CHAPTER 2

Normal vs. Abnormal Behavior: A Continuum

A common question posed to every mental health expert by the "person on the street" is "Who is really normal?" The answer to the question is very complex and one that is open to significant areas of disagreement among professionals. To understand the issue more clearly, let us first consider the concept of normality and abnormality in the area of physical health and disease.

When someone is feeling ill and manifesting symptoms of pain, muscle aches, coughing and dizziness, the physician will take his or her temperature, look into his or her throat and ears and typically take blood and a swab of the patient's throat for analysis. When the physician discovers that the temperature is 102° F, the throat is red, the throat culture reveals bacteria and the person's blood values are askew, the diagnostician can safely say the patient is "abnormal." These "signs" of illness are objective, easily verifiable and would generally be agreed upon as abnormal by all experts. When we apply this "medical" or "disease" model of abnormality to psychological and psychiatric illness, however, agreement over what behaviors represent abnormality is not so clear cut.

In deciding whether psychological symptoms and behavior are "sick" or abnormal, mental health professionals do not typically rely on objective, physical evidence like blood tests, X-rays, or CAT scans. The decision to diagnose an individual as psychiatrically ill or abnormal is far more subjective and relies on clinical judgments that are influenced to some extent by a number of factors that take into consideration the appropriateness of people's behavior in the context of their environment, the effect of their behavior on others, and their culture as well as that of the judge making the evaluation of normality vs. abnormality. While each of these factors is important, no single one can be used to definitively label a person's behavior as "abnormal." We will discuss some of these factors in this chapter.

The Diagnostic and Statistical Manual of the American Psychiatric Association lists symptoms and behaviors for a variety of disorders to

enable professionals to "diagnose" a patient and thus view him or her as "abnormal." Each of these disorders typically involves several symptoms that must be present in order for the diagnosis to be made. However, no single symptom or behavior can be assumed unequivocally to equal abnormality. Some individuals may feel that anxiety is "abnormal," yet it is quite normal when we face dangerous situations. The desire and intent to kill another human being may be seen as a sign of abnormality until we remember that we award medals to soldiers for killing our enemy. Self-mutilation sounds clearly sick until we recognize that tattoos and piercings are common today. The point is that these behaviors and symptoms, when viewed alone, do not provide the basis for an "abnormal" label. We must take the social context and the culture into account as well. This is not usually the case in medical abnormalities. A virus is a virus regardless of the context.

We also rely on statistics as a yardstick to define normality and abnormality. What is statistically most frequent or common in the population may be considered "normal" and what is infrequent or occurs less often would be labeled "abnormal." While we often use this model to assist us in evaluating behavior, especially in psychological testing, it has serious flaws. Most importantly, common or normal reactions may be considered abnormal at times. Many people, civilian and military, participated in the Holocaust that involved nearly annihilating an entire race of people. Despite the numbers of people involved, it would not be realistic to view their behavior as normal. Yet when many of Hitler's top lieutenants were formally evaluated psychologically, their actual responses were quite average or "normal" in a purely psychological sense. In summary, what is common in a population is not necessarily normal in the context in which we are attempting to understand it and cannot stand alone in defining these terms. There is no question that the ability to conform or behave like most people is useful in coping with and adjusting to the demands of life, but it is not usually an end in and of itself.

Often, the general population views abnormality in very simplistic terms that lead them to label others as sick in a very circular manner. For instance, some assume without question that if an individual has ever been labeled with a psychiatric diagnosis, then he or she is by definition "abnormal." They never ask who labeled that person or on what basis the label was assigned. In effect, abnormality becomes what the professional says it is, regardless of the basis of that judgment. Another potential error occurs when someone is seen as abnormal when he or she has been admitted to a psychiatric hospital. While that certainly should be a strong indication of psychiatric illness, community and cultural standards and values are often involved with that decision. Obnoxious teenagers, delinquents, and children whose parents become frustrated with them can often find themselves hospitalized for reasons that do not really reflect true psychological abnormality. Many

subcultures within our society tolerate the idiosyncrasies of their members and never would consider them "abnormal" or admit them to a hospital. Move them out of that subculture, and they may immediately find themselves viewed as mentally ill.

Psychologist David Rosenhan and his colleagues performed a classic study in the early 1970s in which he sent eight of his graduate students into psychiatric admissions offices to act as pseudo patients. They were told only to complain of hearing a voice say "thud" or "empty." Every pseudo patient was admitted to an inpatient unit, but after admission, feigned no other symptoms or strange behavior. They behaved normally and made no further attempt to present as sick. Nevertheless, the staff continued to view them as ill, interpreting all of their behavior from the prism of the original diagnosis of psychosis. If they walked around the ward when they were bored, staff interpreted that behavior as resulting from anxiety. If they became appropriately angry at an attendant who mistreated them, they were seen as projecting the rage stemming from some delusion. In effect, every normal behavior was viewed as abnormal. When the pseudo patients were finally discharged after an average of 19 days, all were diagnosed as Schizophrenia, Residual Type. Here we see a most vivid example of the power of a psychiatric diagnosis and how even trained staff perceive abnormality in the most subjective way, based solely a single and ultimately faked symptom ("thud.").

As a result of the rather subjective nature of psychiatric diagnosis and the ambiguity surrounding the concept of abnormality, many researchers and clinicians have challenged the application of the medical or disease model to psychological problems. Albert Bandura, a noted psychologist, has written that psychopathology or "abnormality" is really a function of social judgments we make when others deviate from social norms regarding "appropriate" behavior. He describes this as social labeling of deviant behavior. He goes on to list several bases we use in making these social judgments.

First, we take into consideration the appropriateness of the individuals' behavior to a particular situation. If we experience the consequences of their behavior as positive, we view the behavior as positive. If it has a negative effect on us, their behavior now is labeled as deviant. A very quiet police recruit who rarely speaks and never challenges a very rigid, demanding sergeant may be seen as extremely cooperative and pleasant. When the same recruit goes to a SWAT team simulation and is expected by the training officer to be active and aggressive, his identical behavior may be seen as depressed and uncooperative. The behavior did not change, but the evaluation of its appropriateness to the situation had.

A second basis of social judgment revolves around behavioral deficits or the lack of necessary skills and behaviors to cope with problems. These deficits are labeled as symptoms of disorders when consequences are troublesome and problems are handled poorly. A firefighter who is

promoted to Assistant Chief may have difficulty disciplining his men because he is concerned that they "like" him. He has great difficulty in setting limits, ordering others to perform tasks and may be labeled by his superiors as "needy," "dependent," and "insecure." When he is demoted to a basic firefighter position, the same behavior is perceived as "cooperative" and "non-authoritarian." The only thing that has changed is the role he played. In one role he is labeled "deviant" and in the other as quite healthy.

The ability of the judge to understand the actor's intention is a third basis of social judgment. When an individual's intention or motivation for a particular act is not understood, that behavior is likely to be labeled as deviant or mentally ill. Take the example of a teenage boy who follows an elderly woman into an alley noticing that she has a very big purse. He walks up to her, strikes her on the head with a crowbar and leaves the scene without taking anything. How would a police officer typically label that behavior, as a sign of delinquency or as a product of psychiatric illness? Imagine the same scenario, but this time the boy takes the purse. Delinquency or mental illness? When the intention for striking her does not appear obvious and is not understood by the officer, the most typical perception is that the behavior would be labeled mental illness, while the more obvious, "understandable" behavior that involved stealing would be seen as delinquency. Remember that the assaultive behavior is identical in both situations. Basically, when we do not understand someone's behavior, we are prone to call it mental illness. How does the judgment of the assaultive behavior change if we suggest that in the first example, the teenager was required to assault the woman as part of his induction into a street gang?

The personal attributes of an individual like age, sex, and occupation serve as a fourth basis of judgment. Certain behaviors are considered appropriate for one sex or at one age, but not for others. One gender-based example involves assertiveness. Assertive men in leadership roles often are considered strong, "go-getting," and competent, while women displaying the same behavior are frequently labeled as aggressive, mean spirited, and controlling. Thumb sucking at two years old is perceived as quite normal, until the very same behavior manifests itself at ten years old when it is viewed quite negatively as a sign of emotional problems. In these examples, the behavior is labeled "abnormal" as a function of a personal characteristic rather than on the nature of the behavior itself.

Keep in mind that the value and social judgments that come into play in these examples of behavior play a far more insignificant role in the diagnosis of physical illness. Consequently, it is incumbent on us to be aware of our own values, background and culture when we evaluate an individual's behavior as "abnormal."

As we can see, our ability to define abnormality and normality is a highly complex process involving a number of factors. Regardless of the

complexity, First Responders will be called upon regularly to make these judgments and will need some basic criteria to support their decisions. The following represent fairly broad areas that define abnormality in rather abstract terms. More specific information regarding several psychiatric disorders and how to recognize them will be provided in the subsequent chapters.

Defective psychological functioning is one major criterion of abnormality. Specifically, impairments in attention, concentration, perception, judgment and memory all result in serious behavioral problems, including disorders like dementia, attention deficit disorder, psychosis and depression. When these functions are disturbed, judgments of abnormality are typically made. Defective social functioning is a second criterion of psychopathology. Here we will encounter mentally ill individuals who cannot refrain from engaging in behavior that is drastically at variance with the cultural norm. This is in contrast to the criminal who is more typically unwilling, rather than unable, to conform. Signs in our culture of defective social functioning include inadequate control of aggression, significant distrust and suspicion, and the inability for self-care and autonomy. A related criterion is basic loss of control. Many individuals are unable to control not only aggression, but their thoughts, fears and moods. Obsessive-compulsive patients are plagued by unwanted thoughts and rituals; phobic individuals understand intellectually that a bridge is safe to cross, but cannot bring themselves to drive over it; bipolar patients are tormented by their mood swings which seem to have a life of their own. They are all out of control. Society, including law enforcement officers, firefighters and emergency medical personnel, also serve to define abnormality along with family friends and mental health professionals. As we saw above, we all make social judgments that play an important role in how others are viewed. Finally, the last criterion of abnormality is the self-evaluation of our own behavior and feelings. Feelings of anxiety, depression, guilt and general subjective distress will play a very significant role in understanding abnormality and represent the most common basis for an individual to seek help from mental health professionals.

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