Part I

Approaches to Mental Health and Illness: Conflicting Definitions and Emphases

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Mental health and mental disorder represent two different areas of theory, research, and policy implications, reflecting our tendency to dichotomize healthy and sick, normal and abnormal, and sane and insane. David Mechanic (2006) has argued that the term "mental health" has no clear or consistent meaning, and in the sociological literature, this argument is generally true. Mental health is not merely the absence of disease or disorder; it involves self-esteem, mastery, and the ability to maintain meaningful relationships with others. The concept of mental health is better developed in the psychology literature, and Carol Ryff has provided an exceptional account of "happiness" that draws on the theories of Maslow, Rogers, Jung, and Allport to develop a multidimensional construct of psychological well-being (Ryff, 1989). Although most of us fall short of achieving optimal well-being or happiness, those who experience mental health problems or psychological distress have been the focus of most sociological research.

However, definitions of mental health problems, or illnesses, or disorders are also not so straightforward. According to Horwitz (2002), "mental diseases" reflect underlying internal dysfunctions that have universal features (e.g., schizophrenia and to a lesser degree bipolar disorder). A valid "mental disorder" reflects some internal psychological system that is unable to function as it should, and this dysfunction is socially inappropriate. For most disorders, symptoms are not specific indicators of discrete underlying diseases (such as schizophrenia); instead many conditions (such as depression, anxiety, and eating disorders) arise from stressful social conditions. Thus symptoms associated with mental disorders are shaped by cultural processes, and it is important to distinguish mental disorders from normal reactions to social stressors. Horwitz (2002) used the terminology of "mental illness" to refer to those conditions that a particular group has defined as a mental illness and that often includes behaviors that are deemed deviant; for example, homosexuality in previous psychiatric classifications. In Chapter 1, Horwitz argues that sociological approaches regard mental health and mental health problems

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as aspects of social circumstances. He provides a very thorough overview of how various social conditions affect degrees of mental health and mental health problems and, consequently, how social context shapes the definition as well as the response to mental health problems.

It is also important to understand that there have been two different approaches to differentiating between mental health and illness. One approach views mental health and illness in terms of a continuum, with health and illness at opposite ends of the poles and most of us falling somewhere in between. In other words, there are varying degrees of healthy and sick, normal and abnormal. In the second approach are theories that view health and illness as opposites, as forming a dichotomy such that one is either sick or well and that, furthermore, one will fit into a specific disease category once specific symptoms are identified. Of course, these two approaches to the definition of mental health and illness may be reconcilable if you can find the point on the continuum that differentiates health from illness. A special issue of the *Journal of Health and Social Behavior* (2002, volume 43) focused on whether sociologists should privilege diagnoses or continuum measures. Medically oriented thinking emphasizes diagnoses – that is, dichotomous categories that determine whether one is sick or not. Such an approach is the basis of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is used in clinical practice as well as in a great deal of epidemiological studies that seek to determine levels of mental disorder in the general population. Currently in the version IV-TR (version V is due to be published in 2011 or 2012), the DSM identifies more than 400 distinct mental disorders. These disorders are assumed to be discrete (i.e., they do not overlap with one another). Other researchers prefer to use continuum assessments of mental health and mental health problems such as scales to assess psychological well-being or distress. Indices assess not only the problem but also its severity and frequency along a continuum (Mirowsky & Ross, 2002).

In Chapter 2, Jerome Wakefield and Mark Schmitz provide an overview of how researchers have measured and assessed mental disorder and illness. In assessing mental illness there are a variety of terms with which the student needs to be familiar. *Epidemiology* refers to the study of the distribution of illness in a population. *Morbidity* is the prevalence of diseases in a population, whereas *comorbidity* is the co-occurrence of disease and associated risk factors. Hence epidemiological research not only assesses rates of disease but also, by identifying who is susceptible to particular conditions, can lead us to an understanding of the specific causes of a disorder or disease. *Point prevalence* refers to the percentage of the population affected with an illness at a given point in time; *lifetime prevalence* refers to the percentage of the population *ever* affected with an illness. *Incidence rate* is the rate at which new cases of an illness or disorder form in the population; for example, many are now concerned with the prevalence rate at which depression is found among all age groups and the fact that incidence rates seem to be increasing for

young women. Ronald Kessler in Chapter 3 describes the most recent estimates of community incidence, age of onset, and prevalence of mental disorders.

People with mental health problems fall into three groups (Mechanic, 2006). First are those with acute mental health problems such as normal depression following a loss or some other stressful event. In the second group are those with acute mental health problems that are more severe or those who have chronic conditions but who can maintain normal role functioning. The third group is made up of those with serious, chronic mental diseases that involve significant functional disability. Although only a small percentage of the population is affected by serious mental illness, the majority of public mental health monies are directed toward members of that third group, most of whom need a wide array of services and long-term supports. The shortage of such services in the past decade has resulted in the criminal justice system becoming the de facto system of care for many with chronic and serious mental diseases. Reflecting the medicalization of mental health care described by Horwitz in Chapter 1, most people with mental health problems receive medication, which is the primary expenditure for mental health care under Medicaid (Mechanic, 2006).

Reliance on psychiatric medication is in keeping with a medical model, rather than a social or psychological model, of the etiology of mental health problems. *Etiology* refers to theories about the causes of illness, yet the etiology of mental illness (or disorder, as mental illness has only recently been considered a disease) is influenced by specific historical and social frameworks, as illustrated by Michel Foucault in *Madness and Civilization* (1965/1988). The DSM-III, which was hotly contested during the 1980s, was a significant factor in the re-medicalization of American psychiatry (M. Wilson, 1993) and served as a catalyst for debate among sociological, psychological, psychiatric, and biological understandings of mental disorder. In essence, "clinicians were replaced by biomedical investigators as the most influential voices in the field" (M. Wilson, 1993, p. 400).

Included in a more organic or biological approach to mental illness are theories that postulate that mental illnesses have genetic, biological, biochemical, or neurological causes (Michels & Marzuk, 1993). This approach conceptualizes mental illness as a disease and places increasing reliance on medication to provide treatment while deemphasizing psychotherapy. There has been much recent work in neuroscience, which combines the findings from several scientific disciplines, that seeks to understand the relationships between brain structure and human behavior. The biological approach to mental illness, as well as sociology's relationship to the biolological approach, is described in Chapter 4 by Sharon Schwartz and Cheryl Corcoran.

The psychosocial model of mental illness, dominant until the 1970s, was based on a continuum definition of mental health and illness in which the boundary between health and illness was fluid and subject to social and environmental influences. That is, it was widely accepted that anyone could become "sick" if subject

to the right conditions or environmental stressors. Since the 1980s, there has been
an increased emphasis on biological or organic views of mental illness and a cor-
responding narrowing of the psychiatric gaze, which has deemphasized the idea of
the unconscious, historical development, family dynamics, and social factors (M.
Wilson, 1993). Christopher Peterson provides a thorough overview of the various
psychological approaches to mental health and illness in Chapter 5. He describes
the overlap between the psychological and sociological in a comprehensible way.

And where does sociology fit into this debate between psychologists and
psychiatrists? Cooperation between sociology and psychiatry faces fundamental
obstacles because of their diverging theoretical perspectives and research agendas
(Coopers, 1991). Most critical is the issue posed posed by Mirowsky and Ross
(1989a): Do mental disorders represent disease entities or are mental disorders
related to social context, which affects the rates of generalized distress, abnor-
mal behavior, and social deviance? Traditionally, sociologists have viewed mental
disorder as deviance from institutional expectations – often referred to as *social
reaction theory* (Horwitz, 1982; Perrucci, 1974; Scheff, 1984; Turner, 1987).
Rather than focusing on the individual, sociologists focus on the social context of
illness and treatment and also tend to take a critical or oppositional stance to the
biomedical model of mental disorders as diseases (Turner, 1987). Consequently,
mental disorder is generally referred to as abnormal behavior or simply disor-
der as opposed to mental illness. Peggy Thoits in Chapter 6 provides a thorough
analysis of the various sociological approaches to stress and to mental health and
illness.

Despite the widespread use of the DSM to classify mental disorders, sociologists
have been sharply critical of the underlying assumption that DSM categories
reflect underlying pathophysiological entities or disease states. Mirowsky and Ross
(1989a) charged that such diagnoses are reified measurement: what is assessed are
psychiatry's *views* of mental illnesses based on clinical observations of those with
psychiatric problems. They assert that "the absence of gold standards, the paucity
and uncertain relevance of latent biological classes, and the symptom factors that
bear little resemblance to diagnostic 'syndromes' lead us to believe that psychiatric
diagnoses, whether simulated or clinical, are mythical entities" (Mirowsky & Ross,
1989a, p. 17).

Others have also researched the politics of the DSM (Caplan, 1995) and have
raised serious questions about the validity and reliability of the diagnostic cat-
egories (Kirk & Kutchins, 1992). Debates continue over the use of the DSM
classification system as more and more behaviors come to be defined as "abnor-
mal"; see for example an *American Journal of Psychiatry* article that addressed the
question of whether or not caffeine abuse should be added to the DSM-IV (Hughes
et al., 1992). Students are directed to a 2007 book by Allan Horwitz and Jerome
Wakefield (*The Loss of Sadness*), which is sharply critical of the classification of
"normal sadness" as a DSM depressive disorder. The problem is that the DSM

does not take into account contextual factors that may account for the existence of various symptoms.

An important addition to the sociological literature since the first edition of the *Handbook* is Corey Keyes' distinction between languishing and flourishing, a conceptualization that includes continuum measures of both mental health and mental disorder. This is a model that moves sociologists well beyond debates over the validity of diagnostic criteria and to a useful approach to understanding the mental health profile of a given community or population. In Chapter 7, Corey Keyes and Barret Michalec provide a philosophical and theoretical justification for a "dual continua" model, as well as a description of research contributing to the ongoing dichotomy versus continuum debate.

If mental health and illness are indeed in some part produced by social context, one would expect some degree of cultural variability in the prevalence and symptomatology of behaviors and disorders characterized as mental illness or insanity. Although some forms of mental illness are universal (i.e., all cultures characterize some forms of behavior as mental illness or disorder), there is much disagreement over whether specific categories of mental illness are indeed universal (Patel & Winston, 1994). Recent research has challenged the widely held belief that rates of schizophrenia are culturally invariant (Morgan, McKenzie, & Fearon, 2008). The question of the universality or culturally specific nature of mental illness presents a test of the medical etiology model that asserts that the source of mental illness is biological, neurological, biochemical, or genetic. If the cause of mental illness is organic in nature, then such behaviors should be invariant across different cultures. However, evidence demonstrates that the social environment influences both the course and the outcome of psychosis (Morgan et al., 2008). Harriet Lefley in Chapter 8 examines the role of cultural context in defining mental health and mental illness and provides an overview of cross-cultural research. She describes the relationship between culture and the experience of stress, as well as a variety of culture-bound syndromes. Services and interventions to treat mental health problems follow from beliefs about the etiology of these problems, and Chapter 8 introduces students to diverse mental health systems.

As this overview should indicate, much more research needs to be done to extend our understanding of mental health and illness before we will be able to resolve the ongoing debates on the existence and causes of mental illnesses, much less that on suitable treatments. We do know that social conditions and environments are critical in understanding not only what constitutes a mental health problem but also the course and outcome of mental health problems. However, the mechanisms by which the social environment influences mental health have not been thoroughly studied (Morgan et al., 2008). Part II will direct more focused attention to the social context of stress, coping, and mental health and illness.

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An Overview of Sociological Perspectives on the Definitions, Causes, and Responses to Mental Health and Illness

Allan V. Horwitz

Sociological approaches regard mental health and illness as aspects of social circumstances. One type of sociological study examines the sorts of social conditions, such as negative life events, ongoing stressful circumstances, demanding social roles, levels of social support, and the strength of cultural systems of meaning, that affect levels of mental health and illness. Another type of study focuses on how social and cultural influences shape the definitions of and responses to mental health problems. These kinds of studies show how key recent trends – including the medicalization of a growing number of conditions, the increased use of prescription drugs to deal with mental health problems, and a greater willingness to identify emotional suffering as mental illnesses that require professional help – are transforming how modern societies deal with psychological problems. The sociological study of mental health and illness is both distinct from and complementary to more individualistic psychological and biological approaches to these topics. What would be an example of the difference between how a sociologist and a psychiatrist might view someone's mental health problems? What are the advantages and disadvantages of each approach? Some people think that using prescription drugs for mental health problems is a helpful way of responding to suffering, whereas others emphasize the dangers involved in growing rates of prescription drug use. Which view do you think is best supported?

Introduction

Why do some people seem to be always cheerful, whereas others are often sad? Most of us believe that our moods have to do with aspects of our personalities that make us more or less depressed, anxious, or exuberant. Others think that temperament results from biological factors such as our genes and neurochemicals. People usually also assume that engaging in therapies that change their states of mind is the natural response to mental problems. These treatments might involve psychotherapies that modify the way people view the world or drugs that alter their brain chemistry. Thus, typical approaches to the nature, causes, and cures of various states of mind emphasize individual traits, temperaments, and behaviors.

Sociological approaches to psychological well-being are fundamentally different. Unlike psychological and biological perspectives that look at personal qualities and brain characteristics, sociologists focus on the impact of social

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circumstances on mental health and illness. The distinctive emphasis of sociological approaches is on how processes such as life events, social conditions, social roles, social structures, and cultural systems of meaning affect states of mind. Social perspectives assume that different individuals who are in the same circumstances will have similar levels of mental health and illness. That is, what determines how good or bad people feel does not just depend on their own personalities or brains but also on the sorts of social conditions they face. These conditions vary tremendously across different social groups, societies, and historical eras.

Some important social influences involve how many stressful life events people confront (Holmes & Rahe, 1967). These events include such circumstances as getting divorced, losing a valued job, having a serious automobile accident, receiving a diagnosis of a serious physical illness, or having a close relative die. Especially serious stressors such as being a victim of a violent crime, natural disaster, military combat, or physical or sexual abuse during childhood are particularly powerful causes of adverse mental health outcomes (Dohrenwend, 2000). The more frequently such events occur and the more serious they are, the worse any person's mental health is likely to be.

Other social causes of poor mental health lie in persistent living conditions that do not appear at a particular time and then go away but are instead rooted in ongoing circumstances (Turner, Wheaton, & Lloyd, 1995). For example, people who live in social environments that feature high rates of poverty, neighborhood instability, crime rates, dilapidated housing, and broken families are likely to have high rates of psychological distress (Ross, 2000). Other enduring stressful circumstances are troubled marriages, oppressive working conditions, or unreasonable parents. Sociological perspectives predict that especially taxing living conditions, roles, and relationships are related to low levels of psychological well-being, over and above the qualities of the particular individuals who must deal with these situations.

Many sociologists study how social conditions affect levels of mental health. Others look at the social reactions to mental health problems. Some factors that lead people to respond to emotional difficulties in different ways involve social characteristics such as gender, ethnicity, age, and education. These traits make people more or less likely to define themselves as having some kind of psychological problem and to seek help once they have made these definitions. Other aspects involved in the reaction to mental troubles concern varying cultural values toward mental health and illness. *Culture* refers to socially shared systems of beliefs, values, and meanings. It encompasses, among many other factors, people's ethnic heritage, religious beliefs, and political principles and the tastes of their age peers. For example, responses to emotional problems in cultures that stigmatize the mentally ill will be very different from those in cultures that highly value professional treatment for these problems. Additional factors that shape the social response to psychological problems involve the accessibility, quality, type, and amount of health care that is available to people.

Sociological approaches share the idea that mental health and illness are not just qualities of individuals but also stem from various aspects of social circumstances. What social groups people belong to, what historical periods and societies they live in, and what cultural values they hold profoundly shape how people feel about themselves, how likely they are to become mentally ill, the kinds of problems they are likely to develop, what they do if they develop mental difficulties, and the kinds of help that are available to them.

What Outcomes Do Sociologists Study?

Most sociologists examine levels of mental health and illness in the natural settings where people live. Sociological research is more likely to take place in schools, family settings, neighborhoods, and communities than in clinical settings where people seek professional mental health care. Therefore, the kinds of mental health conditions that sociologists study are usually different from those examined by other disciplines such as psychiatry or clinical psychology.

Most research that takes place in clinical settings examines particular types of mental illnesses, such as schizophrenia, bipolar disorder, major depression, and obsessive-compulsive disorder. These conditions have symptoms that are believed to indicate the presence of some underlying disease entity and that are different from the symptoms of other diseases. Diagnoses of particular mental disorders are usually dichotomous; that is, someone either has or does not have an anxiety, depressive, substance abuse, attention-deficit, or eating disorder.

In contrast, most sociologists use outcomes that reflect more generalized conditions of distress, not particular types of mental illnesses. For example, the Center for Epidemiologic Studies–Depression scale (CES-D) is the most common instrument that sociologists use to measure mental health (Radloff, 1977). It consists of 20 questions that ask people how they have felt over the past week; for example, "I enjoyed life," "My sleep was restless," or "I felt lonely." The scale is not comparable to any specific mental illness, but instead contains items relating to more global states of well-being. Many of its items (e.g., "I felt hopeful about the future," "I felt I was just as good as other people") tap general attitudes about life or personal qualities such as self-esteem. The CES-D and other scales that sociologists typically use measure global qualities of well-being rather than discrete psychiatric conditions.

The broad nature of these outcomes means that they provide good measures of general states of psychological well-being or ill health, but are not comparable to psychiatric diagnoses and do not measure mental illness. In addition, scales such as the CES-D are limited because they only measure qualities of mental health that reflect internal types of suffering. They do not contain items that ask about other possible indicators of mental health such as heavy drinking or drug taking, violent and aggressive behavior, or severe symptoms such as delusions and hallucinations.

To adequately capture the full range of psychological symptoms, these scales need
to be supplemented by a broader range of mental health outcomes.

Sociologists who examine the social response to emotional problems must use
different sorts of outcomes from those used in studies that examine the social
determinants of well-being and distress. They do not try to explain how symptoms
develop in the first place; rather, they ask how, once symptoms emerge, sufferers
themselves and others around them define, classify, and respond to experiences
of mental distress. Some of these studies ask people about their attitudes toward
mental illness and see how their answers reflect who does or does not enter mental
health treatment. Others use official statistics that are collected about how many
people with psychological problems enter different kinds of facilities such as gen-
eral medical practices, outpatient psychiatric care, or inpatient mental hospitals.
They then view how rates of various kinds of treatment vary across groups with
divergent social characteristics such as race, socioeconomic circumstances, and
immigrant status. Another type of study compares treatment rates across large
geographic areas such as different states, regions of the country, or different coun-
tries to see how general aspects of the mental health system influence patterns of
seeking professional help. For example, far more people with mild psychological
problems are likely to enter professional mental health treatment in the United
States than in other countries (Katz et al., 1997).

Sociological studies, then, are less likely than clinical studies to use small groups
of people who are found in mental health treatment. Instead, they use general
scales that measure mental health in samples of community members. They also
rely on statistics about rates of mental health care across a wide range of facilities
and regions. These studies are good at showing broad social variations in the
development of and response to psychological problems, although they are unable
to say much about individual experiences of mental health and illness.

What Social Factors Relate to Mental Health and Illness?

Sociological studies reveal that psychological well-being and distress are related
to several general aspects of social life: the degree of social integration, inequality,
and meaningful collective belief systems. In addition, the periods of time when
individuals were born and the countries they live in are associated with their states
of mental health. The influence of these factors means that levels of mental health
diverge considerably among people in different social locations.

Social Integration

Emile Durkheim's study, *Suicide*, is generally regarded as the first explicitly
sociological study of mental health (Durkheim 1897/1951). Durkheim compared
the rates of suicide in different European countries at the end of the 19th century

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and correlated them with various social characteristics of the populations of these countries. His central theme was that the nature of the connections people have with each other and with social institutions shapes the likelihood that they will commit suicide. He found that people with strong social ties were least likely to commit suicide. Conversely, people who were socially isolated were more likely to commit what Durkheim called "egoistic" suicides. For example, married people had lower suicide rates than the unmarried, and married people with children were especially unlikely to commit suicide. Likewise, members of religions such as Catholicism that shared common practices and beliefs committed a smaller number of suicides than members of Protestant groups that permitted more free inquiry among individuals. In addition, Durkheim discovered that few people commit suicide during wars and revolutions because of the intensity of shared collective experiences in such periods.

Durkheim also found that a second aspect of social integration, which he termed "social regulation," affected levels of what he named "anomic" suicide. Groups that could successfully control individual expectations for constant happiness and great achievement had lower suicide rates than groups in which most people think that limitless possibilities for success exist. This was because people who always expect to be happy and believe that there are no limits on what they can achieve are bound to suffer serious disappointments. Periods of sudden economic prosperity, for example, can lead people to think they can satisfy all of their desires. Such unrealistic beliefs lead some people to become frustrated and consequently to commit suicide. Durkheim concluded that optimal mental health was found in societies that had strong systems of social integration that connected people to each other and of social regulation that moderated their desires.

Contemporary studies in the sociology of mental health confirm the importance of social integration as a fundamental cause of well-being. For example, people with more frequent contacts with family, friends, and neighbors and who are involved with voluntary organizations such as churches, civic organizations, and clubs report better mental health than those who are more isolated (Thoits & Hewitt, 2001). Married people have less distress than unmarried people because they have more supportive relationships and more ties to community institutions (Umberson & Williams, 1999). Marriage also serves the regulative functions of promoting conformity to social norms, more conventional lifestyles, and lower levels of all kinds of deviance (Umberson, 1987). Conversely, the loss of social attachments that may be caused by the death of intimates, divorce, and the breakup of romantic attachments is associated with growing levels of distress. Socially integrated people not only are less likely to develop mental health problems but they are also better able to cope with stressful experiences that they face (e.g., House, Landis, & Umberson, 1988; Turner, 1999). This is because they receive more social support, help, and sympathy from the members of their social networks.