Psychology of Everyday
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Lecture – 05
Revisiting Normal-Abnormal Dilemma-I

So, welcome back to this session of our Psychology of Everyday Life with Professor Braj Bhushan and myself. So, last time we were talking about aggression is one of the situations and the various situations and factors which can contribute to it. So, we will extend this further and take it on to the, concept of how do we decide, what is normative behavior or so, called normal. And one, when does it become problematic or when does any behavior become or process threshold were some intervention is required, am I right sir.

Yeah.

Right, so, and we were also talking about psychology and psychiatry. So, one of the basic difference between psychology and psychiatry is in a very very gross manner, it is understood in psychology studies normal behavior and psychiatry deals with abnormal behavior, right. So, how do you as a psychologist, conceptualize this whole concept of normal and abnormal? Maybe outside the clinical situation and.

Usually, when we talk about who is normal or what is normality, the easiest option could be to look at a behavior and plot it on a three dimensional situation. Where one way of looking at it could be that whatever majority of people do, that is normal. So, somewhere you assume that normality is a statistical average. Say for instance, couple of years back a UN survey report had come into being, which shows that large number a substantial percentage of the Indian women. They are physically beaten up by their spouses and those who were in this kind of marital relationship, again close to one-fourth of them.

Right.

They think that their husband is legitimate, they have a legitimate region.

Right.

To put them into this kind of a scenario.

Right.

Now if I am in a social kind of a setup, where beating of spouse or verbally abusing kids or all those who are younger to you or not as strong as you, then this might become a statistical average.

Right.

Right, this happens in this house, this happens in this house and therefore, if it happens in my house it is normal.

Right.

Most houses are like this.

Right.

More spouses are like this.

Right.

Most parents are like this.

Right.

Most friends are like this.

Right.

Now, this is one way of looking at things.

Right.

Which it itself is problematic, because the inherent difference that any society has, makes many weird things normal and many normal things weird.

Absolutely.

In this process. And in the modern scenario, the most accepted format of delinking normality from the rest of the behavior which is not so normal is where you have a definition; fixed definition of subnormality or abnormality, which comes from hardcore psychiatry. And because you are convinced that whatever psychiatry prescribes as a disorder is a disorder. So, anything which does not fit in any of the frames of disorder is an order. So, whatever is not abnormal is normal. So, this is the reverse way of looking.

Right. So, would you say that what is statistically normal or what majority of people do, which falls into a major statistical significance that is normal, is it understood this way.

This is one view of looking at things.

Because if this is the truth then normalcy is no concept which has been there from ages number one. And number 2 is not going to last beyond the context, because then as the time changes as the societies change. The normal people would be doing certain thing in their (Refer Time: 05:16).

Exactly.

So.

We can takes for example, say cleanliness is a desirable behavior.

Right.

Now, if I say that I am an aware human being, who knows what is germ, what is contamination, how that has to be prevented. So, as a preventive step I wash my hand.

Right.

Now, this is a routine process nothing to do with normal or abnormal, but then if the frequency increases then you become doubtful.

Right.

So, washing hand does not have a problem, but washing hand beyond a time or number of times you wash it or in what situation, what was before or what is going to happen in between you have this washing process, this suddenly makes you suspicious whether this behavior is normal or not.

Right.

So, what you all would know say that is this a case of obsessive-compulsive behavior. Now washing is washing, cleaning hand is cleaning hand, but then at one point suddenly cleanliness is replaced by an obsessive-compulsive.

Ah right.

Behavior.

Because this brings in many questions.

Yeah.

First the way psychiatry, as we talked last time that the psychiatric classification is unlike medical classification right, it does not talk of causes it talks of behavioral syndromes. So, based on those behavioral syndrome and with some studies and with some data time duration, the intensity of the symptoms all that has been put under some headings which subscribe to a certain mental state.

Yeah.

As you said cleanliness, washing is normal and too much washing is bad right, that most people would say. But, so these are the diagnostic categories have emerged, they have categorical diagnosis, they are different categories. That means, the person may have a mental state of psychosis of depression, of obsessive-compulsive. So, these are all categories.

Yeah.

So, even I see the or DSM as we talk categories, but what you brought in is an important point. Maybe symptoms of schizophrenia are not present in anybody, but everybody has experienced an illusion. Under some substance people experience, the hallucinations they are overvalued ideas, there is something called illusion. So, maybe something like schizophrenia may have certain mental state which normal people, so, called normal people do not experience. But if you take a illness as a, if you take depression for example. The sad affect everybody is experienced,sometimes getting doubts about hands being clean everybody is experienced, a fear everybody is experienced.

So, this debate is still going on whether the normal abnormal is not a category and it is a dimension, right from 0 to 100 you put a scale everybody would have experienced and knows these type of behavioral anomalies within them. So, at some point of time it is called as abnormal or disease state, that is one question, that is one thing which comes up. And so, the dimension versus categorical.

Yeah.

Diagnosis; the psychiatry over time, while dealing with abnormal behavior because it was meant to deal with abnormal behavior has put this classification. Now this thing has come up very startling the latest version of DSM 5 and there are many critics who say DSM 5 has labeled for everything and if it does not have it will have. As a type of research which is coming up, now some I was just going through somebody sent me a link, which is laziness is not normal there is nothing called laziness. So, if laziness is not normal, then maybe someday we will have a category of laziness also as illness.

Yeah.

For example, if you take a childhood condition called ADHD attention deficit hyperactivity disorder, the person who invent coined the term while on his deathbed said it was a fictional diagnosis, but ADHD medication are largely used in US and they are becoming very popular. The pediatrician and the psychiatrist and everybody's trigger happy calling a kid has ADHD. But once you give the syndrome diagnosis to the kid, it sticks forever and then you try to treat it with medication or treat it with behavioral intervention, but if you take both attention and activity level it is one of the temperamental traits.

Yeah.

So, we cannot expect all kids, to be having a certain quantifiable attention level or a quantifiable hyperactivity.

This makes me share one more thing with you. Unlike psychiatry, where there is more of a tendency to fit things into criteria or categories, when you look at the aspect of psychiatry within psychology which is more into quantifying things. Now, there say for instance you mentioned fear, now you have originating point and you have say arbitrary

terminal point. You do not know what that terminal point would be that, you assume that somewhere it will progress up to that level.

Now one way of looking at fear could be that, here we call this fear as an experience or as an emotion as a felt experience and at this threshold, now fear becomes anxiety; combined with anxiety and at some other point fear has a reason, so, it is fear. And at some point it loses it is rationality, so, it becomes phobia.

Right.

And if you even if you look at that linear progression also, there are issues when we know try to understand things from normality versus things which are not so, normal in general terms, the day to day behavior. Similarly attention for instance, now large number of children who would not feel attentive in the class might not be suffering from ADHD.

Yes.

The kind of stuff that they are being fed.

Yes.

Is not of their taste.

Absolutely.

So, as a child I have a reason that this is so boring that I do not have to look into this, I do not have to focus at this.

Right exactly.

And as a parent or as a teacher, I have a fixed notion that no the child should pay attention the child should do this. So, it is the over expectation of the elderly in the society, which forces the clinician to go towards a.

Absolutely.

Specific diagnosis of the child.

So, one group says that the ADHD is a well recognized behavioral syndrome, which requires intervention, either in form of drugs or in form of behavioral training. But equal number of people believe that it is the way kids are being brought up, before one children also have a stress. Second how do they handle stress when they look up to share or to discover or to talk they find adults, who are slightly caught in their own problem or unstable or they are not ready to listen, what does the kid do, the kid takes up the stress inside introjects it or extracts it.

Yeah.

Extrovert it is like externalizing or internalizing. So, in that case the kid will do something and obviously, the clearest thing is that what you told, that if it is not attend important for me, I will not pay attention. So, their attention is not a monolith which goes on like a platform.

Yeah.

It keeps varying up and downright. Similar is hyperactivity right. So, it is becomes very difficult when to.

Yeah, we have to draw the line.

Draw the line.

When to say that you fall in this category.

Now, that is what I was pointing out. You may say it is ADHD because as I said the classificatory systems are based on phenomenology. We mentioned the word phenomenology is, we see the overall pattern of behavior. Looking at the cause is secondary, but in some cases like for example, autism. Autism is a very clear cut syndrome, which not many kids experience; whether we take dyslexia where every kid in a.

Initial period.

Initial period we will do mirror imaging, substitution, it is only after they come to class one or only if it continues by that time, the brain networks have matured a little bit, then we think of diagnosing it as dyslexia. Similarly with ADHD and all kids have because

the frontal lobes prefrontal cortex which is actually controlling and sending the inhibitory signals, does not mature till very late in teenager and young adulthood. So, given that this line of crossing between normal age appropriate. Similarly, if you go to the other end, where does the like forgetfulness what do we call a benign cognitive decline age related and dementia. Especially early dementia.

Yeah.

So, a lot of old people will have some recent memory deaf states and some sort of confusion and lot of people are on medication actually, we do not know the effect of medication. So, in that case how appropriate it is to really diagnose it in the first go, unless we have really analyze the causes. Plus take a civilization especially in India, normally in our homes, kids name is being called for at least 400 times roughly and most of them is either admonishing them or telling them no, yes sort of restrictions which go on very far in life. So, what do the kids do I mean; obviously, they will do something and sometimes in excitement they may become slightly overactive.

Yeah.

So, psychiatry has found around way about it, what they will they have said is duration. If this thing lasts for this long then, but I think that is arbitrary.

Even in duration, theoretically it might sound good or the practitioners might say that based on the overall experience across clinics. They have arrived at some point cutoff point, where this say that if this continues for 1 month, 30 days, if something continuous for 90 days, the way you all know define acute and chronic symptoms, but still that also becomes statistical average.

Absolutely, no.

And statistical average might help us in classifying few things, but then it also forces us to neglect few things which might have merit.

Right; so, the second step which psychiatrist taken is like, for example in depression. Now depression can be because of all the lot of the modern classification the club depression into one rubric. But way back ten years, there were depression could have been because of anything right from adjustment disorder to what used to be called as

neurotic depression. Now we call it dysthymia situational. And viz a viz, what we call endogenous depression.

So, endogenous depression and other depression, dysthymia is a duration of 2 years, but prolonged depressive disorder also can have a longer duration which is because of the adjustment problem. Adjustment disorder by definition is the mental state with most people will undergoes phase to the similar stimuli. Now life events are important in precipitating endogenous depression. But life events can also precipitate.

Yeah.

Adjustment disorder; so, there is lot of confusion actually. So, for anybody to say normal abnormal, we can say sitting in our clinics and while we are trying to read, but that is all a functional issue.

Yeah.

So, now endogenous depression the quality of mood is one thing which separates, that it is a pervasive sadness. Pervasive sadness is nothing makes you happy and lasting for two weeks then you call it endogenous. But, I question it in a different way, if somebody is caught in a personal situation and the grief is so much. Whatever grief? Not necessarily because of death, because of anything relationship and loss of or a continuing stress and that does not make you happy anywhere.

Or there could be multiple episodes.

Multiple stressors, clustering together and so, you just cannot take although you have working and all. So, is the loss of functional ability social occupational impairment amount to calling it abnormal and the other depression is normal or both are equal, or both required treatment.

There could be another angle to this, especially most of the cultures and I am with talking with respect to our Indian culture.

Yes.

There is a mix of philosophy, tradition, certain kind of value belief oriented practices and finally the modern day knowledge, classification and clinical diagnosis. So, if you mix

everything together, a common person does not have the ability perhaps and of course, there is no need also for them, to know bracket each thing with clear cut line of demarcation. Now if I am convinced that my religion, my cultural philosophy, the ethos of both of them is that you should not be too much excited in life and I have really, you know internalized that philosophy. Now I am neither so happy or I am nor so sad. And there is no reason other than the fact that, I have internalize something that I have read, I have now, I am now convinced. And this somehow you know mismatches with the kind of modern-day diagnostic criteria.

Right.

And therefore, I might be put as an outlier, compared to rest of those who have not yet internalized this. Similarly, say for instance, I am passionately in love with someone. And in the absence of the person, I feel his or her presence. I can mentally create it and I experience it. Now we find such kind of descriptions in the epics, we find such kind of description in several.

Poetry.

Stories, poetry, some part of it is considered as say an apex, part of creative outcome and somewhere suddenly it is classified as a possible disorder or not. So, normal kind of behavior.

So, people who come from a certain background, who have a certain cultural baggage, with the kind of life narratives that, they have evolved over period of time which has a mix of their cultural mellow, their philosophy, their own personal experiences. And as an outsider, as a practitioner when I look at that overall you know behavior exhibited and then I say you fall on this part of the access if I am looking at dimension or I say you fall in this category, if I am looking at different categories of disorders.

Right.

So, this could also be you know something that we need to think of.

Yeah; so, culture-bound syndrome were almost described in psychiatry, although they were put under different labels. But what you are saying as a point because theory or a

classificatory or a grid is made and then you try to put it on a certain behavioral patterns or population; obviously, everybody will fall into one grid or the other.

Yeah.

Right; so, does that grid have a box of normal, classification would not have.

Classification would not have the normal.

Where is the category of normal in the classification?

Exactly and that is the reason why we are discussing it here.

Yeah; so, the big question which I think everybody should address and; obviously, maybe psychiatry or other behavioral sciences will address when they are able to know the causes. Like for example, even if you find gene, so in somebody that you have a gene of schizophrenia, I think everybody will have it because it has come through evolution. But does having a gene mean that you are going to have it because we do not find a 100 percent concordance rate in genetic studies. Even the mono psychotic twins, two children who were born of the same zygote by division do not have 100 percent concordance. They should have the same set of genes, but they also have 60 percent or 70 percent.

So, what happens to the rest 30, 40 percent? Is the nurture, is the stress level, something happens which triggers a gene in one person and not in the rest. Right, it is said that all of us have risk of 1 percent of schizophrenia morbid risk, but if somebody in your family has the risk goes up, whatever 17 percent, 10 percent, but still it is 17 percent is not 100 percent.

Also say, I might be carrying the gene in me, but because I am not only carrying the genes from the culture ; from the family inheritance. But it is also the way my family behaves. So, most of the behavior that, I learned is also the behavior which is practiced in my own family. So, I take the gene from my family and I also take the, what you call the manifested behavior.

Epigenetics.

Epigenetics.

Right.

And therefore, say when we look at not something as hardcore disorder as schizophrenia. But something even now, for example, is stress for instance or many such things you know, now that people have been plotting things and they are finding the coordinates of each and every aspect of behavior to one gene, still we do miss on the epigenetic factors.

Yeah; so, genes, it was hope that we will pinpoint every behavior to a gene. But it has not happened till now. In between epigenetics came in that, while in the womb or, so it everything is boiling down to the formation of brain networks right from birth till.

Yeah.

Whatever age and some genes may get triggered some may not normally the genes which are silent in a person because of some stress of the mother or trauma or toxin anything can trigger which is a hell lot of things. So, if it is happening in the womb, it can also happen while growing up. That anything can trigger. So, that variation makes the person; so, if the why I am saying this, that even if we will know the causes this doubt will always linger.

Yeah.

If it is triggered, what does it mean it means if your gene is on or we have normal. We cannot reduce behavior to that point.

Exactly.

We cannot reduce behavior to that point, but you mentioned two words, one the past of human race, the culture and religion and the other word is you said is stress. Now these two things are very important. And I think although we have a lot of reductionist approach because the reductionist approach helps us, give a better control of situation and understanding. Or we can neatly categorize, but the brain it itself does not work that way.

Brain does not work in categorization, it works to a different non-linear process and then at a very later stage it categorizes. So, I think well we should try and look at a slightly

holistic approach, especially in the setup of India. Because obviously, we are trying to discover this because what may be normal in US may not be normal here.

Yeah, exactly.

And we have not sat down and really defined what is normal and abnormal. Even psychiatry has not done it.

Yeah.

Even psychology has not done it. So, I think now that we have got a chance to discuss this. I think in next half an hour, let us try and see what are our traditional things and how people who were trying to manage all these things in the past.

Yeah.

Because that may give us sensible approach.

Thank you.