

Mental Health in Social Context: What Is Normal and Who Defines It?

Anja KNEZ

SFU Ljubljana, 1000 Ljubljana, Slovenia

Email: anja.knez@gmail.com

Essay article

Received: 22-July-2023

Revised: 22-Aug-2023

Accepted: 25-Aug-2023

Online first: 26-Aug-2023

Abstract

The purpose of the paper is to encourage a critical attitude and shed light on the background and perception (and not the definition) of “normal” through the prism of society, which to a large extent conditions human functioning and well-being. Understanding the variability of normality and mental health as a socially defined and ever-changing concept leads to normalisation and de-stigmatisation of not only mental disorders in the narrower sense, but also of mental distress of modern man, and is a prerequisite for reducing false diagnoses. Human vulnerability and inner struggles, which are the norm, not a peculiar, isolated problem, need to be seen as such while taking into account all the factors, i.e., biological, psychological, and social, affecting the person. A better understanding and use of the biopsychosocial model could help improve healthcare and make this world a little kinder.

Keywords: *objectivity, normality, freedom, biomedical model, biopsychosocial model*

Citation: Knez, A. (2023). Mental Health in Social Context: What Is Normal and Who Defines It? Journal of Health and Rehabilitation Sciences, 2023 Oct 3; 2(2):49-55. <https://doi.org/10.33700/jhrs.2.2.84>

Copyright ©2023 Knez, A. This is an open-access article distributed under the terms of the Creative Commons 4.0 International License (CC BY 4.0)

Corresponding address:

Anja KNEZ

SFU Ljubljana, Trubarjeva cesta 65,

1000 Ljubljana, Slovenia

Email: anja.knez@gmail.com

1. Introduction

Definitions of illness and health have long been debated in sociology and philosophy of medicine (Blaxter, 2010; Doust et al., 2017). Society and mental health are inseparably connected: Our cultural background influences how we see the world and cope with stress, cultural factors influence the prevalence and incidence of mental disorders, and culture influences the way mental disorders are diagnosed and treated. Mental health is a socially constructed and defined concept, susceptible to change (Segura, 2015). This is indicated by the already 5th version of the American Diagnostic and Statistical Manual of Mental Disorders (DSM) and the 11th version of the International Classification of Diseases (ICD). The concept of mental disorders and the methodology of their treatment are influenced by many factors such as time, geography, religion, economy and politics. The legitimacy of the label “abnormal” depends on a cultural consensus, and not merely on the consensus of a few selected professionals (Stravynski and O’Connor, 1995).

The first example indicating that mental health is a socially defined concept is drapetomania (Gr. drapetes – a runaway, mania – madness), which was considered a mental illness in the 19th century. It was defined by the American doctor Samuel A. Cartwright as the desire of African slaves to escape from their masters (Domaradzki, 2021). It was based on the belief that slavery improved the lives of slaves so much that only those suffering from some form of mental illness wanted to escape. Another example of the social definition of mental health is homosexuality, which was considered a sociopathic personality disorder in the American DSM classification from 1952 to 1974, and was defined as “disguised pathological fear of the opposite sex due to an early traumatic child-parent relationship” (Cooper, 2004; Stravynski and Connor, 1995). A third example is the concept of mourning. In DSM-IV, prolonged grief disorder did not yet exist. Bereaved people could be diagnosed with depression if the symptoms were unreasonably severe or prolonged, with a time limit for legitimate bereavement of two months after death (Shear et al., 2011). Today, prolonged grief disorder is recognized as a separate diagnosis lasting more than six months in ICD-11 (Eisma et al., 2020) and more than twelve months in DSM-V (Jordan and Litz, 2014). The medicalisation of mourning is controversial, as the causes of grief-related suffering are not medical, and setting time limits for normal mourning can lead to excessive standardisation and pathologising of individual personal experiences (Kaczmarek, 2022).

Psychiatry has had a special position among the various branches of medicine since the very beginning, as defining normal and healthy emotional and behavioral responses is a demanding and delicate task. Allen Frances (2013), a psychiatrist and chair of the DSM-IV Task Force, explains it by stating that “translation from basic science to clinical practice is

necessarily even more difficult in psychiatry than in the rest of medicine, because the human brain is the most complicated thing in the known universe and reveals its secrets slowly and in small packets,” concluding that “psychiatric diagnosis must therefore still rely exclusively on fallible subjective judgments, not on objective biological tests” that would definitively confirm whether or not someone has a mental disorder (ibid., p. 111).

2. On Objectivity, Normality and Freedom

To understand mental disorders within the social context, we first need to understand the concept of objectivity. The latter is best explained by defining three major epistemologies: positivism, constructivism, and critical realism (Fryer, 2022). According to positivism, the world is objective and our senses can accurately perceive it. Positivists believe there are universal laws of nature that can be discovered through scientific inquiry. Constructivists, on the other hand, believe that knowledge is not simply received from the outside world, but is constructed by individuals through their interactions with the environment and is therefore subjective. Critical realism lies between positivism (which emphasises empiricism and objective facts) and constructivism (which accepts a socially constructed view of reality), as it acknowledges the existence of an external as well as a socially constructed world. It accepts that there is an objective reality, but also recognises that an individual’s subjective interpretation plays a part in explaining it (Churchill, 2021).

We influence our experience of the world with our personality. In practice, objectivity, which the Standard Slovenian Dictionary (SSKJ) defines as “what is, exists independently of human consciousness, thinking”, is not accessible (Proietti et al., 2019). People will always be something – hungry or full, tired or rested, satisfied or not, etc. –, we will never be nothing. In gestalt psychotherapy, we talk about the field theory and the concept of figure (the thing we are focusing on) and ground (the context it occurs in), whereby the field represents the totality of all parts of the human relationship. Fields are not a static phenomenon, but are constantly changing and are influenced by the perspective of the “here and now”. What is the figure and what is the ground changes according to each individual experience. Is the glass half empty or half full? Things are the way we see them from our perspective, which is the result of our personality, experience and emotional state. Deciding who is right is a matter of social consensus, with the majority usually being the criterion. What most people think is normal. The human idea of normal, however, is often far outside the scope of reality. We perceive many of our characteristics as unusual, even though they are very common, just not talked about. In part, our misunderstanding of normality is the result of basic human functioning, and stems from the asymmetry between

knowledge about oneself and others (Neubauer et al., 2018). Through direct experience, we immediately know exactly what is happening within us, while our knowledge of others only comes from what we hear and see, which is often a highly modified version of the truth.

Another reason for our distorted understanding of normality is culture, which often projects the ideal of an organised, composed and polished individual as the norm applying to the majority. Human relationships are full of stress and disagreements due to the variety of values and ways to achieve them, and it takes a lot of patience and work to make them somewhat harmonious. Despite this, our society holds an opposite belief: Relationships are harmonious and humans (with issues) make them chaotic.

Normal is becoming a synonym for “the absence of feeling – not numbness, but lack of yearning and a lack of shame. A delightful unawareness, an unknowing. Happily being, without mentally doing” (Glyde, 2014, p. 180). Normality is rarely explicit, but still strongly permeates our daily lives. “Normal” is not a neutral label. In terms of ethical analysis and related statement types, it seems to be a descriptive-normative hybrid: Our beliefs about normality are descriptive (how something is, based on an average) and normative (how something ought to be, based on an ideal), and extend beyond mere descriptions into the realm of moral norms. Any form of normality generates conformity pressure, because it simultaneously defines abnormality, which often results in stigmatisation and social exclusion, and therefore strongly supports adhering to the normal (Rost, 2021).

The SSKJ defines the concept of normal as something or someone “that acts, behaves in accordance with certain established, accepted rules, customs; that occur most often; that, in relation to things of their kind, only has basic, necessary, general properties, characteristics; that is calm, orderly; and that is mentally healthy, balanced”.

Based on the definitions, the dichotomy between normality and abnormality can easily be replaced with conformity and individuality, which raises the question of what price people pay at the expense of their individuality and freedom to appear “normal”. Mazzini (2011) reflects on the latter:

“Conformism is essentially the opposite of creativity. A couple of researches on this topic: The members of the Royal Society [United Kingdom’s national academy of sciences] were not honor students in school, nor were the Nobel laureates. If you want to be successful, you need to lower your obedience level and sometimes think for yourself, it is that simple. Which also means accepting responsibility, which the submissive never have to, since they were merely following orders.” (ibid., p. 127)

In other words, “conformity is the jailer of freedom, and the enemy of growth” (Kennedy, 1961). In spite of that and regardless of individual dispositions, socially desirable behaviour occurs more frequently,

simply because it is rewarded (Tausch et al., 2007). Glyde (2014) outlines too high a price to pay for freedom with an illustrative example:

“Being normal (...) actually means being in a long-term romantic relationship and owning a house. (...) A relationship might be stifling, non-consensually sexless, or fraught with vicious undercurrents and abuse. A house might be damp and noisy, and on paper barely yours because you were economical with the truth in the mortgage application. No matter – the boxes of social acceptability have been ticked.” (ibid., p. 180)

What is more important to me – being myself with everything I truly am, or being an image of what I am supposed to be according to other people’s expectations? And what is more difficult for me to bear – the disapproval of others or denial of myself? It requires a substantial amount of courage and self-confidence to be the misfit, the round peg in the square hole. Emerson writes about it in one of his essays (1940):

“What I must do is all that concerns me, not what the people think. This rule, equally arduous in actual and in intellectual life, may serve for the whole distinction between greatness and meanness. It is the harder, because you will always find those who think they know what is your duty better than you know it. It is easy in the world to live after the world’s opinion; it is easy in solitude to live after our own; but the great man is he who in the midst of the crowd keeps with perfect sweetness the independence of solitude.” (ibid., p. 150)

“On the surface, people come to therapy for as many different reasons as there are people, but existential discomfort is never far away” (Glyde, 2014, p. 179). When basic biological needs are met, each person is faced with the question of their own meaning, their place under the sun.

3. On the Concept of Mental Disorders

Human behavior is almost infinitely plastic. One of the functions of culture is to narrow the vast freedom. A part of this process is classification. Categorising is a fundamental human need to maintain order and harmony (McGarty et al., 2015). We classify in order to have more control: Understanding what is happening gives us a sense of security. On the other hand, the absence of classification requires the recognition of powerlessness, which is a rare and highly sophisticated human achievement, as it implies the acceptance of uncertainty.

Yalom (1980) states ‘freedom is one of the four “ultimate concerns”, an inescapable part of being human. It refers to the absence of external structure, suggesting that we are the sole designers of our lives, and has a terrifying implication of no ground beneath us. This concern is hard to endure.’

On the question of categorising mental disorders? Unlike other diseases, they cannot be evaluated merely from a physical point of view, although they are similar to them in cases, where they are the result of brain

changes due to e.g., Alzheimer's disease, epilepsy, stroke, poisoning, mechanical injuries after an accident, or congenital genetic disorders. These are the disorders of physico chemical processes that can manifest in certain disorders of thinking and functioning. If we are meticulous, the correct terminological definition would be "the disease of the brain", not "of the mind". It is different with so-called mental symptoms, defined on the basis of indirect information (which offers numerous opportunities for manipulation and abuse), and within a specific social context – with behavior deviating from certain psychological, ethical, and legal norms. Here, "no pipeline of promising tests" exists and "it appears certain that we will be stuck with descriptive psychiatry far into the distant future" (Frances, 2013, p. 111). In this case, the concept of mental disorders becomes much more complex, and the biomedical model, which treats the disease as a consequence of a certain disorder in the functioning of the human body, insufficient. This is supported by the accumulating evidence on biological as well as psychosocial factors being involved in the etiology and treatment of many physical and mental health conditions (Bolton, 2022). In regard to the three philosophical positions mentioned previously, the position of the biomedical approach toward mental disorders is a positivist one, assuming objective, universal criteria for mental disorders and an unbiased, uninfluenced assessment thereof. It conceptualises mental health as an objective notion, determined by empirically observable symptoms, corresponding to some sort of statistical, non-individual normality (Rost, 2021). Since the positivist approach equates mental disorders with physical diseases, it makes sense to categorize them in the same way. The consequence of this process is medicalisation, the phenomenon of defining and describing something with medical terminology, understanding it within a medical framework and treating it with medical interventions (Conrad, 2007). One of the effects and its subcategory is pharmaceuticalisation, i.e., when we begin to see a certain phenomenon not only as a health problem, but also as a problem that requires drug treatment (Kaczmarek, 2022; Williams et al., 2011). Among the strategies of the pharmaceutical industry which enable it are the medicalisation of common ailments (e.g., baldness), perception of mild symptoms as serious (e.g., irritable bowel syndrome), treatment of personal or social problems as medical (e.g., social phobia), conception of risk as disease (e.g., osteoporosis) and the creation of prevalence estimates to maximise potential markets (e.g. erectile dysfunction) (Moynihan et al., 2002). Pressfield (2002) illustrates this in his book:

"I once worked as a writer for a big New York ad agency. Our boss used to tell us: Invent a disease. Come up with the disease, he said, and we can sell the cure. Attention Deficit Disorder, Seasonal Affect Disorder, Social Anxiety Disorder. These aren't diseases, they're marketing ploys. Doctors didn't discover

them, copywriters did. Marketing departments did. Drug companies did." (ibid., p. 26)

Pharmaceuticalisation becomes even more problematic in light of studies such as the recent one by Moncrieff et al. (2022), which shows no convincing evidence of depression being associated with lower serotonin concentration, calling into question the efficacy of Selective Serotonin Reuptake Inhibitors (SSRI) and other antidepressant drugs that rely on the "chemical imbalance theory", still put forward by professionals (Read et al., 2020) and widely accepted by the general public (Pescosolido et al., 2010; Pilkington et al., 2013). The findings challenge a strongly established theory and the resulting dominant course of treating depression, which calls for consideration of alternative ways of treatment.

There is now abundant evidence that the involvement of pharmaceutical industry corrupts medical science. Pharmaceutical companies do their own research and skillfully incorporate it into medicine (Sismondo, 2021). It is therefore necessary to monitor the influence of the pharmaceutical industry on the public and scientific discourse on diseases and to ensure that the institutions deciding on official disease classifications and clinical practice guidelines are as independent, impartial and scientifically reliable as possible (Kaczmarek, 2022; Whitaker, 2023).

Moreover, neuroscience should cease to be a dominant force in research into mental disorders, since it has not advanced psychiatry much, and the classification system should not be based on biology, when mental disorders seem more to reflect human experience (Kingdon, 2020). It is absurd to expect that medical interventions designed to treat physical problems will solve problems caused by psychosocial factors in the long term (Deacon, 2013). What is needed is the critical realist position, recognising that some mental disorders are objective (e.g., Alzheimer's), while others are subjective (e.g., depression), and in case of the latter a personalised focus on people's individual characteristics:

"Disease can be determined only by means of a norm which permits taking the entire concrete individuality into consideration, a norm which takes the individual himself as the measure; in other words, as an individual, personal norm." (Goldstein, 1939, p. 433)

The biopsychosocial model offers a basis for a person-centered diagnosis (Papadimitriou, 2017) and enables each person's individual normality. It was proposed by George L. Engel in the 1970s (Engel, 1977) and points out the complex interplay of three major dimensions (biological, psychological, and social) in the development of mental disorders. It explains that "a person does not suffer as isolated organs but rather as a whole" (Tripathi et al., 2019, p. 582). Despite the accumulating evidence of psychosocial factors influencing health and disease over the past few decades (Bolton and Gillett, 2019), the biopsychosocial model has had very little impact on the organisation and financing of healthcare. As chronic diseases account for

the majority of morbidity and many deaths in the Western world, healthcare systems designed around biomedical models aim to improve health outcomes and reduce healthcare costs with increasing difficulty (Hajat and Stein, 2018; Raghupathi and Raghupathi, 2018). Health management is in need of a different approach, which is offered by the biopsychosocial model (Wade and Halligan, 2017). It has been adopted to some extent in psychiatry, with many psychiatrists already paying attention to social factors in their patients. However, this type of treatment is still very limited and by no means clearly formulated as a policy and strategy. The scope and amount of change and effort required for its effective and long-term implementation at a wider societal level are substantial and possibly too overwhelming to take on, as evidenced by the model's reported shortcomings including the lack of a concise theoretical framework regarding its function and content, its complexity, difficulties in its coordination and assignment of responsibilities, as well as problems with the education on it being multifaceted (Papadimitriou, 2017). In the field of mental health, for example, it includes various types of health conditions, professions and fields. It encompasses increased awareness and publicity on biopsychosocial etiology, funding research on social determinants of health, reorganising clinical practice, public health, and service delivery, and establishing prevention programs (Bolton, 2022; Kingdon, 2020). This requires a significant shift in the perception of mental health in the wider socio-political context.

4. Conclusion

Normality is a socially defined concept that changes over time. On the one hand, it is the glue of society, a sign of universal values, social dialogue and connection. It offers a sense of predictability and security. On the other hand, it is restrictive, demoralising and repressive, and threatens individuality, creativity and innovation. To live with its existence is an achievement. The concept of normality in the context of mental health is changing as well, as indicated by the different versions of classifications of mental disorders. The lack of appropriate objective tests that would prove the existence of mental disorders, gives medical science, particularly psychiatry, a lot of room for maneuver. It is, however, not used in an adequate way, as pharmaceuticalisation shows a very narrow and one-sided solution to an ever-increasing multifaceted healthcare problem.

Even a seemingly absurd thing starts making sense when put into context. The latter is offered by the biopsychosocial model, a much-needed expansion of the dominant biomedical model of treatment accepting each person's individual normality, which requires an extensive change in healthcare as well as human mentality.

Conflicts of Interest

The author declares that no conflicts of interest exist.

References

- Blaxter, M. (2010). *Health*. Cambridge: Polity Press.
- Bolton, D. (2022). Looking Forward to a Decade of the Biopsychosocial Model. *British Journal of Psychiatry Bulletin*, 46(4), 228–232. <https://doi.org/10.1192/bjb.2022.34>
- Bolton, D., & Gillett, G. (2019). *The Biopsychosocial Model of Health and Disease: New Philosophical and Scientific Developments*. Cham: Palgrave Pivot Churchill, H. (2021). Critical Reflexivity: A Personal Account of My Counseling Career and Journey. *Waverley Abbey College Journal*, 1(1), 24–34. <https://doi.org/10.52456/wacjo113>
- Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.
- Cooper, R. (2004). What is Wrong with the DSM? *History of Psychiatry*, 15(1), 5–25. <https://doi.org/10.1177/0957154X04039343>
- Deacon, B. J. (2013). The Biomedical Model of Mental Disorder: A Critical Analysis of Its Validity, Utility, and Effects on Psychotherapy Research. *Clinical Psychology Review*, 33(7), 846–861. <https://doi.org/10.1016/j.cpr.2012.09.007>
- Domaradzki, J. (2021). Thomas Szasz: The Uncompromising Rebel and Critic of Psychiatry. *Psychiatria Polska*, 55(4), 851–867. <https://doi.org/10.12740/pp/125902>
- Doust, J., Walker, M. J., & Rogers, W. A. (2017). Current Dilemmas in Defining the Boundaries of Disease. *Journal of Medicine and Philosophy*, 42(4), 350–366. <https://doi.org/10.1093/jmp/jhx009>
- Goldstein, K. (1939). *The Organism: A Holistic Approach to Biology Derived from Pathological Data in Man*. Salt Lake City: American Book Publishing.
- Eisma, M.C., Rosner, R., & Comtesse, H. (2020). ICD-11 Prolonged Grief Disorder Criteria: Turning Challenges into Opportunities with Multiverse Analyses. *Frontiers in Psychiatry*, 11, 752. <https://doi.org/10.3389/fpsy.2020.00752>
- Emerson, R. W. (1940). *The Complete Essays and Other Writings*. New York: Random House.
- Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science* 196(4286), 129–136. <https://doi.org/10.1126/science.847460>
- Frances, A. (2013). The Past, Present and Future of Psychiatric Diagnosis. *World Psychiatry*, 12(2), 111–112. <https://doi.org/10.1002/wps.20027>
- Fryer, T. (2022). *A Short Guide to Ontology and Epistemology: Why Everyone Should Be a Critical Realist*. Retrieved August 16, 2023, from <https://tfryer.com/ontology-guide/>.

- Glyde, T. (2014). Wanting to Be Normal. *Lancet Psychiatry*, 1(3), 179–180. [https://doi.org/10.1016/s2215-0366\(14\)70325-6](https://doi.org/10.1016/s2215-0366(14)70325-6)
- Hajat, C., & Stein, E. (2018). The Global Burden of Multiple Chronic Conditions: A Narrative Review. *Preventive Medicine Reports*, 12, 284–293. <https://doi.org/10.1016/j.pmedr.2018.10.008>
- Jordan, A. H., & Litz, B. T. (2014). Prolonged Grief Disorder: Diagnostic, Assessment, and Treatment Considerations. *Professional Psychology: Research and Practice*, 45(3), 180–187. <https://doi.org/10.1037/a0036836>
- Kaczmarek, E. (2022). Promoting Diseases to Promote Drugs: The Role of the Pharmaceutical Industry in Fostering Good and Bad Medicalization. *British Journal of Clinical Pharmacology*, 88(1), 34–39. <https://doi.org/10.1111/bcp.14835>
- Kennedy, J. F. (1961). Address by President John F. Kennedy to the UN General Assembly. Retrieved August 17, 2023, from <https://2009-2017.state.gov/p/io/potusunga/207241.htm>.
- Kingdon, D. (2020). Why Hasn't Neuroscience Delivered for Psychiatry? *British Journal of Psychiatry Bulletin*, 44(3), 107–109. <http://doi.org/10.1192/bjb.2019.87>
- McGarty, C., Mavor, K. I., & Skorich, D. P. (2015). Social Categorization. In J. D. Wright (Ed.), *International Encyclopedia of the Social & Behavioral Sciences* (2nd ed., pp. 186–191). Amsterdam: Elsevier. <http://doi.org/10.1016/b978-0-08-097086-8.24091-9>
- Mazzini, M. (2011). Če ni ti kaj prav, se pa izseli! Novo mesto: Goga.
- Moncrieff, J., Cooper, R. E., Stockmann, T., Amendola, S., Hengartner, M. P., & Horowitz, M. A. (2022). The Serotonin Theory of Depression: A Systematic Umbrella Review of the Evidence. *Molecular Psychiatry*, 1, 1–14. <http://doi.org/10.1038/s41380-022-01661-0>
- Moynihan, R., Heath, I., & Henry, D. (2002). Selling Sickness: The Pharmaceutical Industry and Disease Mongering. *British Medical Journal*, 324(7342), 886–891. <https://doi.org/10.1136/bmj.324.7342.886>
- Neubauer, A. C., Pribil, A., Wallner, A., & Hofer, G. (2018). The Self–Other Knowledge Asymmetry in Cognitive Intelligence, Emotional Intelligence, and Creativity. *Heliyon*, 4(12), e01061. <https://doi.org/10.1016/j.heliyon.2018.e01061>
- Papadimitriou, G. (2017). The “Biopsychosocial Model”: 40 years of Application in Psychiatry. *Psychiatriki*, 28(2), 107–110. <https://doi.org/10.22365/jpsych.2017.282.107>
- Parens, E. (2013). On Good and Bad Forms of Medicalization. *Bioethics*, 27(1), 28–35. <https://doi.org/10.1111/j.1467-8519.2011.01885.x>
- Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). A Disease Like Any Other? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence. *American Journal of Psychiatry*, 167(11), 1321–1330. <https://doi.org/10.1176/appi.ajp.2010.09121743>
- Pilkington, P. D., Reavley, N. J., & Jorm, A. F. (2013). The Australian Public's Beliefs about the Causes of Depression: Associated Factors and Changes over 16 Years. *Journal of Affective Disorders*, 150(2), 356–362. <https://doi.org/10.1016/j.jad.2013.04.019>
- Pressfield, S. (2002). *The War of Art*. New York: Grand Central Publishing.
- Proietti, M., Pickston, A., Graffitti, F., Barrow, P., Kundys, D., Branciard, C., ... Fedrizzi, A. (2019). Experimental Test of Local Observer Independence. *Science Advances*, 5(9), eaaw9832. <https://doi.org/10.1126/sciadv.aaw9832>
- Raghupathi, W., & Raghupathi, V. (2018). An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach. *International Journal of Environmental Research and Public Health*, 15(3), 431. <https://doi.org/10.3390/ijerph15030431>
- Read, J., Renton, J., Harrop, C., Geekie, J., & Dowrick, C. (2020). A Survey of UK General Practitioners about Depression, Antidepressants and Withdrawal: Implementing the 2019 Public Health England Report. *Therapeutic Advances in Psychopharmacology*, 10, 1–14. <https://doi.org/10.1177/2045125320950124>
- Rost, M. (2021). “To Normalize is to Impose a Requirement on an Existence.” Why Health Professionals Should Think Twice Before Using the Term “Normal” with Patients. *Journal of Bioethical Inquiry*, 18(3), 389–394. <https://doi.org/10.1007/s11673-021-10122-2>
- Segura, K. (2015). Defining Normal. Retrieved June 28, 2023, from <https://www.csustan.edu>.
- Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., Keshaviah, A. (2011). Complicated Grief and Related Bereavement Issues for DSM-5. *Depression and Anxiety*, 28(2), 103–117. <https://doi.org/10.1002/da.20780>
- Sismondo, S. (2021). Epistemic Corruption, the Pharmaceutical Industry, and the Body of Medical Science. *Frontiers in Research Metrics and Analytics*, 6, 614013. <https://doi.org/10.3389/frma.2021.614013>
- Slovar slovenskega knjižnega jezika – SSKJ (n. d.). Normalen. Retrieved July 7, 2023, from <https://www.fran.si>.
- Slovar slovenskega knjižnega jezika – SSKJ (n. d.). Objektivni. Retrieved July 7, 2023, from <http://www.fran.si>.
- Stravynski, A., & O'Connor, K. (1995). Understanding and Managing Abnormal Behavior: The Need for a New Clinical Science. *The Journal of Psychology*, 129(6), 605–605.

- <https://doi.org/10.1080/00223980.1995.9914932>
- Tausch, N., Kenworthy, J., & Hewstone, M. (2007). The Confirmability and Disconfirmability of Trait Concepts Revisited: Does Content Matter? *Journal of Personality and Social Psychology*, 92(3), 542–556. <http://doi.org/10.1037/0022-3514.92.3.542>
- Tripathi, A., Das, A., & Kar, S. K. (2019). Biopsychosocial Model in Contemporary Psychiatry: Current Validity and Future Prospects. *Indian Journal of Psychological Medicine*, 41(6), 582–585. https://doi.org/10.4103/ijpsym.ijpsym_314_19
- Yalom, I. D. (1980). *Existential Psychotherapy*. New York: Basic Books.
- Wade, D. T., & Halligan, P. W. (2017). The Biopsychosocial Model of Illness: A Model Whose Time Has Come. *Clinical Rehabilitation*, 31(8), 995–1004. <https://doi.org/10.1177/0269215517709890>
- Whitaker, F. (2023). *Pogubnost kemopsihiatrije*. Ljubljana: UMco.
- Williams, S. J., Martin, P., & Gabe, J. (2011). The Pharmaceuticalisation of Society? A Framework for Analysis. *Sociology of Health and Illness*, 33(5), 710–725. <https://doi.org/10.1111/j.1467-9566.2011.01320.x>