5.1 Abnormal psychology: concepts of normality

Learning outcomes

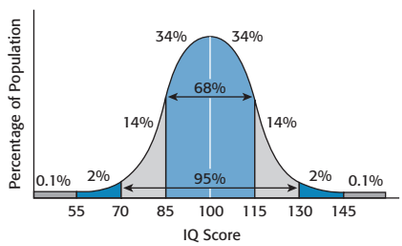
- Discuss the extent to which biological, cognitive, and sociocultural factors influence abnormal behaviour
- Evaluate psychological research relevant to the study of abnormal behaviour
- Examine the concepts of normality and abnormality
- Discuss validity and reliability of diagnosis
- Discuss cultural and ethical considerations in diagnosis

Concepts of normality and abnormality

The area of psychological disorders is called "abnormal behaviour". Abnormal behaviour presents psychologists with a difficult task: it is difficult to define and therefore it is difficult to diagnose because it is, to a large extent, based on the symptoms people exhibit or report. Making a correct diagnosis is extremely important because this dictates the treatment people receive. Psychiatrists and psychologists use a standardized system called a diagnostic manual to help them, but such a system is not without faults. Since there is no clear definition of normality—or abnormality—and symptoms of the same psychological disorders may vary not only between individuals but also between social and cultural groups, it is clear that a psychiatric diagnosis may be biased or even wrong. Definitions of normality and abnormality can also change over time.

Often, a decision about whether or not an individual's behaviour is abnormal depends on a series of value judgments based on subjective impressions. Definitions of "normality" are part of the diagnostic process, which is why it is considered important to establish some objective criteria. At present, there is a tendency to rely on the *subjective* assessments of clinicians, in combination with the diagnostic tools of classification systems.

It is not an easy task to define what is normal and what is abnormal. Behavioural measures, such as intelligence and short-term memory, tend to be normally distributed—that is, the distribution from a sample of people tends to fall within a bell-shaped curve. Being normal falls within this bell curve. There are problems in using statistics in this way when we are dealing with abnormal behaviour because some things that are statistically normal—such as obesity—are not desirable or healthy behaviours—and some that are statistically rare—such as a high IQ—are not dysfunctional.



The bell curve of distribution of IQ scores in a population

Abnormality is sometimes defined as the subjective experience of feeling "not normal"—for example, feeling intense anxiety, unhappiness, or distress. This is often enough to seek help. However, the subjective experience of distress is not always a reliable indicator

of serious psychiatric problems, since patients with schizophrenia may be indifferent or unaware of their condition.

One way to define abnormality is to consider when behaviour violates social norms or makes others anxious. This definition is problematic. Cultural diversity affects how people view social norms: what is seen as normal in one culture may be seen as abnormal in another.

The difficulties outlined here illustrate the problems in diagnosing "abnormal behaviour". Rosenhan and Seligman (1984) suggested that there are seven criteria that could be used to decide whether a person or a behaviour is normal or not.

- *Suffering*—does the person experience distress and discomfort?
- *Maladaptiveness*—does the person engage in behaviours that make life difficult for him or her rather than being helpful?
- *Irrationality*—is the person incomprehensible or unable to communicate in a reasonable manner?
- *Unpredictability*—does the person act in ways that are unexpected by himself or herself or by other people?
- *Vividness* and *unconventionality*—does the person experience things that are different from most people?
- *Observer discomfort*—is the person acting in a way that is difficult to watch or that makes other people embarrassed?
- *Violation of moral or ideal standards*—does the person habitually break the accepted ethical and moral standards of the culture?

These criteria demonstrate the fine line between defining abnormality in ways that focus on distress to the individual, and defining it in terms of what is or is not acceptable to society. The first four deal with how the person is living life; the fifth represents a social judgment because it deals with what is seen as conventional or not; the remaining criteria clearly represent *social norms*. The danger of social judgments is that they often fail to consider the diversity in how people live their lives. There is an increasing awareness of how psychiatric diagnosis of ethnic minorities has been misapplied because doctors do not understand the cultural norms of the groups people come from. Defining abnormality is not easy, and it has a lot to do with the implicit theories people have about what is normal and what is abnormal.

Be a thinker

Discuss whether you would consider each of the following an example of "abnormal behaviour". What could be the possible criteria for your decision?

- Transvestitism
- Nail biting
- Maths anxiety
- Talking to oneself

The mental health criteria

Jahoda (1958) attempted to establish what is abnormal by identifying the characteristics of people who are normal. She identified six characteristics of mental health:

- efficient self-perception
- realistic self-esteem and acceptance
- voluntary control of behaviour
- true perception of the world
- sustaining relationships and giving affection
- self-direction and productivity

It is difficult to define these criteria precisely, so the question is what they actually mean. Jahoda, for example, stated that the unemployed were deprived of many of these characteristics, and that

this might account for much of the reported mental ill-health among unemployed people.

Evaluation of the mental health criteria

Jahoda's list seems intuitively appealing, but if the criteria were applied, most of us would seem somehow abnormal. In addition, they are to a large extent *value judgments*. Most people can agree on what constitutes physical health. However, this is not the case with psychological disorders.

It seems pretty clear that what is considered psychologically normal depends on the society and culture in which a person lives. There is an ongoing debate among psychiatrists involved in making diagnostic tools about how to define abnormality, and the criteria are changing—sometimes because norms change. An illustrative example of this can be seen in the change in views on homosexuality from Gross's *Psychology: The Science of Mind and Behaviour* (1996: 787).

An example of changing views on abnormal behaviour: homosexuality

The orthodox view was that homosexuality was abnormal. The story of the famous writer Oscar Wilde shows that society did not accept homosexuality—he was imprisoned for being homosexual. The older versions of the diagnostic system reflected that view, but DSM-III (*Diagnostic and Statistical Manual of Mental Disorders*, 3rd edn, 1980) declared that homosexuality is only abnormal if the individual has negative feelings about his or her sexual orientation. The same is seen in DSM-IV (1994), under "Sexual disorders not otherwise specified", where it is noted as "persistent and marked distress about one's sexual orientation". In the UK, homosexuality between consenting adults was illegal until the 1960s.

What has happened in the meantime is that people's attitudes to homosexuality have changed. Consequently, the conclusion must be that homosexuality in itself cannot be considered abnormal, and it is no longer classified as such. However, this example illustrates the inherent problem in classifying what is normal and what is abnormal.

Be a thinker

The DSM has classified transsexualism as a disorder. It is called "gender identity disorder" when people feel deep within themselves that they are the opposite sex. Many recent films, such as *Boys Don't Cry*, have portrayed the lives of people who are transsexual.

- Should this be declassified as a disorder, as homosexuality was?
- What are the arguments for and against declassification?

Possible essay question

With reference to research, examine the concepts of normality and abnormality

Assessment advice

"Examine" means that you should consider the concepts of normality and abnormality in order to reveal the problems in defining them (for example cultural variations) as well as implications of the definition in abnormal psychology.

The mental illness criterion

The mental illness criterion is rooted in a view from the medical world that abnormal behaviour is of physiological origin, for example the result of disordered neurotransmission. This is called the **medical model**. Consequently, treatment addresses the physiological problems, primarily through drug treatment. Abnormal behaviour is referred to as **psychopathology**—that is, psychological (or mental) illness that is based on the observed symptoms of a patient.

The term "mental disorder" is used in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association (called DSM-IV); a handbook used by psychiatrists in the US to identify and classify symptoms of psychiatric disorders. This is a standardized system for diagnosis based on factors such as the person's clinical and medical conditions, psychosocial stressors and the extent to which a person's mental state interferes with his or her daily life.

There are several ethical concerns about the use of the medical model to define abnormal behaviour. This model argues that it is better to regard someone suffering from a mental disorder as sick rather than morally defective because responsibility is removed from the patient. According to Gross (2002), there have been examples of misuse of the medical model, since the criteria used for diagnosis are not objective and can be influenced by culture and politics. In the former Soviet Union political dissidents were diagnosed as schizophrenic, implying that they were not responsible for their deviant political beliefs. In the UK in the last century, women who were pregnant without being married could be admitted to an asylum.

Today, psychiatrists diagnose using a **classification system** that is supposed to be objective. The traditional medical model in psychiatry is now assumed to be reductionist, and most psychiatrists use a biopsychosocial approach to diagnosis and treatment. However, this does not prevent a psychiatric diagnosis resulting in the patient being labelled as different, or "not normal".

One of the most radical critics of the concept "mental illness" was the US psychiatrist Tomasz Szasz, who argued against the concept of "mental illness". In *The Myth of Mental Illness* (1962), he argued that while some neurophysiological disorders were diseases of the brain, most of the so-called "mental disorders" should be considered as *problems in living*. By saying this, Szasz went against the idea of organic pathology in psychological disorders.

In Szasz's view, even though people behave strangely and this is classified as mental illness by psychiatrists, such behaviours are not a symptom of an underlying brain disease. Consequently, the concept of mental illness is not used correctly by psychiatrists. According to Frude (1998) there are relatively few psychological disorders that can be associated with identifiable organic pathology.

However, is Szasz's argument still valid today? Neuropsychologists have, in some cases, revealed possible chemical abnormality in the brain (in the temporal cortex) in people suffering from schizophrenia (Pilowsky, 2006) but brain scans haven't yet provided an ultimate answer to the questions raised by Szasz.

Are you too shy?

A recent trend in schools is to diagnose very shy children with "social anxiety disorder". Not only are young students being diagnosed, but they are being treated too. Shyness is so common among US children that 42 per cent exhibit it. By the time they reach college, up to 51 per cent of men and 43 per cent of women describe themselves as shy or introverted. Psychiatrists say that at least one in eight of these people needs medical attention.

Yet it is debatable whether medical attention is necessary. According to Julie Turner-Cobb at the University of Bath, the stress hormone cortisol is consistently lower in shy children than in their more extroverted peers. The discovery challenges the belief that shyness causes youngsters extreme stress.

GlaxoSmithKline, the maker of Paxil, declared in the late 1990s that its antidepressant could also treat social anxiety and, presumably, self-consciousness in restaurants. Nudged along by a public awareness campaign ("Imagine being allergic to people") which cost the drug maker more than US $92 million in one year, social anxiety quickly became the third most diagnosed mental illness in the US, behind only depression and alcoholism. Studies put the total number of children affected at 15 per cent—higher than the one in eight whom psychiatrists had suggested were shy enough to need medical help.

Diagnosing psychological disorders

When an individual seeks help for a potential psychological disorder, how do psychiatrists go about making a diagnosis? While a doctor looks for signs of disease using X-rays, scanners, or blood tests, as well as observable symptoms, the psychiatrist will often have to rely primarily on the patient's *subjective* description of the problem. Diagnosis is accomplished through a formal standardized clinical interview—a checklist of questions to ask each patient. After the interview, a mental health status examination is completed, based on the clinician's evaluation of the patient's responses. Today the clinician—often a psychiatrist—uses a standardized diagnostic system. Kleinmutz (1967) has noted that there are limitations to this interview process.

- Information exchange may be blocked if either the patient or the clinician fails to respect the other, or if the other is not feeling well.
- Intense anxiety or preoccupation on the part of the patient may affect the process.
- A clinician's unique style, degree of experience, and the theoretical orientation will definitely affect the interview.

In addition to interviews, other methods can be used to assist with diagnosis. These include:

- direct observation of the individual's behaviour
- brain-scanning techniques such as CAT and PET (especially in cases such as schizophrenia or Alzheimer's disease)
- psychological testing, including personality tests (e.g. MMPI-2) and IQ tests (e.g. WAIS-R).

Be a critical thinker

1. Why could it be a problem to diagnose shy children with "social anxiety disorder"? Remember to provide evidence to support your answer.
2. Do you think this is a condition that should be treated with medication? Why or why not?

Psychologists refer to the ABCS when describing symptoms of a disorder.

- **A**ffective symptoms: emotional elements, including fear, sadness, anger
- **B**ehavioural symptoms: observational behaviours, such as crying, physical withdrawal from others, and pacing
- **C**ognitive symptoms: ways of thinking, including pessimism, personalization, and self-image
- **S**omatic symptoms: physical symptoms, including facial twitching, stomach cramping, and amenorrhoea—that is, the absence of menstruation.

The two major classification systems used by western psychiatrists today, the DSM and the ICD (*International Classification of Diseases*), are based largely on abnormal experiences and beliefs reported by patients, as well as agreement among a number of professionals as to what criteria should be used. This can explain why the criteria change in revisions of the diagnostic manuals as we saw earlier in the example of homosexuality.

Some argue that the difficulties met in trying to identify characteristics of "abnormality" reflect the fact that abnormal psychology is a social construction that has evolved over time without prescriptive and regulating definitions. It is also argued by some that the DSM-IV is gender and culturally biased.

Validity and reliability of diagnosis

The difficulty arises over whether classification can indeed be made effectively using classification systems. For a classification system to be reliable, it should be possible for different clinicians, using the same system, to arrive at the same diagnosis for the same individual. Although diagnostic systems now use more standardized assessment techniques and more specific diagnostic criteria, the classification systems are far from perfect.

For a classification system to be valid, it should be able to classify a real pattern of symptoms which can then lead to an effective treatment. However, the classification system is *descriptive* and does not identify any specific causes for disorders. It is difficult to make a valid diagnosis for psychiatric disorders because there are no objective physical signs of such disorders.

Appropriate identification of diagnostic criteria is, to a large extent, influenced by psychiatrists. In some cases, psychiatrists have suggested alternative systems for diagnosis because they found that the existing ones were not reliable. For example, The Great Ormond Street Children's Hospital in London has developed its own diagnostic system for children. Reliability of diagnosis using the DSM-IV system was 0.64 (64% agreement between raters), but this figure was artificially increased by the fact that most raters couldn't make a diagnosis. When they used another system—the ICD-10—there was 0.36 reliability. With the Great Ormond Street System, raters achieved a reliability of 0.88.

Be reflective and caring

Abnormal behaviour? Mental illness? Psychological disorder?

- Discuss possible reasons for the difficulty of finding terms that all can agree on as appropriate in abnormal psychology.
- Why can a diagnosis of a psychological disorder often be a problem for the individual?

Diagnosis means identifying a disease on the basis of symptoms and other signs. Diagnostic systems provide a set of templates which the clinician can use to compare information about disorders to the condition of a particular client. In this way, clinicians can use the same models for diagnosis.

The effectiveness of diagnosis can be measured in terms of two variables.

- Reliability: this is high when different psychiatrists agree on a patient's diagnosis when using the same diagnostic system. This is also known as inter-rater reliability.
- Validity: this is the extent to which the diagnosis is accurate. This is much more difficult to assess in psycholocial disorders, for example because some symptoms may appear in different disorders.

Some of the problems mentioned here are illustrated in Rosenhan's classic study.

Research in psychology

Rosenhan (1973)

Rosenhan wanted to test the reliability of psychiatric diagnoses. He conducted a field experiment where eight healthy people—five men and three women, all researchers—tried to gain admission to 12 different psychiatric hospitals. They complained that they had been hearing voices. The voices were unclear, unfamiliar, of the same sex and said single words like "empty" or "thud". These were the only symptoms they reported. Seven of them were diagnosed as suffering from schizophrenia. After the individuals had been admitted to psychiatric wards, they all said they felt fine, and that they were no longer experiencing the symptoms.

It took an average of 19 days before they were discharged. For seven of them, the psychiatric classification of the time of discharge was "schizophrenia in remission", implying that the schizophrenia might come back.

Rosenhan was not content with the findings that normal people could be classified as abnormal, so he decided to investigate if abnormal individuals could be classified as normal. He told the staff at a psychiatric hospital that pseudo-patients would try to gain admittance. No pseudo-patients actually appeared, but 41 real patients were judged with great confidence to be pseudo-patients by at least one member of staff. Of these genuine patients, 19 were suspected of being frauds by one psychiatrist and another member of staff.

Rosenhan concluded that it was not possible to distinguish between sane and insane in psychiatric hospitals. His study demonstrates the lack of scientific evidence on which medical diagnoses can be made. It also raises the issue of treatments—that is, if they are always properly justified.

The Rosenhan study illustrates the concerns about reliability in diagnosis of psychiatric illness. The diagnostic classification systems have been accused of being unreliable. Using the same diagnostic manual, two psychiatrists could easily diagnose the same patient with two different disorders. Beck et al. (1962) found that agreement on diagnosis for 153 patients between two psychiatrists was only 54 per cent. Cooper et al. (1972) found that New York psychiatrists were twice as likely to diagnose schizophrenia than London psychiatrists, who in turn were twice as likely to diagnose mania or depression when shown the same videotaped clinical interviews.

Di Nardo et al. (1993) studied the reliability of DSM-III for anxiety disorders. Two clinicians separately diagnosed 267 individuals seeking treatment for anxiety and stress disorders. They found high reliability for obsessive-compulsive disorder (.80), but very low reliability for assessing generalized anxiety disorder (.57), mainly due to problems with interpreting how excessive a person's worries were.

Lipton and Simon (1985) randomly selected 131 patients in a hospital in New York and conducted various assessment procedures to arrive at a diagnosis for each person. This diagnosis was then compared with the original diagnosis. Of the original 89 diagnoses of schizophrenia, only 16 received the same diagnosis on re-evaluation; 50 were diagnosed with a mood disorder, even though only 15 had been diagnosed with such a disorder initially.

If the same diagnosis has a 50:50 chance of leading to the same or different treatment, this suggests a serious *lack of validity*, probably due to bias in diagnosis. Since diagnostic classification systems are not 100 per cent objective, the diagnosis may be influenced by the attitudes and prejudices of the psychiatrist. Clinicians may expect

Be a critical thinker

1. What are the ethical concerns with Rosenhan's study?
2. In what ways did this study illustrate the problem of reliability and validity of diagnosis at the time?

certain groups of patients to be more prone to depression, and therefore more likely to interpret symptoms as related to depression even though the same symptoms would be interpreted as something else if they were presented by a different person. When this occurs consistently to a specific group it is called **overpathologization**.

Ethical considerations in diagnosis

Szasz (see page 138) also pointed at serious ethical issues in diagnosis. In *Ideology and Insanity* (1974), Szasz argued that people use labels such as mentally ill, criminal, or foreigner in order to socially exclude people. People who are different are **stigmatized**. The psychiatric diagnosis provides the patient with a new identity—for example, "schizophrenic". The criticism raised by Szasz, and the ethical implications in diagnosis, have eventually influenced the classification systems: in DSM-IV it is recommended to refer to *an individual with schizophrenia*. There remain, of course, considerable ethical concerns about labelling which result from identifying someone's behaviour as abnormal, since a psychiatric diagnosis may be a label for life. Even if a patient no longer shows any symptoms, the label "disorder in remission" still remains.

Scheff (1966) argued that one of the adverse effects of labels is the **self-fulfilling prophecy**—people may begin to act as they think they are expected to. They may internalize the role of "mentally ill patient" and this could lead to an increase in symptoms. Doherty (1975) points out that those who reject the mental illness label tend to improve more quickly than those who accept it.

In addition, those who are labelled as mentally ill often endure prejudice and discrimination. In a study carried out by Langer and Abelson (1974), testing social perception, they showed a videotape of a younger man telling an older man about his job experience. If the viewers were told beforehand that the man was a job applicant, he was judged to be attractive and conventional-looking, whereas if they were told that he was a patient he was described as tight, defensive, dependent, and frightened of his own aggressive impulses. This clearly demonstrates the power of schema processing.

There are several types of bias that may affect the validity of a diagnosis:

- **Racial/ethnic:** The study of the "Effect of client race and depression on evaluations by European American therapists" by Jenkins-Hall and Sacco (1991) involved European American therapists being asked to watch a video of a clinical interview and to evaluate the female patient. There were four conditions representing the possible combinations of race and depression: African American and non-depressed; European American and non-depressed; African American and depressed; and European American and depressed. Although the therapists rated the non-depressed African American and European American in much the same way, their ratings of the depressed women differed, in that they rated the African American woman with more negative terms and saw her as less socially competent than the European American woman.

- **Confirmation bias:** Clinicians tend to have expectations about the person who consults them, assuming that if the patient is there in the first place, there must be some disorder to diagnose. Since their job is to diagnose abnormality, they may overreact and see abnormality wherever they look. This was clearly demonstrated by Rosenhan's (1973) study.

Clinicians often believe that the more assessment techniques they use, the more valid their interpretation will be. Kahneman and Tversky (1973) point out that this is not the case. There is no positive correlation between the number of assessment techniques used and the accuracy of an eventual diagnosis.

Another ethical issue in diagnosis also refers to confirmation bias. When patients have been admitted to a hospital, *institutionalization* can also be a confounding variable when trying to establish the validity of a diagnosis. Once the pseudo-patients in Rosenhan's (1973) study were admitted to mental wards, it was very difficult for them to get out; one participant took 52 days to convince medical staff that he was well and the whole thing was an experiment. The problem is that once admitted, all behaviour is perceived as being a symptom of the illness. The behaviours exhibited by Rosenhan's participants were all regarded as being symptomatic of schizophrenia—for example, pseudo-patients were never asked why they were taking notes, but this was recorded by nurses as "patient engages in writing behaviour", implying paranoid behaviour; pacing the corridors out of boredom was seen as nervousness and agitated behaviour; waiting outside the cafeteria before lunchtime was interpreted by a psychiatrist as showing the "oral acquisitive nature of the syndrome".

Other aspects of institutionalization also contribute to the difficulty in assessing patients accurately.

- **Powerlessness and depersonalization:** This is produced in institutions through a lack of rights, constructive activity, choice, and privacy, as well as frequent verbal and even physical abuse from attendants. All these examples of powerlessness and depersonalization are illustrated brilliantly in the film *One Flew Over the Cuckoo's Nest*.

Cultural considerations in diagnosis

Conceptions of abnormality differ between cultures, and this can have a significant influence on the validity of diagnosis of mental disorders. Though many disorders appear to be universal—that is, present in all cultures—some abnormalities, or disorders, are thought to be culturally specific. These disorders are called **culture-bound syndromes**. For example, the disorder *shenjing shuairuo* (neurasthenia) accounts for more than half of psychiatric outpatients in China. It is listed in the second edition of the *Chinese Classification of Mental Disorders* (CCMD-2), but it is not included in the DSM-IV used in the western world. Many of the symptoms of neurasthenia listed in CCMD-2 are similar to the symptoms that would meet the criteria for a combination of a mood disorder and an anxiety disorder under DSM-IV.

Possible exam question

Discuss the validity and reliability of diagnosis.

Assessment advice

The command term "discuss" requires that you that you present a balanced review of the issues involved in making reliable and valid diagnosis and you must include a range of arguments. This means considering the extent to which diagnosis is or is not reliable and valid and why this could be so. Start by deciding what your main claim could be and then construct an argument supporting this. For this you need to include appropriate evidence.

The American Psychiatric Association (APA) has now formally recognized culture-bound syndromes by including a separate listing in the appendix of DSM-IV (1994). However, as Fernando (1988) points out, many of these "exotic" conditions actually occur quite frequently, but as long as they are limited to other cultures they will not be admitted into mainstream western classification, and the potential remains for misdiagnosis and improper treatment.

Depression, which is common in western culture, appears to be absent in Asian cultures. In trying to understand the reason for this, it has been observed that Asian people tend to live within an extended family, which means that they have ready access to social support. However, as Rack (1982) points out, Asian doctors report that depression is equally common among Asians, but that Asians only consult their doctor for *physical* problems, and rarely report emotional distress. They do not see this as the responsibility of the doctor, and instead tend to sort it out within the family. They might seek help for the physical symptoms of depression, such as tiredness, sleep disturbance, and appetite disturbance, but would probably not mention their mood state.

Hence, **reporting bias** may actually make cross-cultural comparison difficult. One of the major difficulties with studies using diagnostic data is that figures are based on hospital admissions, which may not reflect the true prevalence rates for particular ethnic groups or particular disorders. Low admission rates found in many minority ethnic groups may reflect cultural beliefs about mental health. Cohen (1988) explains that in India, mentally ill people are cursed and looked down on. Rack (1982) points out that in China mental illness also carries a great stigma, and therefore the Chinese are careful to label only those whose behaviour is indisputably psychotic—that is, where thinking and emotion are so impaired that the individual is out of contact with reality. In addition to cultural attitudes, low admission rates can also reflect a minority group's lack of access to mental health care.

Some psychologists, however, argue that it is not just a misinterpretation of diagnostic data, but that real differences exist between cultures in the symptomology of disorders. For example, Marsella (2003) argues that depression takes a primarily **affective** (emotional) form in individualistic cultures. In these cultures, feelings of loneliness and isolation dominate. In more collectivist societies, **somatic** (physiological) symptoms such as headaches are dominant. Depressive symptom patterns differ across cultures because of cultural variation in sources of stress, as well as resources for coping with stress. Kleinman (1984) has studied the **somatization** of symptoms in Chinese depressive patients—that is, the bodily symptoms of psychological dysfunction. He argues that it is impossible to compare depression cross-culturally because it may be experienced with substantially different symptoms or behaviours—for example, either as lower back pain (in China) or as feelings of guilt and existential anxiety (in western cultures). This makes it difficult for clinicians accurately to diagnose and suggest treatments. According to Kleinman, it is perhaps difficult to classify such different behaviours and symptoms as belonging to the same psychological disorder.

Be a researcher

Find two different psychological disorders on www.mentalhealth.com/p20.html and read the descriptions of them and suggestions for treatment.

1. Why do you think that there are both a US and a European description of the disorders? Compare and contrast the descriptions.
2. Now search the Internet for the same disorders in another culture, for example Chinese, and compare the descriptions to the other ones. Discuss your findings.
3. Compare and contrast treatments for the disorders you have chosen.

Another cultural consideration in diagnosis is **culture blindness**, that is the problem of identifying symptoms of a psychological disorder if they are not the norm in the clinician's own culture. Cochrane and Sashidharan (1995) point out that it is commonly assumed that the behaviours of the white population are normative, and that any deviation from this by another ethnic group reveals some racial or cultural pathology. Conversely, as Rack (1982) points out, if a member of a minority ethnic group exhibits a set of symptoms that is similar to that of a white British-born patient, then they are assumed to be suffering from the same disorder, which may not actually be the case. For example, within the culture of one ethnic group it might be regarded as normal to "see or hear" a deceased relative during the bereavement period. Under DSM-IV criteria, this behaviour might be misdiagnosed as a symptom of a psychotic disorder.

How can psychologists avoid cultural bias influencing a diagnosis?

- Clinicians should make efforts to learn about the culture of the person being assessed. This knowledge can come from professional development, consultation with colleagues, or direct discussion with the individual (Sattler 1982).
- Evaluation of bilingual patients should really be undertaken in both languages, preferably by a bilingual clinician or with the help of a trained mental health interpreter. Research suggests that patients may use their second language as a form of resistance, to avoid intense emotional responses.
- Diagnostic procedures should be modified to ensure that the person understands the requirements of the task. Symptoms of disorders should be discussed with local practitioners. Often, symptoms are described differently in different cultures. In the psychiatric survey of the Yoruba in Nigeria, it was decided to include culture-specific complaints such as feeling an "expanded head" or "goose flesh". When assessing post-traumatic stress disorder (PTSD) among Rwandans after the genocide, researchers worked with local healers to determine what was a normal Rwandan grief process, and which responses the community considered to be abnormal.

Apply your knowledge

Read the following description of Anne and answer the questions below.

Anne is a 16-year-old girl living in the Midwest United States. She is currently in the IB programme at her local school. Her appearance is strikingly different from the other girls in her class. She wears blouses which she has made out of various scraps of material, and these are accompanied by the same pair of trousers every day. She is a talented artist, and she draws constantly, even when told by the teacher that she will lose marks for not paying attention in class. She has no friends at school, but seems undisturbed by the fact that she eats lunch by herself and walks alone around the campus. Her grades are inconsistent; if she likes a class she gets top marks, but will do no work at all in those she dislikes. Anne often talks to herself. She refuses to watch television, calling it a "wasteland". She even refuses to watch videos/DVDs in class, saying that they are poor excuses for teaching. Her parents say that they do not understand her; she isn't like anyone in their family. Anne seems unaware of her social isolation, but occasionally can be very critical of her classmates. Her brother is embarrassed by her behaviour and distances himself from her at school.

1 Do you think this person's behaviour is normal?

2 Do you think it is dysfunctional?

3 Why or why not?