

Part I

Theoretical Perspectives on Mental Health and Illness

Introduction to Part I

Teresa L. Scheid and Eric R. Wright

Mental health and mental disorder represent two different areas of theory, research, and policy implications, reflecting our common tendency to dichotomize healthy and sick, normal and abnormal, sane and insane. David Mechanic (2006) argues that the term “mental health” has no clear or consistent meaning, and in terms of the sociological literature, this 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. While most of us fall short of 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, illnesses, or disorders are also not so straightforward. Following Horwitz (2002b), “mental diseases” reflect underlying internal dysfunctions that have universal features (i.e. 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 arise from stressful social conditions (such as depression, anxiety, eating disorders). Cultural processes shape the symptoms associated with mental disorders, and it is important to distinguish mental disorders from normal reactions to social stressors. Horwitz (2002b) uses the terminology of “mental illness” to refer to those conditions which a particular group has defined as a mental illness (and often point to behaviors that are deemed deviant, for example homosexuality in previous psychiatric classifications). For simplicity, we will use the term mental health problem or disorder in this introduction – but students should keep in mind the implications of using the term mental illness. In Chapter 1, Horwitz argues that sociological approaches regard mental health and mental health problems as aspects of social circumstances. He provides a very thorough overview of how various social conditions affect levels of mental health and mental health problems, and in turn how social contexts shape

the definition as well as the response to mental health problems. Chapter 1 develops a framework for a sociological understanding of mental disorder and mental health problems and also directs the reader to other chapters in the volume that illustrate Horwitz's arguments.

In assessing mental disorders 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 by identifying who is susceptible to particular conditions it 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. However, in order to arrive at estimates of how many people suffer from mental disorders or illnesses, there needs to be some way to determine who has a mental disorder and who does not. This is not as simple as one might expect. In Chapter 2, Jerome C. Wakefield and Mark F. Schmitz provide an overview of how researchers have measured and assessed mental disorders and illness. They emphasize that there have been two different approaches to differentiating between mental health and illness. First, there are theories that view 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. Second, there are theories that conceptualize health and illness as opposites, a categorical dichotomy, where a person is labeled as either sick or well based on culturally defined criteria.

Medical science and psychiatry are organized around elaborate, formal systems of diagnoses, or an array of dichotomous indicators of whether or not a person has one or more particular illnesses or disorders. These are carefully detailed in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (DSM), which is used in clinical practice as well as in a great deal of epidemiological research to determine whether or not someone has a mental disorder – and to some extent the severity of illness – in the general population. Currently in version 5, the DSM provides the classification system by which clinicians and researchers can identify (i.e., diagnose) distinct mental disorders. These disorders are assumed to be discrete (i.e., they do not overlap with on another). The classification of mental disorders is referred to as psychiatric nosology and has always been controversial. Sociologists have demonstrated that the DSM overstates the amount of mental disorder, viewing all evidence of psychiatric symptoms, regardless of their cause, as evidence of

pathology (Horwitz, 2002b). An extended illustration of this process is provided in Horwitz and Wakefield's 2007 book (*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, which may account for the existence of various symptoms of so-called depression. Wakefield and Schmitz in Chapter 2 provide this argument, as well as an extended critique of the DSM.

Revisions to the most recent version of the DSM were especially contentious, and the roots of this controversy and the ensuing political battles over DSM-5 are described by Allan Frances (2013) in his book *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*. A key critique has been that with each revision of the DSM, more and more conditions are defined as "abnormal," a process Frances describes as diagnostic inflation. Diagnostic inflation is driven in part by medicalization and in part by the pharmaceutical industry, which profits from the medicalization of ordinary, or normal, conditions. Medicalization occurs when non-medical problems (such as sadness) come to be defined in medical terms (such as major depressive disorder), and there is increased reliance on psychiatric medications for more and more "conditions" (such as anxiety). Allan Horwitz in Chapter 1 and Owen Whooley in Chapter 3 both address the medicalization of mental health problems.

In Chapter 3, Owen Whooley reviews sociological research on psychiatric nosology, describing how social and political factors have influenced the classification of mental disorders. He argues that the major problem with medicalization is that it "decontextualizes" mental distress – a point also made by Horwitz in Chapter 1 and Wakefield and Schmitz in Chapter 2. Whooley also describes the development of DSM-5, and the sources of the controversies and critiques of DSM-5. In response to the criticism of DSM-5, the National Institute of Mental Health proposed a new classification system to be used by researchers (as opposed to clinicians, who will continue to use DSM-5 in their diagnosis of patients). The Research Domain Criteria (RDoC) system is based upon the assumption that mental distress is primarily a problem residing in the brain, and research should focus on genetics and neuroscience. Consequently, the RDoC represents an increased medicalization as well as further decontextualization of mental disorder and distress.

Other researchers prefer to utilize 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 the severity and frequency along a continuum (Mirowsky & Ross, 2002). The psychosocial model of mental illness (dominant until the 1970s) was based upon a continuum definition of mental health and illness where 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. In Chapter 4, Corey L. M. Keyes offers a sociological approach to a continuum model

of mental health, which ranges from languishing to flourishing. The “Complete State Paradigm” includes continuum measures of both mental health and mental disorder. This is a model which moves sociologists well beyond debates over the validity of diagnostic criteria and to a more useful approach to understanding the mental health profile of a given community or population. Keyes then provides data on the prevalence of languishing and flourishing.

What are the research implications of using categorical versus dimensional measures of mental disorder and distress? Jason Schnittker takes up this question in Chapter 5. Schnittker is critical of the assumption made by psychiatric classification systems that mental disorders constitute discrete, distinct categories and what he refers to as taxonicity. He describes an alternative, a network approach, which focuses on the relationships between symptoms. Rather than focusing on the causes of mental disorders, the network approach sees the relations between symptoms as a system of causes. Research can also examine the pathways between symptoms, and how some symptoms can cause other symptoms. Consequently, the network approach offers a way to examine comorbidities between mental health problems. Chapter 5 is a critical chapter for future researchers.

Behind debates over how to measure mental health disorders and distress lies a more fundamental question: What is the cause of such mental health problems? Etiology refers to theories about the causes of illness, yet the etiology of mental illness or disorder is not yet understood or known, despite the widespread belief in a biological, genetic, or neurological model. Frances (2013, p. 18) argues there is no way to decide who is normal, nor any useful definition of mental disorder. Frances (2013, p. 21) argues that even schizophrenia, a mental disorder that is widely assumed to have some genetic component, “is a construct, not a myth, not a disease. It is a description of a particular set of psychiatric problems, not an explanation of their cause.” A focus on a “set of psychiatric problems” is consistent with the network approach described by Schnittker in Chapter 5.

Since the 1980s, the medical model of mental disorder has been dominant, where mental illness is conceptualized as a disease and increasing reliance is placed upon neuroscience to diagnose mental disorders, and medication to provide treatment while psychotherapy is deemphasized. The biological approach to mental illness and the evidence from neuroscience is described in Chapter 6 by Sharon Schwartz and Cheryl Corcoran; they also address the role sociologists can play in future research. Cooperation between sociology and psychiatry faces fundamental obstacles as a result of diverging theoretical perspectives and research agendas (Coopers, 1991). Most critical is the issue posed by Mirowsky and Ross (1989a) – do mental disorders represent disease entities, or are mental disorders related to social contexts that affect rates of generalized distress, abnormal 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 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 disorder as opposed to mental illness. Peggy A. Thoits in Chapter 7 provides a comprehensive analysis of the various sociological approaches to mental health and illness, describing stress theory, structural strain theory, and labeling theory (labeling theory is described more fully in Chapter 19 in Part III).

If mental health and illness (or disorder) are indeed, in some part, produced by social context, one would expect some degree of cultural variability in the prevalence and symptomology of behaviors and disorders characterized as mental illness or insanity. While some form of mental illness is 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 challenges 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 which 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 will be invariant across different cultures. However, evidence demonstrates that the social environment influences both the course and the outcome of psychosis (Morgan, McKenzie, & Fearon, 2008). Harriet P. 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 on the prevalence of mental health problems. The relationship between culture and the experience of stress is described, as are 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 the reader to diverse mental health systems.

As this overview should indicate, there is much more research that 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 on suitable treatments. We do know that social conditions and environments are critical not only in understanding what constitutes a mental health problem, but in the course and outcome of mental health problems as well. However, the mechanisms through which the social environment influences mental health have not been thoroughly studied (Morgan, McKenzie, & Fearon, 2008). Part II will direct more focused attention to the social context of mental health and illness.