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Part I

Theoretical Perspectives on Mental Health and Illness

The eight chapters in Part I provide a thorough review of the main theoretical perspectives that have guided sociological scholarship on mental health and illness. In Chapter 1 Peggy Thoits introduces the reader to stress theory, structural strain theory, and labeling theory. After reviewing the main components of each theory, Thoits describes the implications of each approach for treating mental illness.

Chapter 2 addresses the core issue of how mental distress is defined and how mental health disorders are classified. Owen Whooley and Bianca Ruiz-Negrón review sociological research on classification and point to the role of social and political factors in shaping diagnostic practice. Chapter 2 also introduces the critical sociological concept of medicalization.

Jason Schnittker in Chapter 3 advances Whooley and Ruiz-Negrón's arguments by examining the assessment of mental illness, comparing categorical and dimensional approaches, and introducing the network approach to symptoms. Chapter 4 advances the arguments made in Chapter 3.

A central sociological finding has been that socioeconomic status is inversely related to mental disorder, however it is defined or assessed. Those in higher status positions have lower levels of mental distress and disorder. Chapter 4 provides a historical, theoretical, and empirical background for understanding the relationship of social class to mental distress. Two theoretical frameworks (social causation versus social selection) are described and assessed. William Eaton and Carles Muntaner point to the complexity of empirical analysis utilizing classic sociological research on social epidemiology. Chapter 4 also introduces a life course perspective, pointing to the multitude of factors (education, occupation, psychological attributes) that influence the relationship of social class to mental health.

Chapter 5 provides a comprehensive overview of sociological theories of labeling and stigma, with the majority of the approaches having been developed and refined by the authors themselves. Bruce Link and Jo Phelan describe the origins of labeling theory and how it has been modified with decades of research. Key concepts related to stigma, including symbolic interaction stigma, stigma resistance, and structural stigma are clearly described and illustrated. Link and Phelan also address the difficulties in the assessment of stigma.

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Chapter 6 extends the concept of stigma resistance, and introduces the reader to identity theory. Kristen Marcussen considers how stigma and stigma resistance can shape how individuals experience mental illness, and the role of identity in recovery. Opposed to the ideal of recovery is the reality of suicide, and Chapter 7 provides a sociological framework for understanding the relationship of suicide to key aspects of the social structure. Drawing from the classic insights on stigma provided by Emile Durkheim, Jason Manning contrasts the sociological to biological and psychological approaches to suicide.

Part I ends with Chapter 8, a review of the major theories that address the pathways to mental health care and utilization. In addition to classic theories (Parson's sick role) and contemporary theories (the Network Episode Model), Bernice Pescosolido and Elizabeth Anderson provide new theoretical models which target social networks and health inequalities. Taken together, these eight chapters provide the reader with a comprehensive understanding of sociological theory and research on mental health and illness.

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1 Sociological Approaches to Mental Illness

PEGGY A. THOITS

The sociological approach focuses on the factors external to the individual – the environmental or social context – and views mental illness as a breakdown in the face of overwhelming environmental stress. Thoits overviews three dominant theories, or models, and describes their basic assumptions, advantages and limitations, and implications for treating or preventing mental illness. Stress theory is based upon evidence that accumulations of social stressors can precipitate mental health problems. However, the relationship between stress exposure and psychiatric symptoms is not strong because individuals have extensive coping resources to help them handle stress. Researchers focus on the relationship between stress and coping mechanisms, and also on the unequal distribution of chronic strains and a variety of coping resources in the population. One reason that higher rates of mental disorder and psychological distress are found in lower status, disadvantaged groups is that these groups are more likely to be exposed to stressors and less likely to have important coping resources. In order to treat mental illness, one needs to eliminate or reduce stressors, teach the individual different coping resources, and bolster their personal resources. Structural strain theory locates the origins of disorder and distress in the broader organization of society. Mental illness may be an adaptive response to structural strain, or to one's degree of integration into society. For example, during periods of high unemployment, admissions to treatment for psychosis increase, while periods of economic upturn are associated with lower rates of hospitalization. A structural condition, hard economic times, caused people to experience major

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stressors and provoked mental illness. Society's organization places some groups at a social or economic disadvantage. In order to prevent or reduce mental illness, society must be restructured in a fairly major way; for example, creating a guaranteed minimum income to eliminate the strains of unemployment. A third approach to mental illness is labeling, or societal reaction, theory. The logic behind labeling theory is that people who are labeled as mentally ill, and who are treated as mentally ill, become mentally ill. Symptoms of mental illness are viewed as violations of the normative order whereby individuals break taken-for-granted rules about how one should think, feel, and behave. The way to reduce or prevent mental illness is to change those norms that define what is normal versus abnormal behavior. While this may seem idealistic, labeling theory has been very important in alerting us to the consequences of labeling and institutionalization. The reader should think about the various ways the three sociological approaches to mental illness complement each other, as well as how they contribute to the biological and psychological understandings of mental disorder.

1.1 Introduction

The three general approaches to mental illness that are discussed in this volume can be broadly characterized by their underlying metaphors. The biological or medical approach views mental illness as if it were a disease or physical defect in the brain or body. The psychological approach treats it as if it were a sickness or abnormality in the mind or psyche (i.e., the soul). And the sociological approach views mental illness as if it were a breakdown in the face of overwhelming environmental demands. The key distinction between the biological and psychological perspectives on the one hand and the sociological perspective on the other is the location of the primary cause of mental illness. From the biological and psychological approaches, the determinants of mental illness are internal – "in" the person (in the physical body or in the person's mind). From a sociological approach, the cause is external – in the environment or in the person's social situation. Although obviously oversimplifying the differences among the three approaches, this characterization helps clarify the focus of this chapter – on the social, rather than biological and psychological, origins of mental illness.

Within the social approach, there are three dominant theories of mental illness etiology (where *etiology* means the study of the origins or causes of a disease). These are stress theory, structural strain theory, and labeling theory. Each theory's basic concepts and assumptions, theoretical limitations and advantages, and implications for treating or preventing mental illness are described in this chapter.

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1.2 Stress Theory

Hans Selye, a medical researcher, introduced the term "stress" into scientific discourse in the mid 1930s. By stress or "stressors" he meant anything that puts wear and tear on the body, usually unpleasant environmental stimuli. Because he experimented with laboratory animals, stressors meant such conditions as extreme heat or cold, overcrowded cages, and repeated electric shocks. Selye (1956) showed that prolonged or repeated exposure to noxious environmental stress eventually depleted the body's physical defenses and that laboratory animals almost inevitably succumbed to disease or infection when that happened.

Because laboratory studies convincingly established a relationship in animals between prolonged or repeated stress exposure and disease, speculation turned to the effects of stress on human beings. Researchers began to focus on social stressors, in particular, on major life events (Holmes & Rahe, 1967). Thomas Holmes and Richard Rahe defined life events as major changes in people's lives that require extensive behavioral readjustments. They hypothesized that having to readjust one's behavior substantially or repeatedly could overtax one's ability to cope or adapt, thus leaving one more vulnerable to physical illness, injury, or even death. To test this hypothesis, Holmes and Rahe first went through the medical records of Navy personnel, recording the most common life events that preceded Navy men's doctor visits and hospitalizations, abstracting a list of forty-three major life events that included death of a loved one, divorce, job loss, birth of a child, beginning or ending school, and so forth. Next they asked groups of people to judge (independently of one another) how much behavioral readjustment was required by each event on their list, on a scale from 0 to 100. They averaged judges' scores for each event to measure the amount of life change that each event involved. The result of this work was a simple life events checklist, giving social researchers an easy way to assess whether exposure to social stressors (major life events) would have health consequences for human beings. A random sample of survey respondents could go through the checklist and mark all events that they had experienced in a given period of time (say, during the past six months or the past year), and they could respond to questions that measured their current physical or mental health.

Many surveys like this were conducted, and the findings were clear: the more life events that individuals experienced in, say, a year, and the higher their life change scores, the more likely they were to be presently in ill health (Cohen, Janicki-Deverts, & Miller, 2007; Cooper, 2005; Dougall & Baum, 2012). Literally hundreds of studies (with expanded life event lists) showed a significant relationship between the amount of life change that people experienced and the occurrence of illness, including heart attacks, strokes, ulcers, asthma attacks, flu, and even the common cold (Cohen, 1996). Exciting to mental health researchers were studies that also found that major life changes were directly and significantly associated with symptoms of anxiety, depression, schizophrenia, and general states of psychological distress (Thoits, 1983, 1995, 2010). An accumulation of social stressors in a short period of time, then, could precipitate mental health problems.

Soon after the discovery of these basic relationships, investigators' attention turned to the types of stressor that were most likely to precede the onset of mental illness.[1] Researchers found

[1] It is important to understand that laypersons often use the term "stress" ambiguously, and this ambiguity must be avoided for clarity. "Stress" can refer to the cause of psychological problems (e.g., negative events) or it can describe

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that when life events were subdivided into culturally desirable (positive) and culturally undesirable (negative) types, undesirable events were more strongly predictive of psychological problems than desirable events were (Brown & Harris, 1978; Ross & Mirowsky, 1979). George Brown and Tirril Harris's pathbreaking sociological study of life events and depression offered compelling evidence.

Brown and Harris (1978) randomly selected about 460 women in Camberwell, an area of South London, for in-depth interviews. Through the interviews they established whether any of the women met the clinical criteria for major depression and if so, the month when the depression had begun. About 15 percent of the women in the Camberwell community sample were found to be clinically depressed at the time of the study. A central part of the interview canvassed all of the major life changes and chronic difficulties the women had experienced over the past year or up to the point of depression onset. Importantly, this was not a simple checklist type of assessment but instead an in-depth, probing discussion of the various changes and difficulties the women had been through in the past year.

Brown and Harris defined "severe" life events as negative events that most people would agree are serious long-term threats to personal well-being. They found that severe events predicted the onset of major depression much better than "nonsevere" events (minor negative events and positive events). These researchers discovered, too, that ongoing difficulties (also called "chronic strains") were almost as important as severe negative events in predicting depression. Examples of ongoing difficulties are living in overcrowded conditions, having persistent family arguments, and having too little money to buy necessary food, clothes, or medicine. When severe events and long-term difficulties were considered together, Brown and Harris found that 89 percent of the depressed women had experienced one or both types of stressors in the past nine months while only 30 percent of the nondepressed women had had events, difficulties, or both during the same time period. So Brown and Harris concluded that acute negative events and chronic strains put individuals at much higher risk of developing major depression. Not all changes, positive and negative, but only negative changes in people's lives are causes of psychological problems.

Subsequent studies showed that negative events and chronic strains also predicted the onset of schizophrenia, anxiety attacks, and milder states of depression and generalized psychological distress (Thoits, 1983, 1995, 2010; Turner & Lloyd, 1999; Turner, Wheaton, & Lloyd, 1995; Wheaton et al., 2013). In other words, acute events and chronic strains (the latter defined as environmental demands which require repeated or daily readjustments in behavior over long periods of time) were causally implicated in a variety of forms of mental illness, from mild to severe.[2] Research also pinpointed

one's subjective emotional experience (e.g., "I'm so stressed out!"). To avoid this ambiguity, researchers usually restrict the term "stress" or "stressor" to refer to major life events and chronic strains – the environmental causes of emotional problems. The phrases "stress reaction" or "stress response" are used to distinguish emotional consequences from their environmental causes. Psychological distress and mental disorder are the stress reactions of primary concern here, and major life events and chronic strains are the causal factors.

[2] Researchers have also studied "hassles" as types of stressor that may cause psychological problems (Kanner et al., 1981). Hassles are mini-events, small changes requiring immediate readjustment in one's behavior. Examples include getting stuck in traffic, having unexpected company arrive, and losing one's wallet. Although there is evidence supporting a relationship between mounting hassles and emotional upset, hassles scales are problematic because they mix in major life events, strains, and possible psychological symptoms with true mini-events (Dohrenwend et al., 1984). Hence, the findings of hassles studies are not discussed here.

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more specific types of events that preceded psychological disorder: events that were unexpected, uncontrollable, clustered in time, traumatic, or unresolved problems. You will learn more about these various types of stressors and their effects in Part II of this volume.

As findings on the psychological effects of stress mounted, researchers turned their attention to a related problem: although there clearly is a relationship between exposure to stressors and the subsequent development of psychological problems, the relationship was not strong. The strength of a relationship is measured as a correlation. A correlation between two variables ranges in value from 0.00 (no relationship at all) to 1.0 (a perfect positive relationship – i.e., for each negative event experienced there is an accompanying unit increase in psychological symptoms). Most studies reported correlations around 0.30, which is only a modest association between stressors and symptoms of psychological distress or disorder. In other words, many people who experience severe stressors do not become disturbed while others who experience few or minor stressors do. Why was this?

According to elaborations of stress theory (Lazarus & Folkman, 1984; Pearlin, 1989; Pearlin & Bierman, 2013; Pearlin et al., 1981), a modest correlation between stress exposure and symptoms occurs because many individuals have strong coping resources and use effective coping strategies when handling stressful demands, thus buffering the negative psychological impacts of those stressors.

"Coping resources" refer to social and personal assets from which people draw when dealing with stressors (Pearlin & Schooler, 1978). Social support is a key social asset, consisting of emotional, informational, or practical assistance from other people. Support can be received from other people or simply perceived to be available if needed. Studies consistently showed that individuals who perceive they have support available when they need it are in better mental health and also suffer less psychological distress when they encounter major life stressors – a stress-buffering effect (Turner & Turner, 2013). The other broad kind of coping resources, personal assets, included high self-esteem and a sense of control or mastery over life. People who have high self-esteem and those who strongly believe that they are in control of their lives are more likely to engage in active problem-solving efforts to meet stressful demands (Folkman, 1984; Pearlin et al., 1981; Taylor & Aspinwall, 1996; Taylor & Stanton, 2007), to use a variety of coping strategies flexibly (Mattlin, Wethington, & Kessler, 1990; Pearlin & Schooler, 1978; Folkman & Moskowitz, 2004), and to be in better mental health (Ross & Mirowsky, 2013).

Coping strategies also buffer the effects of stress exposure. Coping is defined as behavioral or cognitive attempts to manage situational demands that one perceives as taxing or exceeding one's ability to adapt (Lazarus & Folkman, 1984). Coping strategies are typically subdivided into two types: problem-focused and emotion-focused. Problem-focused coping efforts are directed at changing or eliminating the stressful demands themselves. Emotion-focused strategies are attempts to alter one's emotional reactions to stressful demands, for example, through distraction, avoidance, or venting. Pearlin and Schooler (1978) added what might be called meaning-focused coping (see also Park, 2010). Meaning-focused coping consists of efforts to alter one's perceptions of stressful demands so that they seem less threatening or overwhelming (e.g., reinterpreting the situation as less threatening, looking on the bright side of things). Meaning-focused strategies can reduce one's emotional reactions to stressful demands (so some

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investigators view these strategies as emotion-focused in nature) but they do not change the demands themselves.

Research shows that in most stressful episodes, people use both problem-focused and emotion-focused strategies, including meaning-focused ones (Folkman & Lazarus, 1980; Taylor & Aspinwall, 1996). For example, when facing a major exam, students may attack the problem directly by studying an hour or two each day and practicing answers to possible test questions. They may control their anxiety by telling themselves that they understand more of the material than other students do, reminding themselves that they have done well before on these kinds of test, and perhaps engaging in strenuous exercise for tension release. Despite the fact that most people use a variety of coping strategies when facing stressors, difficulties that can be changed or controlled tend to elicit more problem-focused efforts, while intractable problems tend to generate more strategies that are emotion-focused or meaning-focused (Park 2010; Taylor & Aspinwall 1996). Strategies that involve escape or avoidance are consistently associated with poorer mental health (Folkman & Moskowitz, 2004).

Coping resources and coping strategies help to explain why the relationship between stress exposure and psychological problems is far from perfect – in essence, people are able to protect themselves from being overwhelmed by stressful demands. Conversely, some people are poorly equipped to protect themselves because they lack social support or a sense of control over their lives or have not acquired effective coping strategies.

Of crucial importance to sociologists of mental health is the finding that life events and chronic strains, as well as social support, self-esteem, and a sense of mastery, are unequally distributed in the population, leaving some groups of people (e.g., women, the elderly, the very young, the unmarried, those of low socioeconomic status) more likely to experience certain stressors *and* more vulnerable to the effects of stressors in general (Turner & Lloyd,1999; Turner & Marino, 1994; Turner & Roszell, 1994; Turner & Turner, 2013; Turner, Wheaton, & Lloyd, 1995). Further, lower-status, disadvantaged group members may be especially likely to undergo what Leonard Pearlin (1989) called the process of "stress proliferation." This happens when a primary stressor, such as job loss, generates secondary stressors, such as trouble paying bills, marital conflict, housing eviction, loss of health insurance, and so forth; essentially, a cascade of further negative events and chronic strains follow from an initiating stressor. For people without many resources to stem the tide of misfortune, stressors propagate and accumulate, putting them at increasingly greater risk of distress and disorder (Aneshensel, 2015; Pearlin, Aneshensel, & LeBlanc, 1997).

These key findings point very clearly to the important role that social factors can play in the etiology of psychological distress and mental disorder. Moreover, they suggest an explanation for the higher rates of distress and disorder found in lower-status, disadvantaged groups (see Part II of this volume) – these are the groups that are more likely to be exposed to stressors, to experience stress proliferation, and to have fewer important coping resources.

The advantages of stress theory are several. First, the theory focuses on aspects of the individual's current social situation that the biological and psychological approaches tend to deemphasize or ignore as etiologically important. Second, it helps to explain why psychological distress and disorder occur more frequently in lower-status groups than in higher-status groups, patterns that the biological and psychological perspectives have difficulty in explaining. Third, stress theory

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allows for more direct empirical testing than biological and psychological approaches do. Conventional survey and interview methods allow researchers to measure key concepts (e.g., stressors, personal coping resources, social support) and to test relationships among them explicitly, unlike biological studies where researchers must infer an association between, for example, serotonin uptake and major depression from the effects of specific drugs. Similarly, psychological researchers often assume a relationship exists between childhood traumatic experiences and mental illness when psychotherapy uncovers such past experiences. Finally, as you will see in Part II, there is substantial empirical evidence that supports the stress explanation of psychological disturbance. Despite these advantages, however, the limitations of the theory should not be ignored.

One key limitation is that stress theory cannot explain why this person and not that one became mentally ill; in other words, it cannot explain individual cases of psychological disorder. Stress theory is better suited to explaining group differences in psychological problems – for example, why lower- and working-class persons are more likely to have a mental disorder in their lifetimes than middle- and upper-class people are, or why individuals without social support are more vulnerable to stressors than people who have support. Second, stress theory is "nonspecific" with respect to outcomes; that is, it does not explain why some groups are more prone to certain disorders while other groups develop different disorders (for example, why women become depressed and anxious and why men more often abuse drugs and alcohol). Finally, the theory does not apply equally well to all types of mental disorder. Stress theory is most applicable to mood-related disorders and to adjustment disorders; people clearly become depressed or anxious in response to stressors or have trouble adjusting to them. It is more difficult to explain the etiology of psychoses with stress theory; by their very seriousness and complexity, psychoses seem to require additional explanatory factors, such as genetic predisposition, imbalances of certain chemicals in the brain, or faulty childhood socialization. In short, to explain psychoses, and perhaps to explain most clinical disorders adequately, one might have to employ diathesis-stress theory (Rosenthal, 1970). The idea is that disorder is the result of a "diathesis" (technically, a constitutional or genetic weakness, but more generally a particular vulnerability factor) *combined with* exposure to stress. Diathesis-stress theory suggests that stress experience alone is not sufficient to cause mental disorder; instead, stressors may cause disorder when they occur along with other vulnerability factors in a person's body, psyche, or circumstances.

The treatment implications of stress theory are straightforward and quite different from biological and psychological approaches. To treat or prevent mental illness one needs to change the person's situation (eliminating or reducing stressors), teach the person different coping strategies (allowing better management of stressors), or bolster their personal and social resources (e.g., by increasing available social support, raising self-esteem, or reinforcing a stronger sense of mastery). Because directly changing people's life situations can be intrusive and/or expensive, interventions aimed at people's actual sources of stress are less frequently attempted than efforts aimed at their coping strategies or their personal and social resources. Well-crafted experiments (e.g., Caplan, Vinokur, & Price, 1997; Scott-Sheldon et al., 2008; van der Klink et al., 2001) show quite clearly that interventions to change people's coping strategies or to bolster their social support do, in fact, reduce their emotional reactions in response to major life events (e.g., HIV/AIDS, work stress, major surgery, divorce, unemployment). Thus, stress theory offers real promise for devising preventive mental health interventions.

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1.3 Structural Strain Theory

"Structural strain theory" is an umbrella term that covers a number of more specific sociological hypotheses about mental illness etiology. In contrast to stress theory, which focuses on the causal effects of negative events and chronic strains in people's social lives, structural strain theory locates the origins of distress and disorder in the broader organization of society in which some social groups are disadvantaged compared to others. Merton's (1968) "anomie theory of deviance" provides a useful example of a structural strain theory.

Merton's anomie theory attempts to explain the occurrence of deviant behavior in general (including criminal, addictive, and rebellious behaviors), not just mental illness. Merton argued that American culture emphasizes success and wealth as important values; Americans are taught to desire and strive for economic success almost above all other goals. American society also views educational attainment as one key means, if not *the* key means, to economic success. Merton assumed that most people view the educational system as a legitimate route to the widely shared goal of financial success. Unfortunately, large segments of society also perceive (correctly) that their means to success are systematically blocked. Poor persons and minority group members more often live in neighborhoods with inadequate school facilities and poorly trained teachers; they lack the preparation, encouragement, and financial assistance to pursue higher education; and they experience class-based and race-based discrimination in schools and in the labor force, which defeats efforts to succeed while following legitimate paths.

Merton uses the term "anomie" to describe the gap between cultural goals (desires for financial success) and the structural means to those goals (access to adequate education and employment). He argues that people who experience anomie adapt to that dilemma in one of several possible ways: by changing their goals, pursuing alternative means, or both. Merton described five adaptive responses, which are displayed in Table 1.1.

"Conformists" are people who continue to adhere to culturally shared goals and to pursue conventional means to those goals, despite awareness that these efforts are unlikely to pay off. "Ritualists" are those who reduce their aspirations (give up the possibility of ever achieving success) yet continue to behave in socially acceptable ways (they perhaps finish high school and work steadily at a low-pay, low-prestige job). Neither conformist nor ritualist responses create major social problems. However, the remaining three adaptive responses are generally viewed

Table 1.1 Merton's anomie theory of deviance: responses to anomie.

	Adherence to cultural goal of economic success	Seek legitimate means to success
Conformity	+	+
Ritualism	–	+
Innovation	+	–
Retreatism	–	–
Rebellion	+/–	+/–

+ = acceptance
– = rejection
+/– = rejection and substitution of new goals and means

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