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COMMENTARY

I Had a Normal Childhood

By Lawrence D. Blum, MD |February 19, 2013
Dr Blum is a psychiatrist and psychoanalyst in private practice in Philadelphia. He is on the faculty of the Psychoanalytic Center of Philadelphia and is Clinical Assistant Professor of Psychiatry at the University of Pennsylvania in Philadelphia.

In my work as a psychiatrist and psychoanalyst, it is not unusual for a patient to tell me that he or she had a normal childhood. This always alarms me. Childhood has so many conflicts and worries, so many triumphs and disappointments—how can one reduce it to a notion of normality? What does invoking this concept conceal? Isn't the idea of a normal childhood, with its denial of complexity, itself a wishful, childlike fantasy?

My patients have reported some remarkable "normal childhoods." One was on a farm where the patient was socially isolated, suffered an accidental stabbing with a pitchfork, and broke bones falling off a truck overloaded with hay. Other "normal" childhoods have included alcoholic parents, chronically ill siblings, surgery early in childhood, and family bankruptcy. And what *would* be a normal childhood? Where? When? With how many and what sort of parents and siblings? Urban or rural? In the Nintendo era? With Smartphones?

When patients claim to have had a normal childhood, they may be hiding underlying feelings, such as embarrassment, humiliation, hurt, guilt, or anger. Often they may be protecting a parent from criticism. Denial can help to maintain an outward calm and the appearance of emotional integrity, even when these may be lacking inwardly. But there is also a cost, typically in distorted relationships or restrictions on how a person leads his life. Inner shame and guilt, secrets and self-doubt remain in place. Healing these difficulties is contingent on being able to give up the pretense of normality.

For those who are most dedicated to preserving the notion of a normal childhood, the ordinary questioning and curiosity that facilitate an exploratory, insight-oriented psychotherapy are unwelcome, threatening intrusions. When this type of reaction can be usefully examined and understood, and the worries about trying to understand diminished, the patient may indeed benefit from such psychotherapy. When the patient still finds such exploration too threatening, he may be able to participate only in a more limited treatment that is oriented toward preserving or restoring one or another idea of "normality." The following vignettes briefly describe a patient from each of these 2 categories, those who can successfully question the notion of a normal childhood, and those who seem unable to.

CASE VIGNETTES

Ms A, a social worker, grew up with caring working-class parents in a stable suburb of a large city. She had satisfactory relationships with her siblings and her "normal childhood" left her with no clues to understand why she always felt hurt in relationships with others, and why she always had to take care of others, to her own detriment. It had not occurred to her that childhood hospitalizations for serious illnesses are not "normal," and had formed the template both for being hurt, by endless medical procedures, and for wanting to take care of people, like

the doctors and nurses who saved her life. Helping her to understand how much of the past was alive in the present helped her to diminish its damaging interference in her life.

Mr B, a perpetually tense young lawyer with clipped speech and constant quantitative measurement of his experience, was distressed that in his late 20s he had yet to accomplish a number of his major goals. That he described a childhood spread over three continents, cultures, and languages as “normal” and unrelated to his present concerns suggested there might be much he preferred not to examine. After several meetings over many tentatively scheduled and then rescheduled appointments, he declared that he was getting insufficient return on his investment and departed having barely arrived. What made his childhood so normal I will likely never know.

DISCUSSION

Only careful attention, kind questions, and gentle confrontation of contradictions allow a patient to cautiously address the emotional struggles he or she fears to face. This is unlikely in the many common symptom-focused or do-your-homework therapies. Nor does it happen with automatic prescription of fluoxetine or one of its relatives. And it does not happen without protection of privacy. The therapist must avoid the temptation to try to impose his or her own version of normality on the patient. For example, is forgiving a tormentor normal or abnormal? Desirable or not? To what extent? How or when? The therapist must help the patient overcome defensiveness and find his own answers to questions like these.

Just as we strive to help patients overcome their attachment to the defensive, counterproductive idea of a normal childhood, we should attempt to do the same for psychiatry and psychology. Instead of thinking of development as leading to normality or abnormality, it is more useful, usually, to understand it as leading to types of adaptation having a complex variety of advantages and disadvantages. Clearly some people experience childhoods that are more traumatic and more challenging than others, but if we recognize that no one has a normal childhood, and that everyone’s childhood is unique, we better our opportunity to understand each individual and to be more tolerant of differences. Understanding and valuing each person’s individual experience has more to offer than the false promise of an imagined normality.