it is as much other people's responsibility to change as it is the "patient's" (ibid).

No one definition is the correct or the best definition. To a certain extent each one captures a different aspect of the meaning of abnormality. When we talk about abnormality, or when we study it or treat those suffering from it, we inevitably invoke one or more of these definitions, either explicitly or implicitly, either we are aware of the definition(s) we are using or we are not. But we do use some definition. All of us have some definition in our heads about what psychological abnormality is, whether or not we could clearly state it. In any event, it is important, especially as therapists, that we make as explicit as possible the definition(s) we use, and acknowledge any limitations. To operate implicitly hinders our ability to develop further - our awareness is limited because as long as our definitions are implicit, they remain unchallengeable, we ignore alternatives, we don't "stretch" ourselves. And each definitional stance can certainly be challenged.

Any definition of abnormality is extremely problematic, unusual behaviour attracts ethical value judgments often based on moral or philosophical grounds without

relevance to medicine or psychology, and the practical applications of such judgments cause great dispute.

There are major social, cultural and class issues affecting judgment of normality.

There is disparity in methods for diagnosis of specific conditions; lending credence to the feeling that mental health issues are presently almost entirely subjective. However this great scope for improvement in categorisation of mental health diagnoses may simply await both further advances in medical science and advances in how we all behave towards each other.

Great social power exists in labelling, as abnormalities attract stigma (Kelly, 1955), which often far outlast any illness. Abuse of this procedure has been a means of social control and suppression of dissent. Public ignorance of mental health only serves the efficacy of such abuses, along with creating problems with the patient's reintegration into society, even if their abnormality was nothing much in the first place. Overcoming the label can often be harder than overcoming any disease.

It truly is a self-perpetuating leviathan. More disorders gives us more psychiatrists and increased funding, which then gives us more disorders, and round and round it goes.

#### Across The Borderline Lyrics

(by Ry Cooder, Jim Dickinson and John Hiatt)

There's a place where I've been told  
Every street is paved with gold  
And it's just across the borderline  
And when it's time to take your turn  
Here's a lesson that you must learn  
You can lose more than you ever hope to find.  
When you reach that broken promised land  
Where every dream slips through your hand  
Then you'll know that it's too late to change your mind

Cause you've paid the price to come so far  
Just to wind up where you are  
And you're still just across the borderline  
Up and down the Rio Grande  
A thousand footprints in the sand  
Breathe a secret no one can define  
The river flows on like a breath  
In between our life and death  
(Tell me) Who's the next to cross the borderline?  
But hope remains when pride is gone  
And it keeps you movin' on  
Calling you across the borderline  
And when you reach the broken promised land  
Where every dream slips through your hand  
Then you'll know that it's too late to change your mind  
Cause you've paid the price to come this far  
Just to wind up where you are  
And you're still just across the borderline.

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I hold Master's Degree in Medicine, Social Psychiatry and am studying towards my doctorate degree. A major part of my professional interest is psychopathology and its critical evaluation.

I Work as a senior lecturer/programme coordinator on degree and diploma courses in New Zealand, teaching various subjects from the psychology, mental health and counselling field. To keep up to date with theory and practice, I run a small psychotherapy practice and have regular clinical supervision. The PhD proposal has been accepted at the School of Psychology, Victoria University, New Zealand. The thesis "Injunctions and social stigma in developing personality disorders" has been presented at the ITAA Conference in Mexico, 2003.

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