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Normality and mental health: The ethical dimension

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ABSTRACT

This article applies the concept of normality, in both its descriptive and normative connotations, to the field of mental health, emphasizing its ethical undertones in different cultural and situational contexts. Ethics is defined as the linguistic justification of morals, and bioethics is characterized by arguments based on dialogical, discursive, and deliberative processes. Bioethical decision-making influences human relationships and has implications for diagnosis, prognosis, interventions, and evaluation of therapeutic results and outcomes. Normality in mental health should be reformulated on bioethical principles to avoid being a source of stigma and discrimination, at a time when human diversity and cultural change impose a redefinition of conceptual boundaries and depathologization of different forms of behavior and experience.

Keywords: Normality, mental health, ethics, bioethics, discrimination, stigma.

RESUMEN

Se aplica el concepto de normalidad en sus connotaciones descriptiva y normativa al campo de la salud mental, destacando su tonalidad ética en diferentes contextos culturales y situacionales. Se define la ética como la justificación lingüística de la moral y se caracteriza a la bioética como fuente de argumentos basados en procesos dialógicos, discursivos y deliberativos. La toma de decisiones en clave bioética influencia las relaciones humanas y posee implicaciones para el diagnóstico, el pronóstico, las intervenciones y la evaluación de resultados y consecuencias. La normalidad en salud mental debiera ser reformulada sobre la base de principios bioéticos a fin de impedir ser fuente de estigma y discriminación en una época en que la diversidad y el cambio cultural imponen una redefinición de límites conceptuales y la despatologización de diferentes formas de conducta y vivencia.

Palabras clave: Normalidad, salud mental, ética, bioética, discriminación, estigma.

DIFFERENCES BETWEEN INDIVIDUALS

Human behavior is characterized by its variability. Differences between individuals can be relatively permanent and are conceptualized as personality traits. The personality construct refers to the permanence of propensities and behaviors. It has the value of a predictive description. There is also situational variability, which is alluded to in the concept of state. A person can feel anguish, fear, or joy, have certain desires, and act unexpectedly. Such states, by definition transitory, are not used to characterize people but rather to evaluate situations or capacities.

When traits or states cause impairment, disability, or handicap, altering social relationships or causing suffering, the result can be called a disorder. Disorders can be brief and transitory or prolonged and permanent, configuring psycho-pathological patterns. Persistent affectations are usually classified as personality disorders and transitory ones as symptoms of possible "diseases" that psychiatric nosology distinguishes based on their intensity, frequency, or degree of disturbance of habitual life.

Not all psychopathology requires specialized interventions. Depending on the culture and circumstance, manifestations that in one context may seem minor or that can be remedied over time or through social support, in others may be cause for concern and a cry for professional help. A typical case is mourning the loss of a significant or loved person, which begins to be considered pathological when its duration or intensity exceeds the tacit frameworks established by a person's environment.

CONCEPTS OF NORMALITY

The concept of normality became culturally ubiquitous in health in the mid-twentieth century. Previously it denoted a statistical notion, meaning a distribution according to certain quantitative parameters. Strictly speaking, it equated to a high probability of an event or a high frequency of a characteristic.

The concept of normality has at least two connotations (Rost, Favaretto, & De Clercq, 2022). It is a descriptive notion, which indicates a state of affairs or belonging to a group or habitual situation. It has also normative connotations, indicating what "should be" appropriate, correct, and desirable according to accepted standards, either quantitative or qualitative. In physiological research, for example, what the aggregation of process studies indicates as habitual for the human species becomes the norm. Thus, for example, a temperature higher than 37°C is both a description and an indication of being outside the norm, in which case one speaks of "fever" (Lolas, 2001).

In medicine, the notion of normality has different uses open to criticism (Catita, Águas, & Morgado, 2020). The first derives from statistics. A value or state found in most measurement events or situations specified by theory is normal. Most laboratory tests give results depending on the conditions and methods of measurement. The accumulation of measurements under standardized conditions allows for the definition of a range of variation considered normal. This is the case of glycemia, body temperature, blood electrolytes, hormonal assessments, heart or respiratory rate, and a wide variety of parameters. Thus normality turns into normativity (Lolas., 2001).

The second connotation of normality is associated with a set of desirable or ideal attributes. The body accepted in a culture without objection, or the manifestation of culturally desirable attributes is normal. There is also a dynamic or temporal consideration. Certain bodily processes that run without alterations are normal, with their appropriate and accepted rhythms and in the expected places in the body. For the classical medical mentality, what makes a process abnormal is heterochrony, going out of the expected rhythm, or heterotopia, occurring in unusual places.

Normality is usually associated with adaptation to changing environments and with the biological and social advantage of existing without major modifications when conditions change. Cannon's classical notion of homeostasis conceives of adaptability as part of biological normality, and Claude Bernard suggested that the constancy of the internal environment is a condition for a free existence. Normality is adaptability, resistance, and resilience.

It is customary to consider normality as a component of the complex concept of health, understood not only as the absence of suffering, but as fullness and enjoyment of capacities. To the consecrated definition of the WHO, a prospective factor of permanence and expectation must be added, which takes on importance when talking about mental health.

"Mental health" is a pleonastic construction, that is, a phrase or combination of words with excessive and redundant valence. There can be no health without mental health in any animal species, especially human. What is insinuated with the over-meaning added to the idea of health by the adjective *mental* is both the self-perception of a satisfactory and pleasant interiority and the ideas, projects, and perspectives that people harbor according to their knowledge and beliefs. The mental is the conscious or the unconscious that is accessible to the word, the relation of behavior to meaning, or behavior according to the social norm. When any of these aspects of the mental show abnormality, the result is called a mental disorder. Technically, it is unlikely or impossible that ideation or behavior does not have some form of correlation with processes in the central nervous system. However, debating dualism versus monism, determination, or physiological modulation is not the objective of this text (Armstrong, 2005).

ETHICS AND MENTAL HEALTH

The concept of normality, which in physiological or physical medicine is assimilated, albeit with reservations, to average magnitudes of measurable parameters, is confusing in the field of mental health (Jäger, 2018). Many variants of behavior, self-perceptions of subjective interiority, and sensibility are unequivocally incommunicable. The psychiatrist or psychologist has sources of information such as the word (which roughly reflects interiority), manifest behavior (motor behavior), and physiological signals (chemical or electrical). This psychophysiological triad (Lolas, 1988b) is expanded with the consideration of personal history as biography (self or other), the material products of personal activity (writings, drawings, objects), and family history as suggesting abnormal predispositions or diathesis.

If morality can be considered the social behavior "accepted" by a society, ethics is the verbal justification of what is correct and what it should be. It is not a question of verifying only what is, or what nature can be. Ethics justifies what should be according to the ideals of a culture. It is a philosophical discipline that uses language to support prescriptions and prohibitions. It requires a source of authority that imperatively allows justification: a religious belief, a philosophical conviction, the mandate of reason, the knowledge of nature, or any source recognized as an authority worthy of compliance and respect. The variant known as bioethics highlights the relational role of this "justificatory language game," by proposing that norms should come not from the monological derivation of a system of thought, but from the dialogical and participatory appropriation of conventions. In bioethics, dialogical or "multilogical" deliberation predominates, basing its acceptability on consensual procedures rather than on the imposition of doctrines. Its decisive cultural contribution has been the installation of social institutions known as committees that combine different visions and interests to make decisions. There may be tensions between the ethics of convictions and the ethics of responsibility (which considers the consequences of actions). The bioethical discourse accepts the plurality of rights and duties and combines perspectives and interests.

It is not surprising that ethical prescriptions and prohibitions can be read in a psychological key and that many disorders today considered psychiatric (in medical psychiatry) have been attributed to "moral idiocy," "perversion," or "demonic possession." The abnormality is thus confused with moral deviation and the disturbance is interpreted in an ethical key. Remnants of such a position persist in the notions of deviation and degeneration, less useful today since they have been associated with etiological considerations that are no longer valid. The "causes" of so-called mental disorders oscillate between physiological and anatomical determinations, oppressive or limiting social contexts, and genetic predispositions.

DIMENSIONS OF BIOETHICS IN PROFESSIONAL PRACTICE

When we address here the interface between ethics and mental health, we do so from a special, limited perspective. It is about elaborating on the form of ethics that can best serve to help people who suffer from disorders, and the appropriate behavior of those who can and should help people who need and require help. The appropriate practices in a given context are defined by multiple interests: social, economic, cultural, and institutional. Thus, from a bioethical point of view, it is a matter of specifying the ethical dimension that justifies individual or collective interventions to alleviate disorders of ideation, emotion, or behavior (Lolas, 1988a).

The need for bioethical discourse begins with the adequate training of professionals, who must know how to support their actions on a technical level, and also how to justify them ethically. The perception of one's value architecture is possible with introspection and experience, which can be exercised in teaching. It is part of the didactic analysis used in psychoanalytic training, but its principles should be considered in any educational process.

In a professional relationship, there are a multiplicity of planes. The people who meet—therapist-patient, doctor-patient—are just examples. However, each person entering into the dialogue does so with a personal and cultural background, in addition to the presence of many relevant people, who, although physically absent, never cease to influence the relationship. There are "significant others" in the lives of the interlocutors, authority figures, and the pervasive influence of law and custom. The relationship also includes what in psychoanalysis is known as transference, sometimes with vicariant identifications (the therapist replaces the father or mother, and the patient can awaken associations with people from the therapist's biographical memory, for example).

In the dialogic situation, these various layers of meanings can be identified. It is not always easy. The medicalization of psychiatry reduces the interview to the search for a diagnosis, a label that is reached inductively, depending on the thoroughness of the examiner, the identification of relevant signs and symptoms, and their division into significant groups (syndromes, clinical pictures, disease entities). The idea of a patient in society is that of a "labeled person" or "cataloged individual." The power of professionals consists in giving names to what worries or torments people. It is not always possible; many complaints and the feeling of limitation or impairment sometimes do not fit with the categories in which "diseases" are coded. Feeling sick is not the same as having a disease or being considered sick (illness, disease, sickness). This discursive dissociation forces us to consider different points of view in the construction of a common concept (illness negotiation) based on the "offer" of signs or symptoms that the expert can group into mean-

ingful categories and that can be labeled with a view to intervention. The psychiatric diagnosis is not only a description; it is also a prognosis and an indication to intervene. However, there are also the perceptions of people who tend not to communicate where there is no trust in professionals or if communication implies unwanted stigmatization (Lolas, 2014).

Diagnosis, therefore, has an axiological dimension (Lolas, 2009). Designations, and words, have effects on people's lives and often initiate a "patient career," since with this labeling an identity element is added that can cause stigmatization and discrimination. People labeled as "carriers" of a condition assume an identity that modifies their lives, induces concern or anguish, and determines behaviors (Lolas, 1997). It also has legal and social consequences, since it can generate actions to repair damage or limitations on interpersonal treatment. It is understandable to use diagnostic terms that avoid these consequences, distorting statistics and leading to negative consequences (although sometimes the diagnostic label is used to advantage). The psychological or psychiatric diagnosis requires consideration of its consequences and is ethically relevant.

The relationship between professionals and applicants for help is marked by prohibitions and limits that are part of the ethical context of professional practice. In medicine, most of the codes of behavior highlight the obligation to keep secret what is exchanged in meetings and to practice the trade following the ancestral precept of "do no harm," which also finds expression in prescriptions and interventions. Especially in the case of vulnerable people or those in need of esteem and support, the relationship must be carefully elaborated in order not to generate harmful dependencies or affective transfers that alter the necessary "equanimity" that must prevail. Empathy and willingness to help, as William Osler indicated, should not prevent the necessary distance that avoids the clouding of clinical judgment and distinguishes professional intervention from friendly comfort. People do not go to professionals just to be sympathized with. They also want expert knowledge, experience, and accuracy.

There is a frequently highlighted tension here. The alleged dehumanization of medical practice and the reduction of people to numbers or cases, the basis of some criticisms of the medical model propagated by some sociological currents, is usually based on the convenience of not affecting judgment based on feelings, the self-protection of professionals against the pain that is contagious and damaging, or administrative reasons that simplify communication in health institutions. The balance between understanding, empathy, warmth, truthfulness, honesty, and technical competence is an achievement of correct professional training.

Therapeutic interventions are of many types. They begin with the word, and what Michael Balint has called the "medical drug": the mere presence of someone who knows and has authority is a component of the healing or curative action. Like any drug, it must be dosed and administered at times and in ways appropriate to each subject. These are semiotic and discursive technologies, part of the "hidden curriculum" of professional studies because they are not always explicitly taught. Collecting data for a medical history is not the same as reconstructing a biography. The ethics of the verbal or pre-verbal intervention must be considered when defining the abnormality in conjunction with those who want help. The ultimate foundation of the anthropological orientation of medicine, observed Viktor von Weizsäcker, is the recognition of the Other as a person and the reformulation of the interpersonal relationship as "communicative praxis." In psychiatry, "encratic" technologies (related to the management of professional power) have historically played an important role, as noted by Foucault, who observes how the prescriptions of the French alienists of the eighteenth and nineteenth centuries explicitly highlighted manifest "psychiatric power" in the appearance, the institutional design, and the hierarchies of "caretakers" that the "moral treatment" then in place demanded (Foucault, 2007). It was a sign of abnormality not to abide by such relationship designs. It is necessary to examine the historical changes in the ethics of professional practice leading to more egalitarian forms of treatment and the abandonment of old notions about the incapacity and incompetence of the "mentally ill."

Instrumental interventions, from the technification of the diagnostic process to pharmacological, surgical, and telematic treatments, are part of the ethics inherent in the labeling of abnormality that precedes any non-verbal action in the technical process of "therapy" (which means help). The complexity derives from the fact that it is never a simple exchange or relationship between two people. The significant others are present in the lives of therapists and patients, the prejudices rooted in culture, the institutional context in which the interaction takes place, and the omnipresent influence of economic factors. The latter involves external actors, such as industry and social security systems. Factors and interests that affect the "quality" of care, such as the prescription of novel drugs or sophisticated techniques not available to all communities or individuals, play a role. Not recognizing or ignoring these factors does not nullify their influence on decisions, and requires, apart from the usual regulations in professional behavior codes, an acknowledgment of the conflicts of interests or loyalties that their existence inevitably generates.

Finally, there is an ethical dimension (that is, morally expressible and in need of justification) in the analysis of costs and benefits generated by professional work. It is different to talk about "effects" as different from "results." Even perceptible curative interventions must be judged in the context of the "satisfaction" that their final result generates in consultants and professionals. In the field of men-

tal health, with its diffuse and incommunicable results, this evaluation must incorporate not only the convictions of the participants, but also the individual and collective effects of the interventions. Evidence-based psychiatry cannot be separated from value-based psychiatry. This second formulation, however, is ambiguous. It refers both to respect for the values of patients and therapists and to the social and economic cost of decisions. Not infrequently the normality achieved for one group of people is unattainable for others, and professionals are faced with working in the contexts imposed by the resources and the possibilities of the populations to be cured and healed.

The normality predicated on the experiences and behaviors of people requiring help for disorders not exhibiting a physically measurable substrate requires considering the validity of this conceptual category. As medicine becomes a search for normality through curative procedures, it condemns many individuals to exclusion and discrimination. It dichotomizes a complex reality. The ethical challenge is to distinguish abnormality from acceptable or condemnable varieties of human beings. Historical evolution indicates that many diagnostic labels of the past have been "depathologized" and have become acceptable variants of the human condition (think, for example, of homosexuality, which went through the stages of "egosyntonic" and "egodystonic" before becoming a socially and medically acceptable variant of personal life). It is not about reducing psychiatry to a mere social control device or denying the existence of pathological conditions, but about reformulating what is normal and abnormal on a plane that is independent of what is pathological. Canguilhem (1966) implicitly suggested the need to deconstruct normality as normativity and not simply to oppose the terms normality and disease, especially if the former is identified with "the average" or "the usual". What is pathic, what makes one suffer, is not necessarily pathological, worthy of diagnostic labeling.

BIOETHICAL CONTEXTS FOR A REDEFINITION OF NORMALITY

The redesign of a broad concept of normality requires considering the diversity of human existence and demands a reformulation, at the level of what is loosely called "mental health," the changing boundaries of the pathological. It is a challenge for a psychiatric and psychological metatheory to rescue the original use of the idea of normal, which in its statistical meaning is equivalent to "probable" or "frequent" (Rost, 2021). When adopted in the medicalizing (or pathologizing) language game, it poses ethical dilemmas. As a language game that reflects vital worlds, bioethics as a deliberative and dialogical exercise reconsiders differences, deficiencies, and impairments as challenges. It invites us to explore the "testimonial injustice" that makes social and physiological norms inflexible in pursuit of a desired objectivity never reached by professional work in mental health. It places importance on recognizing and celebrating the perfections of imperfection, as well as understanding the power of mental resilience. To reach normality is to embrace abnormality and accept the variability, inconsistencies, and discrepancies that are naturally part of all human life. As a concept it demonstrates the importance of lifting oneself up to build a brighter and more hopeful tomorrow, and encourages individuals to make conscious and proactive efforts towards revitalizing their well-being.

The bioethical enterprise is in essence the discursive reformulation of relational contexts through the deliberative process embraced jointly by those who help and those who seek help (Lolas, 2002). In this endeavor, bioethics goes beyond the simple application of principles and calls for pro-active thinking and a thorough examination of normality and normativity.

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