Idea of what is normal psychology essay

To be able to categorize and label something as an illness, ailment or an abnormality we first must consider what ‘ normal’ behaviour is and how it can be defined. The dictionary states that normal is ‘ conforming to the standard or the common type; usual; not abnormal; regular; natural’. As can be seen, the definition of normal itself is very vague, ambiguous and open to interpretation therefore labelling behaviour as abnormal should be a very delicate, complex procedure. Labelling someone as ‘ abnormal’ is potentially a life changing experience and the stigma attached could be detrimental to the individual.

Psychologists take this idea of ‘ what is normal’ further and have four definitions to define abnormality; deviations from social norms; deviation from statistical norms; failure to function adequately; and deviations from ideal mental health. Moreover, psychologists and psychiatrists use the Diagnostic and Statistical Manual of Mental Disorders (DSM) to classify mental disorders. This supposedly provides standard criteria for the individuals which have to diagnose a patient with a mental illness. Despite these criteria and classification system being generally accepted with open arms by experts and patients alike, they each have limitations.

Deviating from social norms means someone is not complying with the socially constructed values and belief systems in place. An example of this could be inappropriate dress, driving on the wrong side of the road and or not eating a lot. A limitation for using deviating from socially constructed social norms as a criteria to define abnormal behaviour is that a lot of socially constructed things depends on the situational context; for example, wearing pyjamas in the house is a social norm, whereas wearing pyjamas to

an opera would be seen as deviant. Furthermore, social norms change with time; previously it would have been socially deviant to be homosexual but now it is a perfectly acceptable sexual orientation. In addition, this criteria also presents cross-cultural issues, for example if you are in an Indian rainforest and speak to spirits, you are a shaman; if you are in England and speak to spirits, you are probably experiencing psychosis.

Deviation from statistical norms is based on the percentage of the population who have a particular trait, personality or behaviour. A good example of a statistical norm is shoe size. Most female adults – statistically – have a shoe size between four and seven. If an individual falls either side of this, their shoe size could be classed as abnormal, statistically. However, this definition of abnormality definitely presents some limitations. One limitation is what characteristics do we choose to be abnormal? An example of when deviation from social norms is when looking a persons I. Q. and sport. When a person has a statistically high I. Q, they are not labelled abnormal, but a ‘ genius’. Furthermore, if someone runs faster than what is statistically normal, they become a top athlete and a leader in their event, rather than abnormal or an anomaly. Another problem with viewing abnormality through statistical deviations is: where do you draw the line? I. Q. reference charts suggest divide intelligence into ranges and categories. If someone scored 84 on an I. Q. they would be classed as ‘ borderline mentally disabled’, but if they scored two more points, they would then be classed as ‘ average’. When statistics present such concrete categories, there is no room for the fluidity and manoeuvre that should be involved when classing an individual as ‘ abnormal’. Another problem with this statistical definition of abnormality is

that there are some conditions a lot of the population have. In American, approximately 75% of adults have to use some form of vision correction (Jobson Medical Information LLC and Vision Council of America, 2006). In this circumstance it could be seen that the remaining 25% of adults which do not need any aid to help them see and have perfect vision, are actually ‘ abnormal’.

Deviations from ideal mental health are essentially a deviation from what is considered normal ideal mental health, such as the criteria put forward by Jahoda. The six criteria she put forward are: positive attitude towards the self; self-actualisation; resistance to stress; personal autonomy; accurate perception of reality, and; adapting to the environment. There are several problems with the criteria she suggests. For example, it is difficult to ever achieve the kind of self-actualisation Maslow proposes. Furthermore, there are many reasons a small level of stress could actually be more beneficial for your health; with correct stress management and individual could actually be healthier. Also, as noted in deviating from social norms, there could be a large difference as to what is a deviation from culture to culture.

The final deviation is the failure to function adequately. This is when an individual is unable to live a ‘ normal’ life. This may be because they do not experience a normal range of emotions, or have a normal range of emotions. There are five indicators to decide when an individual is failing to function adequately: Dysfunctional behaviour/maladaptiveness; personal distress or discomfort; observer discomfort unpredictable behaviour and; irrational behaviour. However, this isn’t a reliable definition of abnormality; it is very vague and is definition individual problems. Furthermore, context needs to

be taken in to account. If a student is anxious because of an essay, this may be uncharacteristic for the student, but this would not be abnormal.

The DSM IV TR provides definitive criteria used to classify mental illnesses globally. Clinicians evaluate a patient's condition by using five separate axes before making a complete diagnosis. Axis 1 looks at clinical syndromes which may cause significant impairment, the most common of these are anxiety and mood disorders. Axis 2 looks at mental retardation and personality disorders; patients are usually diagnosed with either something on Aix 1 or Axis 2, however, this is not always the case. Axis 3 looks at other medical conditions, e. g. diabetes. Axis 4 looks at psychosocial and/or environmental problems, for example school and housing. Finally, Axis 5 is a global assessment of functioning (GAF). G. A. F. looks at the psychological, social and occupational functioning over all. As the DSM IV TR is multi-axial, it gives a more thorough and detailed idea of how to treat the patients; however, there are still many problems with this idea.

Zimmerman (1988) argues that change in classification do not always reflect changes in knowledge. For example, in 1973, homosexuality was no longer considered a mental issue; this classification essentially changed over-night. This consequently makes the classification seem arbitrary and questionable. Also, we must bear in mind the ' continuum concept'; to what extent is certain behaviour just an addition to ' normal'. Furthermore the DSM IV TR presents us with problems relating to validity. If a diagnosis predicts the course of an illness, it is a valid prognosis. Rosenham and Rosenham (1973) suggest that diagnosis can have good reliability yet poor validity as often doctors misdiagnose patients whose symptoms can be faked. A way to

combat this could be to use both the DSM IV TR and the ICD-10 (International Classification of Diseases) to cross reference and see whether the classifications agree; however, when 1500 were assessed, it was found there was good agreement on depression, anxiety and substance dependence, but only 35% agreement on PSTD and a 68% agreement overall (Andrews et al, 1999). There is also multiple problems with the reliability of diagnosis. A method used to try and increase reliability is ‘ Inter-rated reliability’; this is when more than one psychologist diagnoses the illness and if two psychologists agree, the diagnosis is more reliable. However, Beck et al conducted a study which showed that psychiatrists only agreed 54% of the time. Also, diagnosis is subjective as patients may give different information, or the evidence gathered is not sufficient. Additionally, cultural factors affect reliability. The DSM IV TR may not be useful for other cultures and it depends whether the phenomena is absolute, universal or culturally relative. It is important that psychiatrists are aware of cultural factors and Sabin (1975) further suggests that language barriers may cause over-diagnosis of mental illness. Lopez (1989) disagrees with Sabin’s suggestion and believes that if we take every cultural belief into account we would under-diagnose. However, Cooper et al (1972) conducted and study which suggested psychiatrists in the U. K and U. S. over-diagnose; the U. S. psychiatrists diagnose patients with schizophrenia twice as often as their U. K counterparts, and in the U. K bi-polar disorder is diagnosed twice as often.

Labelling can have some advantages, for example people like to know what is wrong with them, and a diagnosis can give them that assurance and ‘ finding’ a certain illness brings new discovery and treatment, therefore

advances the medical word. However, labelling can also have negative effects (Goffman, 1968), as there are often certain connotations with certain illness. Previously in Japan, schizophrenia was rarely diagnosed because of the stigma and only 20% of patients with it were aware (Kim & Berrios, 2001). In 2002, the Japanese Society of Psychiatry and Neurology changed the old term for the disorder into a new term which translates to ‘ integration disorder’, which a “ shift from the Kraepelinian disease concept, to the vulnerability-stress model” (Mitsumoto, 2006)