Why Are They So Normal?

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A significant part of my professional life is associated with the study and management of cleft lip and palate. It seems natural, therefore, for me to welcome this opportunity to put forth my position, as well as my uncertainties, about the whys and wherefores about the behavior status of our patients.

I find it exciting to pose the question, “Why are they so normal?” First of all, for me, normality is a dynamic state characterized by each person’s ability to meet the vicissitudes of life; it means coping with, rather than succumbing to, circumstances over which there may be little or no control. More importantly, it calls for a change in emphasis in research from the effects of clefts upon behavior to determining how the cleft palate experience is integrated into the behavioral and social systems of patients and their families.

How can I say, “Why are they so normal?” The weight of the evidence is crystal clear. First of all, a number of investigations have all reached similar conclusions; not only is there little or no psychopathology associated with having a cleft, it cannot be assumed that having a cleft leads to specific personality patterns. Children with repaired clefts enter school at approximately the same age as do their non-affected peers. Progress through the educational process appears to be unremarkable as well. Most of those born with clefts graduate from high school and go on to further training, often exceeding the accomplishments of their parents. Their paths, however, are not completely strewed with roses. “Negative” attributes discussed in the literature include the observation that children and adolescents with repaired clefts exhibit a greater degree of shyness or withdrawal than their non-affected peers; fewer adults with repaired clefts marry and, when they do marry, they tend to do so at later ages and have fewer children than their non-affected siblings. These are hardly descriptions of pathology, however. In general, by almost any criterion, it is virtually impossible to refute the conclusion that those born with clefts tend to demonstrate behaviors within the normal range, and that this occurs at every level of development.

Why are they so normal? Why is normality demonstrated at almost all stages of development? Can we attribute the achievement of normality, directly or indirectly, to cleft palate team management? Frankly, I am uncertain; I would like to think so, but I have my doubts. I want to believe that the achievement of normality is facilitated by cleft palate team practices because I am convinced that team treatment is best for patients, that dialogues among team members extend the boundaries of knowledge, and that teams are socially responsible in providing important services to their communities. However, in all candor, I suspect that many people with clefts, for whom teams are not available, do quite well, perhaps equally as well, psychologically.

Doing well with or without a cleft palate team, however, may not be the acid test, for we do not know what it is precisely that the team contributes. It is possible that by their very availability cleft palate teams influence adaptation to the circumstances of cleft lip and palate. In one sense, the medium might be the message, which quite clearly states that clefts are repairable and that reasonable functioning can be achieved despite the presence of current problems. The message implies that help is available and that appropriate resources exist beyond the immediate community which can be called upon. Thus cleft palate teams may contribute to the achieve-

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ment of normality simply because they exist and because their influence extends beyond their immediate geographical locations.

How does the management of cleft lip and palate, either by the team or the individual practitioner, lead to the attainment of normalcy? I believe it is because treatment efforts are achievement oriented. Recognition is given to improvements in appearance, status, and functioning. Emphasis is placed upon the achievement of competence. Personal efforts, particularly if they are part of a treatment regime, are identified and rewarded. Our commonly shared professional culture believes that appropriate management will be successful and this may be absorbed into the value systems of our patients. I think it is possible that, through practitioner interactions with patients, sufficient anxiety is diffused so as to enable those born with clefts to cope more effectively, rather than being overwhelmed by their problems. In doing so, I believe we provide a psychological support system by aiding families at stress points and by rewarding adaptive behaviors of parents and children.

Why are they so normal? Why should they be anything else? Is it not possible that our professional concerns about appearance, dentition, speech, and hearing assume additional importance because of our clinical heritage? We may attach significance to a clinical finding which does not have equal significance or implication for the family or the patient. It would not surprise me to find that the psychological import of a clinical finding is stressed in order to emphasize the gravity of the situation, or to induce compliance. I cannot believe that every structural, functional, or appearance deviation inevitably leads to some adverse psychological reaction. Obviously, we lack information about how a cleft, its sequelae, and its subsequent treatment and modifications are assimilated into the self-system.

Why should they be anything else but normal? Although many mention facial disfigurement when they refer to clefts of the lip, the term may be pejorative, particularly when adverse reactions from others are expected. In a similar vein, speech distortions and hearing impairments do not invariably lead to disruptions of communication or impairments of interpersonal reactions. For an unknown number of patients, the only time that having had a cleft intrudes upon them may be when they return for periodic reevaluations. It is possible that whatever residual sequelae of the cleft condition remain, they may not exist within the patient's consciousness with sufficient intensity as to interfere with normal coping processes.

Finally, from my vantage point, the challenge in studying those born with clefts lies in their normality at every stage of development. Too much emphasis has been placed on the potentiality for behavioral pathology or deviance and too little on the meaning of the cleft palate experience for patients and families over time. Because of our clinical heritage, we stress the effects of treatment, particularly on subsequent behavior, and we usually search for a one-to-one relationship, i.e., treatment results in improvement. I submit the time has come to fit the cleft palate experience into the context of the life space of each person. The question then focuses upon how each person fits the treatment into his or her self-system. We need to know how the fact of this particular birth defect, and its subsequent management, is accommodated into the personal and familial systems.

Why are they so normal? Perhaps it is because of the services we offer. Perhaps it is because being born with a cleft has no implication for future adaptations to life's circumstances. Perhaps they are normal because there are no viable alternatives.