

Normalizing as the Opposite of Labeling*

Thomas Scheff

Abstract: In modern societies we often make judgments of certain kinds of behavior that are virtually automatic: delusions show that one is crazy, wrong answers show that one is ignorant, etc. The theory of labeling/normalization suggests caution in making these judgments because of the effect they are likely to have on the social relationship, feelings of rejection and embarrassment. There is a social-emotional component in all human contact that can be managed independently of the content. Equal care is needed to avoid both labeling and enabling. Two extended and three brief concrete examples of normalizing are discussed. The social-emotional component seems to be critical in most relationships, both in psychotherapy and education, as suggested by the examples.

This essay begins with the labeling theory of mental illness (Scheff 1966; 1985;1999) because it came first. It was accepted by most sociologists, but had little impact in other disciplines and even less on the public at large. It sought to challenge the medical model of what is called mental illness with a social model. In this model, symptoms of mental illness are recast as violations of residual rules: social norms so taken for granted that they go without saying. Most social rules, perhaps, are largely invisible.

For example, in modern societies at least, when one is conversing, one's gaze should be on the other's eyes, rather than forehead or ear. Yet asking anyone to explain the rules of conversation, this idea is so taken for granted as to be unthinkable. After all the rules in awareness are named, there is still a universe of other rules that are taken for granted, a huge residue of unconscious rules. This is the territory that Erving Goffman explored in Behavior in Public Places (1964) and in many of his other studies as well.

To find one's ear or forehead the subject of attention might be upsetting. We would be apt to think that the person is not merely rude, but in another world than ours. In our society we call that world insanity, but there may be a better approach. In modern societies, those who are thought to be depressed or deluded are usually drugged with little consideration of the details of their particular case. The average dispenser of psychotropic drugs has little incentive to sift through the details (For a film that makes this point extravagantly, see Numb). Drugging often carries with it labeling and rejection in the sense that such person are not one of us. Rejection may not be obvious and outright, but subtle in varying degrees.

Labeling theory suggests that in some cases a better way might be normalizing those who break the residual (unstated) rules, rather than labeling, ridiculing or rejecting them. This is not to say that one should always normalize. Automatic responses, whether labeling or normalizing, are equally undesirable. Labeling/normalization theory suggests that we need to decrease automatic responses of both kinds. Automatic normalizing results in enabling, automatic labeling results in social rejection.

The main effect of labeling of any kind is implied by Goffman's treatment of what he called facework, saving and losing face. When one is labeled, one loses face and gains embarrassment,

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shame, or humiliation. There is a social-emotional element in all human contact. This point is made more directly in Fuller's study (2003) of somebody and nobody feelings. We feel like a somebody when we are accepted, and like a nobody when we are not. What percentage of time in twelve or sixteen years of school do students feel like nobodies? What does a high percentage of nobody feelings do to students and to our society?

Feeling a nobody can obviously result from flagrant rejection. However, it can also occur when rejection is subtle. This is a difficult point to make because feeling accepted (connected) is not only hard to achieve in real life, its even difficult to describe. There are many terms that are used to describe this state: attunement, shared or mutual awareness, and so on. We take it for granted because we do it, or at least try to do it, for our entire lives.

As indicated above, labeling theory has had little impact in the real world. Perhaps one of the problems was that the opposite of labeling, normalizing, was not spelled out concretely enough to be understandable. Many examples of labeling were provided, but few of normalizing. Below are some concrete examples in mental illness and in education. One of the examples is fictional, a film, the other four factual, to try to remedy my earlier omissions.

Normalizing in a Film and in Real Life

The film *Lars and the Real Girl* (Oliver 2007) although a comedy, also teaches a powerful lesson: how a community might manage mental illness without the social side-effects ("It takes a village..."). The crucial moments occur early in the film. Because Lars has been treating a life-size doll as a real person, his brother, Gus, and sister-in-law, Karin, bring him to their family doctor.

Early in the session, the Doctor asks:

Has Lars been functional, does he go to work, wash, dress himself?

Gus: So far.

Doctor: Has he had any violent episodes?

Karin: Oh no, no never. He's a sweetheart—he never even raises his voice.

This dialogue establishes limits the film sets to normalizing: able to take care of self, unlikely to harm self or others. However, there are many other limits that must be set in order to avoid enabling. For example, does he take drugs? In the educational context, to be discussed below, the teacher must take care to accept the student without confirming their mistakes.

Gus: Okay, we got to fix him. Can you fix him?

Doctor Dagmar: I don't know, Gus. I don't believe he's psychotic or schizophrenic. I don't think this is caused by genes or faulty wiring in the brain.

(Preliminary normalizing statement, rejecting diagnosis)

Gus: So then what the hell is going on then?

Doctor: He appears to have a delusion.

Gus: A delusion? What the hell is he doing with a delusion for Christ's sake?

(Gus's manner implies that Lars's behavior is abnormal)

Doctor: You know, this isn't necessarily a bad thing. What we call mental illness isn't always just an illness. It can be a communication, it can be a way to work something out.

(This is the doctor's central normalizing statement: Lars is not abnormal, he is just communicating)

Gus: Fantastic, when will it be over?

Doctor: When he doesn't need it anymore.

In this fable, Lars has been scripted to find an extraordinarily unconventional doctor. Not prescribing psychdrugs for symptomatic patients now amounts to heresy, or at least is not acceptable practice. I have a psychiatrist friend who is a real life Dr. Dagmar. She left her first and only fulltime job under pressure because she normalized rather than prescribing psychdrugs.

For example, she treated a young man who unable to keep still, complained of restlessness, fidgeted, rocked from foot to foot, and paced. She told him and his employer that he was not mentally ill, but drugged by the antidepressant he was taking (Prozac), which proved to be correct. Lest this instance seem too obvious, I know of many similar cases where the presiding physician decided that the problem was not too much drug, but too little. A vast difference of outlook separates the great majority of labeling physicians from the few normalizing ones.

My friend (I will call her Dr. D) has had nothing but trouble from the establishment because of her normalizing approach. Seven years after leaving her fulltime job, she has been unable to find a regular position as a psychiatrist, even though she is recognized as an authority in her psychiatric specialty. (If anyone knows of a job for a normalizing psychiatrist, please let me know.)

A much more likely response to Lars in real life would have been for the doctor to say: "OK. Let's start him on an anti-psychotic medication, since we don't want his symptoms to get worse." If Karin had said, "But what about side effects? Aren't they sometimes more dangerous than the illness?" The doctor: "Karin, I'm sure you realize that he could become much more ill, or even violent."

For drama and comedy, the film enlists the whole community to help Lars. But in real life, perhaps fewer people would be needed; even one person might be enough. Jay Neugeboren (1999) investigated many cases in which there was great improvement or complete recovery from what had been diagnosed as "serious mental illness." The common thread he found was

that at least one person treated the afflicted one with respect, sticking by him or her through thick or thin¹.

Until recently, I hadn't realized that in the actual dialogue, in order to normalize suspect behavior, the healer must specifically translate the discourse out of the labeling mode and into the normalizing mode, and be prepared to accept the consequences from the world of automatic labeling. In the fictional case, the doctor said, in effect, you are not mentally ill, you are just communicating. In the real case, the psychiatrist said, you are not mentally ill, you are just drugged.

Inadvertent Normalizing

It is ironic that because I didn't understand the actual look of normalization, I didn't recognize it occurring in my own next study. At the time that my book was being first published (1966), I observed a series of very brief recoveries from depression. As a visiting researcher at Shenley Hospital (UK) in 1965, I was present for all intake interviews of male patients for 6 months: 83 patients in all. Of this number 70 patients were sixty or older.

The comments that follow concern the older men. Every one of them presented as deeply depressed in their speech and manner. However, to my surprise, there were moments in some of the interviews that seemed miracles of recovery. It took many years for me to understand what I had observed in terms of labeling theory.

Many of the patients were virtually silent, or gave one-word answers. Long before I came, some of the interviewing psychiatrists had found a way of getting more response to their questions. In the interviews I observed, 41 of the patients were asked about their activity during WWII. For 20 of those asked this question, the responses shocked me. As they begin to describe their activities during the war, their behavior and appearance underwent a transformation.

Those who changed in the greatest degree sat up, raised their voice to a normal level instead of whispering, held their head up and looked directly at the psychiatrist, usually for the first time in the interview. The speed of their speech picked up, often to a normal rate, and became clear and coherent, virtually free of long pauses. Their facial expression became lively and showed more color. Each of them seemed like a different, younger, person.

The majority changed to a lesser extent, but in the same direction. I witnessed 20 awakenings, some very pronounced, however temporary. The psychiatrists told me that they had seen it happen many times. After witnessing the phenomenon many times, like the psychiatrists, I also lost interest.

Many years later, because of my work on shame, I proposed a partial explanation (2001): depression involves the complete repression of painful emotions (such as shame, grief, fear, and anger), and lack of a single secure bond. The memory of the patients' earlier acceptance as

¹ The biography (Nasar 1998) of John Nash, a Nobel Prize winner, is similar. Although Nash is not included in Neugeboren's book, the biography shows that Nash's mother and wife aided his recovery, since they never gave up on him.

However, A Beautiful Mind, a film purportedly based on Nash's biography, misinformed on the drug issue. Nash, played by Russell Crowe, attributes his complete recovery to "the newer antipsychotic drugs." But the biography states that Nash refused to take drugs after 1970, long before the newer antipsychotics. Indeed, the biographer states that his refusal may have been fortuitous, making possible his complete recovery (1998, p. 353).

valued members of a nation at war relived the feeling of acceptance. This feeling generated pride that counteracted the shame part of their depression.

Telling the psychiatrist about belonging to a community during WWII had been enough to remove the shame of being outcasts. Conveying to the psychiatrist that “once we were kings,” had momentarily relieved their shame and therefore their depressive mood.

When the psychiatrists asked the depressed outcast men about their experience during WWII, they were inadvertently normalizing the patients, returning them, for just a few moments, to what it felt like to be an accepted member of society, rather than labeled and rejected. My recent article on depression (2009) explained some of the implications for social, rather than medical treatment of mental illness.

However, because I had not used enough concrete instances in my theory, I still had not recognized the way the psychiatrists’ question could be interpreted in terms of labeling theory. The psychiatrists’ intentions were to continue to label the patients: “You are mentally ill, so I need more information to assist me with your diagnosis.” However, twenty of the patients understood the meaning as normalizing: “You are socially acceptable now if you were ever accepted even once as a valuable member of a community.” Perhaps a long-term therapy based on this and other social ideas might do better than just temporary recoveries.

Two Examples from Other Fields

A psychotherapist in bereavement and end of life care told me this story. The first time she met a new patient with dementia from brain cancer, the patient said to her: O, my! What have you done to your hair? At this point a relative might have argued: Oh Mom, I’m not Jenny, I’m Victoria. The therapist, instead of arguing, made a gesture of absentmindedly straightening her hair with her hand, saying: I haven’t been able to do a thing with it! They both laughed, and proceeded to have a lively session punctuated with laughing and crying. (For an argument that catharsis lives, see Scheff 2007).

The final example comes from the field of education. My UCSB colleague (Weissglass 2009) also teaches math in an elementary school for underprivileged children. He explains his method:

I ask students leading questions about mathematical situations in order to help them discover, understand, and become proficient in mathematics. The basic principle is that when asked to explain a wrong answer, students will discover their mistakes, and by working together as a group, develop their understanding.

A key aspect is not quite described; the teacher usually tries to save students from the automatic embarrassment of a wrong answer. One question: How many sides does this milk carton have? He is prepared to normalize many of the different answers by having thought ahead: your answer is about the visible side, outside, flat, etc. His method seeks to avoid automatic judgments: students are not always wrong, just as teachers are not always right. More importantly, in the long run, social acceptance, rather than automatic rejection, might improve our schools and our society. Teachers can learn to give corrective responses without putting the students down: normalizing without enabling.

An example from my own student days. A senior in physics, I had one professor that I particularly respected. I thought that he respected me also. However, one day when I went to the blackboard prepared to grind out the answer to the problem he had given me, I thought of an intuitive answer that was correct. My professor was so astounded that he said, Did Jim (the star student) tell you that? The beginning of the end of my love affair with physics: he had labeled me as a plodder and embarrassed me in front of the class.

Conclusion

This essay has suggested an idea that might help us individually be better therapists or teachers, and in the long run, change our medical, psychotherapeutic and educational institutions. The theory of labeling/normalizing alerts us to the dangers of automatic reactions of labeling as well as enabling, and gives examples of how both extremes might be avoided. These ideas might help both individuals and societies grow and prosper.

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