Chapter 5. Am I Crazy? What Is Normal?

Obviously, these are loaded questions. No one wants to be "crazy," and most of us would prefer to be considered normal. On the other hand, most people want to be "unique," not a cookie-cutter clone of some gray cardboard portrait of normalcy. We all want to be competent but special and one of a kind, capable of managing our thoughts, feelings, behaviors, and relationships, but not so common or standardized that we are boring and b-flat. But how are we to determine what is psychologically normal? What is mental health? We can approach these questions from a variety of angles, some of which are quite subjective, involving value judgments.

For starters, we can distinguish between STATISTICAL normal and HEALTHY normal. Statistical normalcy requires a statistical comparison between you and the masses. Healthy normalcy requires a judgment based on some criterion of mental health, but how do we decide on these criteria? Either way, subjective values can easily intrude into these determinations. Statistically, do you do what other people do? Do other people commit murder when frustrated by others? How about killing in the name of Allah, or Christ? What about killing for your country? This is statistically far more common than killing out of frustration or in the name of religion. Does that make it normal? Do most people graduate from high school? Are you abnormal if you didn't? What if you dropped out of high school but later formed a company which eventually earned billions of dollars? Would your economic supremacy trump your educational failure? What percentage of people feel depressed? What about depression after the death of one of your parents? Is it normal then? How depressed? How commonly do people hear voices? Voices telling them to kill others, the voice of their recently deceased mother saying she's okay, or the soothing voice of God answering a prayer? Do most people have panic attacks? How about anxiety in a dark parking lot at night? How about such anxiety in the aftermath of a parking lot assault last week? Is this statistically common? Is it healthy?

As you can see, discussions of normalcy can quickly degenerate into controversy, whether we are comparing people statistically with each other, or deciding what is healthy. Statistical comparisons indicate how common or uncommon your personality features are, whether they be thoughts, feelings, behaviors, etc. But the context and origins of your

uncommon or unhealthy behavior need to be taken into consideration. And many would quickly argue that some statistically common personality features are unhealthy, such as denigrating and persecuting black men or Jews in past eras in locales where such behavior was typical and accepted or encouraged. In addition, the circumstances of emotional distress are important. You are certainly in the minority if you experience severe depression, or consistent inability to experience sexual pleasure, but what if these conditions are the result of being sexually abused as a child. Such conditions are far more common statistically under such circumstances, though few people would describe either depression or sexual anorexia as healthy. In a general way, we typically consider ourselves normal if we have more desirable and fewer undesirable characteristics than other people statistically. Also in a general way, we tend to share a notion as to what is psychologically healthy. However, both of these approaches to normalcy can be criticized as being somewhat dependent upon subjective values, cultural and religious norms, and a relatively ordinary, nontraumatic set of childhood and adult experiences. Statistical comparisons simply tell us what is common, but we must decide what is psychologically healthy.

The Diagnostic and Statistical Manual (DSM, current version DSM 5) of the American Psychiatric Association is the professional standard for classification of mental illnesses, and is used by clinicians, insurance companies, and researchers. By this standard, you are mentally ill if you have any of the disorders listed in this compendium of psychopathology. From this perspective, your odds of being crazy are increasing with every revision of DSM. As Maddux observed (2002), the number of mental disorders in DSM increased from 106 to 297 between 1952 and 1994. At this rate, our great grandchildren will all be crazy. Maddux points out a variety of problems with DSM, including an exclusive focus on pathology without due regard to positive feelings, coping strategies, and virtues. In this vein, he notes that the fourth version of DSM was so focused on pathology that even affiliation, altruism, and humor were described as defense mechanisms. Just as an imbalance involving excessive negative versus positive self talk can impair your self esteem, an exclusive focus on pathology can impact your identity make you feel crazy. It is just as important to ask what is right or healthy about you as it is to ask what's wrong. You will probably benefit from a focus on improving your strengths rather than just addressing your weaknesses. Such issues are pursued further in our chapter on positive psychology,

where you can find references to websites that allow you to take tests of personality strengths.

Maddux went on to describe various underlying assumptions of DSM, many of which can be readily challenged. Diagnosable conditions are often on a continuum, from healthy to unhealthy. The "discontinuity assumption" falsely views a mental illness as a discrete entity, with a black and white difference from its normal counterpart. As Maddux notes, there are many relatively healthy people who seek professional help before their problems become severe. However, diagnoses are typically not rated on dimensions, so you either do or don't have X, and your insurance company requires a diagnosis of X for them to pay for treatment. Fortunately perhaps, especially for psychologists and psychiatrists, there are now so many Xs that nearly anyone can qualify for treatment.

Maddux further notes that our concepts of psychological normalcy and abnormality, and our diagnostic labels, "are not facts about people, but social constructions," and that DSM is more a social than a scientific document. From this angle, mental illnesses are not discovered, but invented. They are social artifacts that serve the value system of those in power, designed to maintain the social order. The most glaring example is homosexuality, which was deemed a mental disorder by DSM in 1952, but then depathologized in 1973. Take antisocial personality disorder as another example. Many of the characteristics of APD, all reflecting "a pervasive disregard for and violation of the rights of others," specifically criterion #1, "failure to conform to societal norms with respect to lawful behaviors…" are valued as clever and effective by the individual with the diagnosis, particularly if he or she lives in a jungle so to speak. APD is clearly a social construct, reflecting prevailing social values, norms, and rules, rather than a mere set of facts about individuals. It has social utility, but should not be seen as a solely internal condition, existing independently of its social context and prevailing social values.

In this vein, I want to take a moment to integrate my research (master's thesis and doctoral dissertation) on anthropocentrism into the discussion. Anthropocentrism, as the word implies, is an ideological position that considers mankind as the most important entity in the natural world (Chandler, 1978). In this viewpoint, the well being of humanity is the core, central value judgment which, consciously or unconsciously, determines the way in which we view the world. Viewed differently, anthropocentrism is a form of prejudice, played out at the

species level, as opposed to a racial or ethnic level. For example, in a political context, when there is a conflict between the two, do we value human jobs or the preservation of other species? Or from a moral and legal standpoint, do we establish laws against and punish the killing of humans? How about mammals? What about reptiles? Insects? It seems that our valuation of a given species depends on how closely an animal resembles us. Are humans more important and worth saving than elephants? What about homeless dogs or cats? Cockroaches? The answer may seem self-evident, but is your answer based on unconscious anthropocentrism, as you have been taught from birth to value people (especially those who gave you love and guaranteed your survival) and devalue insects? We have been taught that God created mankind in His own image, or did we create God in our own image in order to provide external validation for our own anthropocentric value judgment (the value of humanity), which we then impose on the rest of the planet? Am I crazy or delusional to raise this possibility? Are you crazy and in denial if you refuse to consider this possibility, and automatically dismiss it? If you believe a falsehood that most other people believe, are you crazy? Or does the fact that you were raised in a social environment where everyone espoused that belief get you off the hook? Does craziness depend on objective truth, or social context? Are you crazy if you drink the Kool Aid, or does it depend on the flavor? If we are raised to devalue insects, and I slap a mosquito to death when it sucks blood from my arm, am I wrong to kill it? If a boy in the ghetto is exposed to consistent violence and abuse, and the devaluing of human life, is he wrong to shoot an adversary dead if that opponent draws blood in a fist fight over a girl? When you get down to the bottom line, what is the difference? I believe we are talking about attachment and values. We are taught to value human beings more than insects. Since we are human beings, this makes sense to us, but is it objectively right, or just a subjective value that serves our own purposes? As we grow up, we become attached to other humans, particularly our families, and our animal pets, but we usually do not attach to insects. If a boy in the ghetto is abused and neglected from birth, and does not develop an attachment to other humans, and later slaps humans dead as if they were mosquitoes, we are likely to say that he is mentally ill, diagnose him with antisocial personality disorder, and kill him (for killing) in an electric chair. Meanwhile, how many mosquitoes and cockroaches have I killed in my life, with impunity? I'm not trying to say that I should be jailed for this,

or that the ghetto survivor should go free, but I am suggesting that subjective values, which are often unconscious, are quite prevalent, but often unrecognized, in our moral values, legal rules, political decisions, and yes, in our definitions of mental illness.

Similar issues involving psychiatric imposition of societal values arise for conditions such as schizoid personality disorder. If you have no interest in people, but are not bothered by this, are you abnormal? To be fair, DSM does require "clinically significant distress" for many diagnoses, but not for personality disorder diagnoses. So who decides if you are crazy, you or society? If you yourself are disturbed by a certain set of thoughts, feelings, or behaviors, we are perhaps on more solid ground when talking about a mental illness. But then again, some of us are so far into denial that the man in the moon knows we're sick more than the man in the mirror. There are gray zones everywhere, and as usual, the truth is usually a combination of opposites.

One angle on what is psychologically healthy or normal is whether you experience primarily positive or negative emotions. Do you frequently experience sadness, guilt, anxiety, frustration, anger, etc., without much pleasure, joy, love, gratitude, etc.? This criterion of mental health is commonly applied, simply because feeling good, and not bad, at least most of the time, is important to all of us and drives much of our behavior. But some would argue that morally virtuous behavior is more important than feeling good, even if you feel good consistently. Ultimately, mental health and normalcy, like beauty and morality, have a large subjective component. Some would say entirely subjective, i.e., YOU determine what is normal for YOU, while others would argue that morality is objective, and God given, with mental normalcy perhaps being objective as well.

A rather different, integrative view on normalcy is the notion that mental health involves combinations of opposites, and the ability to shift up and down any given dimension to find the behavior that is most adaptive to your situation. If we look at self-esteem as an initial example, healthy self-esteem involves a combination of opposites, specifically, valuing oneself coupled with humility. We are each unique and special, yet mere specks of dust in the universe as a whole. Without humility, we become narcissistic and self-aggrandizing, though if we cannot value ourselves, our low self-esteem may form the bedrock of a chronic depressive state. To be healthy, we need a simultaneous combination of opposites, self-esteem tempered by humility. Most of us have very well

developed skills on one end of any given dimension, but how are your skills on the opposite end of that dimension? Tackling another example, many of the women I treat are very kind, loving souls who are very giving, but lack boundaries and assertiveness skills. Therefore, they attract self centered, controlling men, and essentially become shark bait. If we take a pair of dimensions, each zero to one hundred, with one dimension ranging from submission through assertiveness to aggression, while the other dimension taps warmth and affection at one end versus acting cool and distant at the other, these women are well skilled in the 0 to 40 range on each scale. Their warmth and ability to give/cooperate works well in relationships with likewise kind and giving men, but they will be exploited and dominated by self centered men, and often seek therapy because of depression and anxiety regarding their troubled marriages. They are often down on themselves for being too kind or vulnerable, but their capacity for love is not the problem. The problem is their failure to develop the opposite skills, to be distant (non-reinforcing, non-engaging) when unhealthy men approach them, and to assertively set limits, aggressively when necessary, to prevent domination and exploitation. The loving behavior needs to be maintained, for loving relationships, but their assertive and aggressive skills need to be developed to deter the advances of sharks, and to set limits when tested during otherwise healthy relationships. We want a range of skills, with all options on the table, rather than one size fits all solutions. Thus, on the submissive to assertive to aggressive dimension, I would prefer to be submissive when pulled over by a policeman for doing 60 mph in a 40 mph zone. Likewise, if someone assaults me in a dark alley robbery, I want the aggressive skills needed to physically disable him. And in most situations, I want a range of assertive skills from 30 to 70, as well as the ability to gradually escalate from gentle assertiveness toward increasingly aggressive assertiveness, or visa versa, if the situation calls for either escalation of or patching up a conflict. I certainly don't want to be aggressive with the police officer, or submissive with an assailant who is swinging a crowbar. This is just one such personality dimension, but if we have multiple skills across multiple dimensions, and can shift as needed up and down these scales, then we have maximum adaptability to our environments. This ability to successfully adapt to one's environment is another measure of psychological health or normalcy.

From yet another angle, normalcy may involve connectedness. Human beings are a very dependent species. We raise our young until age 18 or so, which is rare in the animal world. Thus, we are quite dependent upon our connections with others. Spiritual connectedness, and feeling connected with the environment are important to many of us as well. And self esteem is a crucial building block of personality. Liking oneself, i.e., being connected to oneself in a positive manner, is essential to happiness. Thus, our ability to be positively connected both internally, to ourselves, and externally, both socially and spiritually, might be considered an important criterion of psychological health.

For practical purposes, most clients have an internal sense of psychological health, and seek help to decrease negative feelings (most commonly sadness, anxiety, or anger), negative behavior (e.g., aggression or addiction), or preoccupation with traumatic experiences, while others seek to improve relationships. This book is organized around these common therapeutic goals, of managing feelings, resolving traumatic experiences, and improving connectedness. Some clients further feel that they have lost so much control over their minds that they feel "crazy," in the street sense of the term, i.e., out of control. Either their thinking (e.g., constant worrying, paranoid beliefs), behavior (e.g., violence or addiction), or feelings (feeling overwhelmed by negative feelings or unable to sufficiently experience positive feelings) are substantially beyond their control. In this street sense of the term, they are indeed "crazy" and feel like it, even though they are not clinically crazy, i.e., psychotic, out of touch with reality in either their perceptions (hallucinations) or beliefs (delusions). They want to gain greater control over their mind and behavior, to feel more normal, less crazy. Thus, normalcy is the absence of "craziness," and the presence of a feeling of being in control over one's thoughts, feelings, and behavior.

Just feeling crazy can make you crazier. Crazy carries a stigma. Mental illness and sexual difficulties, that is, insanity and impotence, give rise to far more shame than most other problems. A broken mind or penis is far more disturbing than a broken arm or a gallbladder stone. Such shame can be poisonous to our self esteem and identity, which each need to be solid for good mental health. As a psychologist conducting psychotherapy, the context and origins of your negative feelings, behavior, and relationships is very important to me. Many clients feel "crazy" in the street sense of the term, and indeed, they are quite abnormal, both statistically, and in terms of most criteria of mental

health, if you compare them to the general population. But if you compare such clients to other people who have been through a similar degree of trauma, e.g., growing up with alcoholic, violent, or sexually abusive parents, their level of emotional distress, relationship difficulties, and behavioral disturbance suddenly looks quite "normal," at least statistically. An accepting attitude toward oneself, coupled with an acknowledgment of the impact of our genetics and upbringing upon our past behavior, can be a good start. An early part of recovery involves acceptance that such difficulties are "normal" consequences of such an upbringing, thereby improving self esteem by depathologizing behavior, accepting that such behaviors are normal consequences of abnormal environments, while working on altering these same behaviors. Additionally, we need to support and nurture our core identity, even if we reject some of our behaviors. Self-denigration is not a prerequisite to change, and in fact slows the process. When we parent our children effectively, we love the child while confronting the behavior. Likewise, we need to learn to love ourselves while investing sufficient energy into changing our behaviors. From a variety of angles, good self-esteem tempered by humility is a core requirement for mental health.

Finally, there is the well-known lay definition of craziness, that is, repeatedly engaging in the same behavior despite the same old negative consequences. We need to feel effective in managing our emotions, our traumatic experiences, and our relationships. In the chapters ahead, we will devote an entire section to each of these issues, with one section focusing upon managing, negative feelings, another devoted to working through trauma, and a final section on developing connectedness.