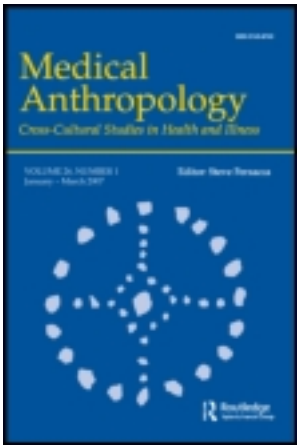

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Pursuit of a 'Normal Life': Mood, Anxiety, and Their Disordering

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Pursuit of a 'Normal Life': Mood, Anxiety, and Their Disordering

Stephanie Lloyd and Nicolas Moreau

Throughout the process of being treated for mood and anxiety disorders, people dream of the "normal life" that awaits them. However, post-therapy, the distinctiveness of clinical normality (i.e., reduced symptomatology) and social normativity become more apparent. In this article we suggest that for people who have long felt socially excluded because of their psychiatric symptoms, being "normally shy" or "normally awkward" is not enough. Instead they aspire to an ideal life. This confusion between means and ends, between a nonsymptomatic self, a normative self, and an ideal self, leads these individuals to long-term self-doubt and confusion about how to reach their elusive goals. Yet, their never-ending pursuit of normative ideals applies to "normal" and "abnormal" people alike. An analysis of narratives of exclusion allows us to reflect the life-long search for social inclusion via a normal life.

Key Words: anxiety; Canada; depression; France; ideals; norms; psychiatry

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> You know better than me the unfortunate fate of this word "normalization." What is not normalization? I normalize, you normalize, and so on. However, let's try to identify some of the important points in all this. (Foucault 2007:56)

> If I look at the lives of my friends . . . they already have families with five-year-old kids and maybe another child. They spend weekends going to the park, teaching their children how to walk. It seems to me that their lives are so full. I went to visit my sister, who is like that. She has two kids who are now teenagers; one was arriving home from school. She started playing music, the other was singing, they were all hanging around in the backyard. A house full of life, see? (Carmen,[1] Montreal)

Symptoms, normality, disorders, norms, ideals: these are the themes that run through narratives of mental illness experiences. The people we spoke with, despite their different diagnoses, symptoms, and daily hardships, were virtually in unanimous agreement: they just wanted to be "normal." In this article, we examine the experiences of people in various stages of coping with mood and anxiety disorders. Many of those we interviewed, like Carmen, could not remember a time when they had been normal. A married woman in her late 20s, Carmen suffered from depression and longed to surmount the disorder that she felt had robbed her of a full and happy life. Ultimately she wanted a "house full of life," the kind of life she attributed to her friends and family.

Carmen was one of many people with whom we spoke who described recovery from their disorders—in terms of symptoms—as but a step in the pursuit of a normal, happy life. The former was a clinical goal; the latter a life goal surpassing the reduction of psychiatric symptoms. Simply put, they wanted to live and do things "that . . . other people do," as David, a Parisian suffering from social phobia, explained. Our interest in normality thus emerged from these fieldwork experiences with people suffering from social phobia, parenthetically called "social anxiety disorder," in Paris (Lloyd) and people suffering from depression in Montreal (Moreau 2009).[2] The two field sites are regions that both use globalized, standardized means of describing mental illness. All people with whom we spoke had been diagnosed or had self-diagnosed according to categories defined in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) of the American Psychiatric Association. The criteria of the diagnostic categories in the DSM are increasingly widely known and accessible via the Internet, and information is often spread through public health awareness campaigns. While this is expected in Canada, it is still somewhat atypical in France because of the distinct histories of psychiatry that inform patient experience and diagnostic patterns and treatment regiments selected by physicians (Lloyd 2008). The people interviewed for our respective projects suffered

from different psychiatric conditions, but there is substantial overlap between the two in terms of patient populations who suffer from them either sequentially or as comorbid conditions (Kessler et al. 1999). The two patient populations share difficulties with action and mood regulation, which lead to social retreat, professional or educational difficulties, and an inability to live up to expected behavioral standards (i.e., norms) of their cultures.[3]

The similarities between the narratives of our Parisian and Montreal interviewees led us to wonder about the common features of a particular, disorder-centered, way of knowing the self and its relationship to perceptions of norms in societies deeply influenced by globalized psychiatric systems. Our critical intervention in this essay is to provide an analysis of perceptions of the norm as an idealized "other" state by which people know themselves to be irregular, disordered. Our interviewees attributed to "normal people" an ease in everyday life and an effortless attainment of professional, interpersonal, and romantic ambitions. It was this kind of normal life, a highly idealized life, they aspired to postdisorder. The fact that these people fell consistently short of the ideal makes them no different from anyone else, but confusion between the expected outcomes of clinical normality, acceptable normativity, and the ideal contributed to their continuing struggles.

THE PRACTICE OF NORMALITY AND NORMATIVITY

> . . . depression, it's not that because you had one once [and got over it] that you'll never have one again. How you manage your life is going to decide whether you will have another period of depression or not. All of a sudden you can learn lessons from that . . . you have to have an action plan to be stable. . . . In the end, it takes a lot of help, psychological help, for it to recede. They can't just prescribe medications then let you go. That does nothing, absolutely nothing. You need introspection to really get over it once and for all. That's what I call the voyage; it's the voyage that human beings have to go through alone at times. (Gabrielle, Montreal)

Becoming a normal person—a happy, stable one—is quite different for Gabrielle, a 31-year-old single woman in Montreal, than being treated for symptoms. Certainly, the two overlap and coincide in a number of daily experiences, and she sees clinical treatment of symptoms is an integral part of surmounting mental illness. But for Gabrielle and others, the voyage to normativity is something distinct from the clinically measurable normality of symptoms. These two things are difficult to tease apart, as they have long been entwined in her experiences, constantly informing each other, in part because medical and clinical techniques are used both to assess and identify

abnormality and to assist in the restoration of normative behavior in day-to-day life. But there is a point at which the clinical and personal voyages diverge, specifically where normality and normativity are concerned.

Lennard Davis (1995) argued that the concept of a norm has not always existed, and that comparing oneself to a norm is in fact "less a condition of human nature than it is a feature of a certain kind of society" (24). Davis (24) argued that the words normal, normalcy, normality, norm, average, and abnormal all entered European languages—and consciousness—quite recently, roughly during the period of 1840–1860.[4] While these terms have become widely used, it has been argued that this occurs with a lack of precision. Jürgen Link, in an article translated by Mirko M. Hall, attempted to clarify the language of norms, following on the work of Michel Foucault. Link described normal as having a technical sense of "average," a statistical norm defined "postexistent" to action (2004a:18). The identification of normality, he argued, follows from this type of analysis and is particular to data-processing societies in which statistics, averages, and collections of data about populations define what counts as normal and what does not. He differentiated between normalcy, which he identified as the normalization of life according to statistical analysis, and normativity, which Link described as "an ancient and probably (in a literal sense) antediluvian phenomenon" (2004b:35). In this article, we adopt Link's definitions of normativity, normality, and normalcy.

The introduction of the concept of an average, statistical norm—or normal patient—changed the way that clinicians and policymakers, among other professionals, saw populations. The concept encouraged attention to citizens' mental and physical normality. Beliefs about normal and subnormal individuals came to affect the ways in which physicians saw their patients and how people saw themselves and their fellow citizens (Gilman 1991; Kevles 1985; McLaren 1990). While the effects of this new concept of normality were powerful, a context-based normativity remained an important way of knowing oneself. Central to the concept of normativity was flexibility, the ability to adapt to new norms of life (Canguilhem 1978:197, 200; Martin 1994), or their ability to live according to their most valued individualistic norms. This is not taken into account in conceptions of a normal patient. What constitutes successful treatment and return to normal functioning therefore can have very different meanings for clinicians and their patients.

Anthropologist Seth Messinger outlined how professional assessment of a return to normal for amputees focuses narrowly on physical functioning, which "suggests a kind of reduction of knowledge and experience that constitutes the person, to the body as machine" (2009a:18). This assessment of normal functioning ignores many factors important to amputees, such as having a robust social life and personal development not strictly related to

physical adaptation to limb loss. For example, an army therapist might consider a person a successful "case" if he is able to run on a prosthetic leg, even if he remains jobless and unhappy. The same man is, Messinger pointed out, considered a failed case if he does not use his prosthetic limb to its potential, even though he has been able to move on in other areas of his life. This kind of research demonstrates the way in which "individual experiences with suffering and affliction both complement and confound medical practices" (Messinger 2009b:2130) and explores the sometimes profoundly different perspectives of the clinician and patient (DelVecchio-Good 2007).

While differences of opinion between clinician and patient sometimes diverge as they relate to different functional priorities, at times opinions diverge because of more fundamental questions about normal life. An example can be found in a recent study of sleep disorders. Matthew Wolf-Meyer argued that the naturalization of our current normal sleep patterns that have led to the use of medical treatments to adjust aberrant individual patterns of sleep is an "artifact of the industrial consolidation of sleeping and work time" (2009:15). In this way, the new norm of constant daytime alertness has displaced an older, more flexible, more individual pattern of sleep. Conformity here has little to do with existing or preexisting norms. Instead, people are pressured to conform to an idealized social and economically useful behavior, pushing aside individual difference and the nonmedical factors involved. Wolf-Meyer described the ambivalence with which people approach the normalization strategies of their physicians, at times rejecting the medications meant to afford them a normal life rhythm (i.e., as defined by medicine) because of the secondary effects of the drugs. One of these people, suffering from narcolepsy, specified that he would rather sleep more than is considered normal, which is the case when he does not take his medications whose effects resemble those of speed, but to be "himself" when he is awake (14). In this case, the clinical priority of normal sleep conflicted with the patient's priority of being what he recognized as his authentic self. Here the gap between diverging views of normal life appear.

Gabrielle, quoted at the outset of this section, recounted a similar mismatch between clinical goals and her own; however in this case medications were seen as part—although only part—of the solution rather than as part of the problem:

> Effexor . . . I see that it helps me, because when I have not taken it for a couple of days, I cry for nothing, I fall squarely back into depression. . . . The medication is the base that allows me to face my problems and solve them. It's like a sort of crutch, but I must not become dependent on it . . . because it is just there to help me, but it is me who has to look inside to resolve my emotional and psychological problems. A pill is not going to do that.

What she appreciates about the medications is that they keep her from going to extremes, keep her mood "moderate" as compared to "amplified" without medications. She believed that her medications allowed her first to take small steps, such as getting up and making coffee in the morning, to the larger step of considering looking for a job. Nonetheless, she suggested that this all would amount to nothing if it were not a part of an overall process of "self discovery." This "voyage" inside oneself, she believed, is the most important part of the experience of moving forward with life and establishing an identity. "You can't just prescribe medications like that, and send someone out into the world. That offers nothing, absolutely nothing," she explained, and she was convinced that this form of treatment could lead to future destabilizations. For Gabrielle, knowing her place, or desired place, in the world was most essential. Gabrielle drew attention to the limits of her clinical improvement, which placed an emphasis on day-to-day expectations of autonomy and function rather than on other aspects of life that she found equally meaningful:

> See, I live alone in an apartment, I'm able to go to my [medical] appointments and I can engage with other people. But still . . . I have a lot of difficulty with interpersonal relations, so really not a lot of friends. I have trouble with that. It's another problem.

For Gabrielle, improvement is not simply the capacity to do basic tasks such as regularly attending appointments; it includes her day-to-day life and social inclusion, revealing a chasm between a clinical and personal view of the mental illness trajectory.

Anthropological studies of the normal and the experiences of Gabrielle draw attention to the contradiction at the heart of our interests: on the one hand, individuals have learned to put their faith in medicine and medical practices in order to have their bodies and behaviors normalized, but on the other hand they continually run up against the fact that clinicians are ultimately concerned with normality, that is, symptom reduction and not normativity or a normal day-to-day life.[5] The rehabilitation that Gabrielle and others have in mind includes but goes beyond psychiatric and even psychosocial goals; it is part of a larger project of self-improvement via social, personal, and professional normalization in its most idealized form.

THE SOCIAL LIFE OF NORMS

> My objective, in my daily life, is to be able to do the things that, really, other people do. (David, Paris)

Like so many of the people we spoke with, David judged the success or failure of his own life based on his perception of how "normal people" lived. Although he believed he had come to manage the symptoms of social phobia, he remained dissatisfied with his solitary life in Paris:

> I haven't really gotten to the point where I have a life. . . . I can do leisure activities but during these activities I can't have normal relationships, make friends. Really, [I don't] have any relations other than professional.

What David referred to as the absence of "a life" has eluded him since he moved to Paris in his 20s from a small town. When we spoke, he was in his mid-30s. He felt alienated from other people and far from attaining what he saw as the most natural signs of achievement, such as romantic relationships and a successful career:

> Notably, I've never had a girlfriend in my life, so [I'd like] to have a relationship with a girl. Eventually, well, on the professional level, I haven't been able to. . . . I've worked in the same place for 15 years now and I haven't been able to. . . . It's not that I don't like the work but I would like to be able to get another job to prove to myself that I am autonomous, that I can make decisions, that I can make the life that I want. In fact that's it: that I am not able to do, to manage my life in the way I want.

David's concerns about the regulation of his symptoms appeared secondary to what he insisted he really sought: a life that conforms to the norms he associates with the lives of others who are, he presumes, happy. David was like many people we interviewed; clinical interventions to manage their disordered selves had yet to yield what they recognized as a normal person.

While clinical discourses are powerful factors that shape identities, they are but one means among many. Norms, sociologists tell us (Butler 2005:40; Le Blanc 2004:13–14), must be considered as they are inescapable, and it is impossible to live and to think without reference to them. Simply put:

> If one lives in society, and one cannot live otherwise, one cannot escape this reference to the norm, not forcibly to bend oneself to it, to contest it or to try to abolish it, but most often to take a position (and at the same time, distance) with respect to it, while forcibly establishing a common language with "others." This common language, this normative grammar, constitutes the social body. (Otero 2005:69)

Norms are at times described as monolithic and consistent in a given society, unchanging and all encompassing. We argue, however, that while

patterns exist in particular countries, communities, and cultures, we do not want to perpetuate the presentation of norms as stagnant, timeless, and explicit (Le Blanc 2004:11–19), regardless of whether we are considering the anthropological or sociological referents. Careful sociological studies of norms emphasize their malleability in the sense that they are functions of age, sex, culture, geography, economic status, and profession (Moreau 2009:70). Thus, many norms and forms of normativity are possible within any society. This widening of the normative space in many Western societies is encouraged by the movement away from the regulation of individuals based on permission (i.e., what they are allowed or not allowed to do) to a self-regulation based on a constant search for individual potential (Ehrenberg 1998:14–17). This was reflected in the narrative of each person we interviewed, each of whom aspired to a slightly different proximity or position vis-á-vis norms, informed by his or her economic situation, family background, educational level, and individual interests. Consequently, in each environment the normal individual is someone who perceives, interprets, and acts on the social world in a manner that conforms as much as possible to what is asked (verbally), prescribed (in rules), or suggested (implicitly) of him or her (Le Blanc 2004:21–22).

Despite important differences in the milieus in Paris and Montreal, the people we interviewed shared middle-class contexts that we believe influenced the types of norms to which they aspired. They valorized similar norms and behaviors that they believed, if reached, would mark them as normal members among their peers (Bourdieu 1979). They additionally seemed to have been affected by similar "micropenalties" (Foucault 1975:209–216) that continually informed them of their abnormality as a result of their traits, now described by their depression or social phobia diagnoses. People suffering from both of these conditions are characterized by their intense sensitivity and fear of judgment. What was constant was their pursuit of an idealized, if situationally variable, normative life. As in the case of David, after having felt left at the margins of life for so long, they now aspired to the most normal of normal lives. What they aspired to is a complete, as possible, conformity with what they see as their middle-class peers' lifestyles. They aimed for the adoption of conducts and manners of thinking and behaving that are the most common and widespread within their particular milieus.

These desires appear substantially out of step with the normativity arguably dominant in France and Canada. It has been suggested that in highly industrialized countries, we live in an era of "flexible normalism" (Link 2004a:29) in which the border between normality and abnormality is broad and loosely defined. This leaves space not only for normal suburban families

but also normal Goths and normal porn stars who can exist on the margins of a normal society without presenting a threat. All these normal people, however, are functioning vis-à-vis norms. For flexible normalism to exist effectively,

> subjects must be capable of "normalizing" themselves. . . . They must be able to "freely" choose their "locations" in the respective fields of the normal (if near the average in the "middle," or more or less removed in the zones of tolerance, or even on the border of normality) by making tactical calculations, especially risk calculations, but also frequently with a certain "spontaneity" (i.e., the just-for-fun principle)—but above all, always under the consideration of the totality of normality, which it should not endanger. This ability of self-normalization (in the sense of dynamic self-adjustment) presupposes a new type of inner-direction. . . . This flexible-normalistic kind of inner-direction is acquired, in particular, through psychotherapeutic training programs in the widest sense (counseling, self-experience, creativity, and so on). (Link 2004a:29)

In light of this description of flexible normalism, what is striking about our interviewees is the extent to which they appear to have identified a place as close to the "middle" of normal as possible as their target. It is possible that having stood out in variance to social norms, David and others now eschewed the possibility of existing at the margins of flexible normalism in their urgency to be as normal as possible, whether by tactical decision or not. They hoped that medical interventions will allow this bull's-eye form of normativity. The reduction of their "disorderedness" rarely allowed them to attain this goal, however, because the normal does not exist. Their goal tends instead to resemble an ideal.

THE ENCROACHMENT OF IDEALS

> Curiously, it's true that my studies, etc., in the end, did not give me any confidence in myself, it's this that is strange. . . . You see, I set very high standards for myself. It is not enough for me to be average, it's not enough to be just good enough, it's necessary that I really succeed. It's my top concern. I think that I'm just made like that, and now it causes me problems. (Sebastien, Paris)

Upon closer inspection, the almost extreme normativity—a mythical normativity—sought by the people we interviewed begins to resemble a life based not on existing norms but on ideals or, at the very least, idealized norms. These people were not happy with their post-therapy status quo.

Sebastien consciously evaluated his position, which was well above status quo, as insufficient:

> I say to myself, "Okay, for the moment, I have managed my existence without material problems, I did very well in my studies, I have a job that is not too bad, I did this even if it is a little more difficult for me than for someone else [who does not suffer from social phobia]." ... I work in finance in an industrial company though it's true that I got it without really knowing why because many of my friends who are looking for work—the situation in France is very difficult, I don't know about the United States or Canada, but in France I have friends who have search for six months or a year. So I say to myself, "Okay, I found that, it's not too badly paid, it's not too interesting, but I'll take it."

Sebastien is a well-dressed, composed looking man in his 20s who strictly monitors his professional and personal life success. He has high expectations of each and is profoundly disappointed at not reaching his objectives. Up until his early 20s, Sebastien considered his life normal. He had a large circle of friends, he was successful at school, and although he felt a great pressure to succeed, he was happy. This changed when he did a student exchange abroad. The rupture from his previous life, including a new country, a new language, new friends, and a new school, took its toll. He found himself rarely leaving his studio apartment and feeling extremely nervous when he did. He identifies this as the moment of onset of his social phobia, a condition that persisted even after his return to France:

> For example, at work, I'm very, very afraid of failure. At school, I was a very good student, I was always a very good student, I never had a problem with that, and I had very, very high standards for myself. In fact, I'm still trying to prove, to prove, I don't know what. Maybe it's related to my father, that's what came out with my psychologist, etc. And I don't tolerate my own errors. And so, this is what happens in my professional life, I replicate this path. One small error, for example, and it seems to me to be a sign that things are going to go all wrong. I have a very, very low tolerance of negative comments. If someone points to something I did wrong, I say, "shit" ... and I turn in on myself. And so, I try to manage this, I try not to let others see it, but it's difficult. I think that it's really the fear of failure that paralyses me.

Sebastien deemed any "failure" to meet the goals he set for himself unacceptable, and he correlates his failures with the onset of his disorder. He looked back with nostalgia at his old life, his memories of ease in social interactions and what he felt was relatively effortless scholastic success. Although therapy had taught him to master his somatic symptoms—

reddening, trembling, and increased heart rate—allowing him to appear normal in public, he wondered whether he would ever be able to have a normal relationship or be as successful as he once dreamed he would be:

> I think that, in my case, I think that it [his remaining anxiety] could pass with time.... There was a man at the support group meeting [for people suffering from anxiety in Paris], Michel, who had three kids and he had more or less succeeded in life.... I hope to be like this and it's true that I am becoming more myself again. So I tell myself, "Maybe it will be like that for me." I'm not there yet... [his condition] is something that is pretty difficult for me to acknowledge in my life generally. Michel, I don't know if he does, but he has kids, etc. that is something, his family must know [about his problems], his kids, etc. But me, for the moment, apart from my parents it's something that I hide.... I am hoping that it will just pass.

If his problems were to "just pass," Sebastien believed he could then have the life he wanted and achieve the goals he set early in life. Recovery meant an end of failure. When he looked toward his future, his minimally acceptable normal life was modeled on that of Michel, a successful middle-aged businessman. Michel, who Lloyd also interviewed, acknowledged his success but expressed fear that his career might fall apart at any minute despite a long track record of success and his ability to adapt his professional track to the social phobia and panic he experienced.

Not everyone had such high hopes as Sebastien or Michel, for instance, not everyone we spoke to had such high professional expectations, but there was a consistent romanticization of the normal and the belief that nonsymptomatic people have easy lives, happy relationships, and control over their careers. Further, they appeared to believe that if they were able to shake the last of their symptoms, their idealized life would follow, that it was natural that one should lead to the other. All these desires highlight the idealized norms they perceive around them. The ideal—at least their individualistic ideals—was their goal rather than the norm in the sense of an average sort of existence.

While using the language of norms, the people we spoke to during our research seem to orient themselves using ideal-type references. Although they were not blind to the difficulty, perhaps even impossibility, of their transformations from disordered to hyper-normal idealized individuals, this did not seem to affect their goals. Take, for example, the case of Dyne, a young woman suffering from depression in Montreal:

> I'll never be able to be perfect and marvelous no matter what I do. And so, it's not even worth trying. So, for me, to have projected myself endlessly and forever against that image, that I will be in good health, I will never be

> anxious . . . that everything will be good. I will feel good around people, I'll be able to go to parties, all that. It brings me back to my daily life. Then I see myself, with all of my faults, all of my limits and I say, "I have wanted that for so long, and I'm just not able to get there". I'm 27 years old now and I don't think that I am really near that. . . . So, I say to myself, I will construct my life as I am able to. . . . I want to do that by being, by respecting my capacities and my limits at the same time. There will be things that probably, I will never be capable of doing. . . .[But] what do I want? That ideal. Yes, I project it onto myself. . . . This comes from the deepest part of me—I want to be like that.

Even for people like Dyne, who question not only their ability but the point of trying to reach the ideal to which they strive, doing better symptomatically is important but still not good enough. If they do not reach the ideal life they want, their self-work is not considered complete. Clinical interventions and self-improvement strategies are both key to reaching their objectives, despite the difference in their normal goals. These people, often despite long histories of psychiatric care, still seem to believe or want to believe that once they are no longer disordered, they should be perfect. Confusion continues between the nonsymptomatic self, the normal self, and the ideal self.

SYMPTOMS, NORMS, AND IDEALS

Interviewees identify themselves in at least two ways. The first is as a disordered self—a symptomatic self—and the second is the desired normal self. The disordered or symptomatic self is how people come to know themselves by means of their psychiatric disorder, as the "type of person" who suffers from their conditions; people become increasingly attentive to the clustered symptomatology at the base of their diagnoses and see themselves through the prism of their symptoms. Viewed this way, their daily experiences are reinterpreted as results of their shifting symptomatology. Significant aspects of their pasts and futures are rewritten either as symptoms or as a consequence of their symptomatic thoughts and behaviors. Once the symptomatic self is understood in terms of a diagnosis, a treatment plan to reduce symptoms is the usual next step to achieve normality. By normality, we mean a return to a normal in the statistical sense (Link 2004a:18). The symptomatic self, then, is defined by normalistic clinical terms following on the terminology of Link who defined normalistic data as characterized by comparability and quantifiability on a mass basis with the goal of homogenization (2004c:52). When patients become normalistic subjects it provides them with a means to learn of their non-normality and a means of managing their daily

lives to control symptoms and return to normality. Put another way, this form of normality creates statistically defined people based on their symptomatology and introduces the goal of movement toward the clinical norm or average through the normalization of symptoms, for instance, as people with normal moods—neither too high nor too low—and normal degrees of actions—neither too impulsive nor too slowed in terms of psychological and motor traits. The disordered or symptomatic self is a kind of self-knowledge that results from clinical interventions and psychological information of all kinds, including, for example, popular psychology, Internet resources, and support group exchanges.

The extent of the obstacles facing these people becomes evident, however, when people achieve a state of medical normality. At this point, at least for our interviewees, it became apparent that statistical and symptomatic normality often has little to do with idealized normativity. With normativity as their goal, individuals' perceived state of being "better" is distinct from that of their clinicians, who aim to return patients to a nonsymptomatic state (i.e., normality). For the people with whom we spoke, the normal self does not relate specifically, or solely, to symptoms. It is shaped instead via their interpretations of the lives they see in their immediate and larger social circles. Carmen, for example, assessed her own situation in contrast with her sister's "full of life" existence. People often identified a potentially normal person within themselves who they wished to become. This was, we judged, either based on nostalgia for a lost normativity or on a hope that there existed in them the seed of a normal person even if they had never experienced this form of normativity.

While not always mutually exclusive, the disjuncture of these two selves—the nonsymptomatic (i.e., normalistic) versus the normative self— and on the particular ways that the normal self sought by individuals differs from the nonsymptomatic self of their treating clinicians, is remarkable. A person with very few, or very mild, psychiatric symptoms should be able to get by in life: have a job, communicate with other people without disproportionate anxiety, and integrate into social circles. Even if these people are not able to be the life of the party or a corporate executive, this nonsymptomatic life can in theory render them quite normal in that everyday sense of the word, particularly if we accept Link's argument about flexible normalism, with its broad and negotiable normal existence (2004a). So, slightly awkward, mildly nervous, or anxious people who have greatly reduced the intensity of their symptoms in therapy but who still exhibit low level traits of their disorders should be sufficiently normative. But, as already indicated, our interviewees did not find this normativity acceptable; they wanted something different. They were not interested in existing at the margins of norms and instead sought to realize the most normal form of normativity they

identified in their respective societies. They wanted all of the most normal traits in society such as (at least) a middle-class status, a relationship, children, and the idealized happiness they saw as accompanying this life. They desired a hyper-normativity that would allow them to blend seamlessly with the norms they saw around them, most often based on traditional middle-class standards. However, political and economic changes, particularly from the end of the 1960s, have destabilized previously acceptable ways of securing a stable economic and personal life in France and Canada. In both regions, although more so in France (Castel 2003), a middle-class lifestyle is increasingly difficult to achieve. But, even if a person reduced his or her symptomatic thoughts and behaviors to the point of being virtually non-symptomatic, approaching a middle-class life, the normal self often remained elusive: it was based on mythic normativity, a utopic, idealized life.

IDEALS FOR ABNORMALS AND NORMALS ALIKE

If it is accurate that we live in an age of flexible normalism, it is worth considering why those people with whom we spoke were dissatisfied with their lives in the broad margins of the normal. They did not want to be a normal shy person or a normal withdrawn or normal melancholic individual, as Dyne described. She was not interested in being a part of a subculture of awkward people. Although Dyne recognized the futility of her aspirations, she could not convince herself to dream otherwise. The other people we spoke to wanted, like Dyne, to position themselves at the heart of the norm. They aimed for the most common and conformist norm possible; to be exceptionally unexceptional: blending seamlessly within their milieu while achieving all normal standards of success: happy marriage, healthy kids, great job, and life of the party. Anything short of this was considered failure and attributed to their persisting psychiatric disorders.

Their efforts to attain an ideal life led to a great deal of self-inflicted pressure, although their persistence was less surprising given that both depression and social phobia are associated with perfectionism (Antony et al. 1998; Ashbaugh et al. 2007; Hewitt and Flett 1991; Juster et al. 1996; Kawamura et al. 2001). Even when this trait was addressed in therapy alongside other personality traits and symptoms associated with their conditions and modulated to become normal in its expression, perfectionism remained visible in the idealized lives they sought. Their interest in this extreme conformity was perhaps accentuated by their often long-experienced feelings of exclusion. We suggest, however, that this pursuit of normativity, although widespread in the accounts of our interviewees, is not limited to people treated clinically as abnormal. Rather, the

idealization of norms and the pressure of normative ideals apply to normal and abnormal people alike.

Since the displacement of ideals by norms, all people are left in a state of abnormality—some straying so far from the norm that they are characterized as disordered or disabled, others not—and while it is not expected that individuals can live up to ideals, there are expectations that individuals should strive for norms (Davis 1995). Individuals are normal or abnormal insofar as others assess them as such, but also in their self-judgments, as expressed by the individuals we interviewed. They learn and are encouraged to adopt norms—often becoming idealized norms—in their therapy, which focus on returning their thoughts and behaviors to an average point, in theory allowing them to return to work, establish relationships of one form or another, and move on with life. And while normal people may not be educated explicitly about norms, the internal drive toward normative ideals of what the self should and could be is as evident in normal as in disordered individuals (Wolf-Meyer 2008).

Anthropologists have been long interested in the role of norms and values on both normal and abnormal people whether in the form of analyses of the cultural specificity of normal and abnormal behavior and personalities (Benedict 1934), the categorization of subnormal people (Jenkins 1993), the subjectivity of abnormal experiences (Littlewood 2008), the return to a normal life during and after periods of geopolitical instability (Greenberg 2011), or stages of life including normal birth (Bledsoe and Scherrer 2007), family life (Patico 2009), and death (Lock 2002). Within this body of literature, what is most relevant to the experiences of the people described in this text are anthropologists' reflections on the ways in which culture and cultural norms inform the way people seek out normal lives and assess their own normativity after medical, including psychiatric, interventions. These reflections on the reassertion of normal life postsurgery (Manderson 1999), for example, or on the identity work of the chronically mentally ill (Estroff et al. 1991) add a powerful counter-voice to medical attention directed at disability and functionality. This work contributes to our understanding of people's "illness identity work," which Estroff and colleagues underlined is "directed at the periphery of normalcy, at defining who and what is inside and outside the boundaries" (363). Whether the narratives of these people focus on their place inside or outside the periphery of being normal, their words, and anthropologists' analyses of their narratives, provide us with a means of better understanding the multifaceted nature of individuals' experiences with medicine and psychiatry and how these experiences involve complex interactions of normality and normativity.

We can then better comprehend how normal and abnormal people live with the constant effort of working toward normative ideals, often with little

comfort from the flexible normalism allowed in Western societies, striving to fill a perpetual internal void and looking for acceptance in the eyes of all around them (Lasch 1978). It might be argued that they have been socialized to seek this acceptance and strive for the conformity they believe will deliver their normal life. ''Becoming is not always heroic'' (Biehl and Locke 2010:336). This phrase seems particularly apt to describe the process in which our interviewees and many of their normal counterparts are engaged. While their sensitivity to the exclusionary, individualized aspects of the societies in which they live and the pressure they perceived to always improve and blend in with normal people led these individuals to decry the coldness and isolation they perceived, they did not fight back by, for example, finding novel ways to create full lives. Instead, they turn in on themselves, engaging in a lifetime of self-work to get through their day-to-day lives, forever in pursuit of a normal life. So there is no revolution in the never-ending process of wanting to measure up to all normative standards and aiming for a ''should be'' self that often remains elusive. It simply leads to an enduring quest for a house full of life or nothing. It seems quite impossible for ''normals'' or ''abnormals'' to dream otherwise.

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NOTES

1. All names have been changed, and identifying traits have been removed or altered.
2. Research on people suffering from social phobia was conducted in Paris by Lloyd for 10 months in 2003–2004. Moreau's research on people suffering from depression was based in Montreal in 2006. Specific objectives and modes of analysis differed between these projects, but the results shared a particular orientation toward desired post-therapy lives. To initiate his research Moreau advertised in the most widely circulated newspapers in Montreal to recruit people suffering from depression. His interviews were primarily with adults in order to maximize respondents' ability to reflect on social phenomena and general behavior (Moreau 2009). In order to speak broadly about depressive states and emotions and to take a critical distance from the psychiatric definition of depression, the advertisements were

open-ended in their references to depression, using phrases such as "to feel depressed" alongside "being diagnosed with depression." This method allowed insight into signs and behaviors that people identified as traits of their depressive disorders outside a strict psychiatric framework, and in turn permitted Moreau to analyze interviewees' definitions of social normality. Lloyd sought interviewees through a support group for people suffering from anxiety disorders in Paris. She attended group meetings and left leaflets explaining her interest in speaking with people suffering from the symptoms of social phobia. The leaflet was phrased to reach out to individuals who had self-diagnosed with the disorder in addition to those who had been formally diagnosed. This was necessary as many French physicians consider the condition ontologically suspect and chose to refer to people with the symptoms of social phobia as suffering from normal shyness, obsessive or neurotic conditions, depression, agoraphobia, or unspecified forms of anxiety. Lloyd looked for people for whom the label social phobia was an important part of their identity and aimed to identify where social phobia fell in their illness trajectory.

3. France is a country in transition in many ways, with high unemployment, immigration, and an uncertain sense of where the country fits in global economics and politics. Montreal, although in a politically more destabilized Quebec, has a more constant economic and political status as part of Canada. Both Paris and Montreal are destinations of young people hoping to prove themselves professionally, as the economic engines of France and Quebec, respectively. They are both youthful, culturally vibrant cities, but newly arrived individuals can feel alienated by their relative anonymity.
4. The time frame in which the concept of a "norm" was introduced into France was roughly the same (Hacking 1990).
5. This hope that medicine will bring about not just a cure but salvation has been discussed in terms of the soteriological dimensions of medicine (Good 1994).

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