CHAPTER 1

Introduction to the Sociology of Mental Illness

> "It takes two to make a psychotic—an actor and an observer."
>
> —Morris Rosenberg (1984)

Learning Objectives

After reading this chapter, students will be able to:

1. Paraphrase sociology's approach to studying mental health and mental illness.
2. Explain the variations and difficulties in defining mental illness.
3. Interpret how sociology defines mental illness.
4. List the social forces that impact individual mental health.
5. Demonstrate how the tension between psychosocial needs and the social environment has resulted in a new search for meaning in everyday life.

Introduction

We have all used words like "crazy," "insane," and "nutty" to describe a person or incident that struck us as unusual, bizarre, or undesirable. If an otherwise "sane" friend, for example, were about to buy an automobile that you saw as a heap and a really bad idea, you might say, "You're crazy if you buy that car!" to emphasize that your friend is about to do something without your approval or, in your opinion, in bad judgment. Typically, we use such language to identify things that do not match our expectations of what should happen or fit our sense of good judgment. We also use these words to label people with psychological and psychiatric problems.

Terms describing physical illnesses, however, do not carry a similar dual purpose. For instance, we would never say, "You would have to be sick with a cold to buy that car." This simple linguistic exercise is quite telling. It may suggest that we

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diminish mental illness, or it could mean that anything we disagree with or is different from our own expectations is, in fact, "crazy." Using the same words to describe someone with mental illness and making a bad life decision or behaving in a way we think is improper may give clues to how we understand what mental illness is. It may also represent a hierarchy in perceptions of illness where physical medical conditions are viewed more sympathetically, and psychiatric and psychological problems are suspect.

All societies have a vocabulary for defining and responding to mental illness and emotional distress; however, there is no cross-cultural agreement on what mental illness actually is. Nor is there agreement within societies. Regardless of how people define mental illness, they all believe that they have *the* truth and *the* explanation of mental problems. Even though these "truths" and explanations change greatly over time and that no one approach has any more supportive evidence than another, we tend to have passionate beliefs about the origins of mental illness and who is mentally ill.

The main point here is that we do not yet have a definitive causal explanation for psychological distress and mental illness, and that means there is no exact definition of mental illness that everyone agrees on. Different socio-cultural groups and academic disciplines, including sociology, have strong opinions about mental illness, and conversations about what constitutes psychological problems are broad and sometimes even a bit contentious. We will begin our foray into this debate by exploring sociology's approach to the study of mental illness.

Sociology and the Study of Mental Illness

The sociological approach to understanding psychological well-being differs from those offered by psychologists and psychiatrists. Rather than focusing on individual pathologies and coping abilities, sociologists working in health and medicine are generally interested in asking two different types of questions. First, sociologists are curious about how society understands and responds to health problems. These studies, known as the **sociology of medicine** (Straus 1957), help us understand how the medical system works and how we define what is health and what is ill-health. Sociologists asking these questions may explore how a society labels behavior as mental illness and the behavior of health care providers. Here the focus is health and medicine as a social institution and the social and psychological consequences and experiences of someone being labeled mentally ill.

Sociologists working within this approach might ask questions regarding the ways a therapist interacts with patients from a different culture or ethnic group, or they may investigate governmental policies affecting funding of community mental health services or the ethics of certain types of psychotherapies. Other sociologists may ask what is it like to be a psychiatric patient? It is often the case that receiving mental health services places people in a different and stigmatized social category; that is, they are treated differently than before they received those services. How do people respond to this? Do they accept or resist this new identity? Do people labeled mentally ill believe they are mentally ill?

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A second type of sociological studies focuses on **sociology in medicine** (Straus 1957), which is employing sociological theory and method to help solve the puzzle of who is more or less likely to experience mental health problems and what may cause social patterns in mental illness. Examples here are studies on the relationship between poverty and mental health or the impact of economic development on mental health in a poor, pre-industrial country.

A major focus of sociology *in* medicine is **health disparities**, which refers to differences in the distribution of preventable ill health and opportunities for good health that are caused by social inequality. Does everyone have the same likelihood of experiencing a psychological problem or getting treatment? While many health problems occur randomly in a population, many others, especially psychological distress, happen in predictable social patterns. Psychological problems are often related to structural inequalities, which can cause persistent hardships and limit access to health promoting resources. The impact of chronic deprivation, exposure to discrimination, and the lack of mental health services are central to explaining why some groups are more likely to experience a higher burden of the psychological problems found in a population.

Using the sociology *of* medicine and sociology *in* medicine as a guide, this book centers on two themes. We will look at how mental health is defined and how societies decide which behavior is "normal" and which is "abnormal." Sociology's perspective envisions mental illness not as a purely individual pathology, but as a consequence of social forces that produce conditions that create psychological distress. Our focus on health disparities will lead us to discuss the distribution of mental health in the United States. Who is more exposed to the risk factors of mental distress? Who is more likely to develop psychological problems? How do wealth, poverty, and discrimination contribute to the likelihood of distress?

What Is Mental Illness?

What do we mean when we say someone is mentally ill or has a psychological disorder? It's not always clear. Mental illness is one of the most difficult terms to define in the social and behavioral sciences. While definitions and conceptual schemes have been around for decades, none is completely convincing as a single definition of mental illness. Many are broad in scope, while others are narrow (Goldman and Grob 2006), and all reflect the culture in which they were written (Watson 2012).

However, none of these definitions is particularly wrong, nor do they necessarily prevent us from understanding mental illness despite their seemingly contradictory nature. As sociologist Howard B. Kaplan (1975) wrote many years ago, while there may be no true definition of mental illness, each attempt to define it has its own value in terms of explaining psychological problems.

It is not difficult to see the great variation in definitions. In many Asian cultures, for example, mental illness is defined quite differently than in the West. In China, for example, depressive symptoms are often perceived as physical complaints rather than as emotional or cognitive (Lee et al. 2007). Tsai and colleagues (2007) contend that Chinese people typically somaticize their emotional experiences because they use

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more somatic and social words than Americans do. To somaticize means to express psychological issues as physical complaints. Because Chinese culture views mind and body as intertwined and essentially indistinguishable, they cannot be separated (Xur 2016). If a problem exists in one area of the body, the other is equally affected.

In the West, definitions of mental illness are more formal and usually treat mind and body separately. These definitions vary, however, in orientation and focus.

Some definitions prefer to focus on mental wellness, rather than illness. The World Health Organization (WHO) (2004), for example, defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Such characterizations, however, do not account for conditions in which well-being, as described in the definition, does not exist. It may not be true that the failure of individuals' ability to reach self-fulfillment or cope with stressors is the consequence of their lack of emotional fortitude or feeble physical constitution. If someone does not achieve these life accomplishments because of life circumstances, social barriers, or personal choice, is that person necessarily mentally ill?

Definitions of mental illness, on the other hand, typically attempt to specify deviations from what is thought to be usual human psychological well-being and functioning, but agreement on what this looks like is hard to reach. Schinnar and associates (1990) uncovered 17 dissimilar definitions in the scholarly literature between 1980 and 1990 alone.

The National Institute of Mental Health defines mental disorder in terms of functional impairment. In this view, mental illness is a cognitive, behavioral, or emotional condition that limits a person's major life activities (2022).

The ***Diagnostic and Statistical Manual*** (DSM) is a handbook published by the American Psychiatric Association (APA) that lists and describes all the psychiatric and psychological disorders recognized by the APA. It is a guide that clinicians use to diagnose individuals, and its current edition is known as the DSM-V. The APA's definition, however, is fluid. Prior to the DSM-III, the APA defined mental illnesses as existing along a continuum of problems in cognition, emotion, and behavior. Psychological complaints were the result of environmental conditions that produced difficult life problems. As Mayes and Horwitz (2005: 249) stated, until the 1980s, symptoms were "reflections of broad underlying dynamic conditions."

In the 1980s, however, a radical shift occurred in how formal psychiatry perceived disorders. Mental illnesses were reconfigured to be categorical diagnoses akin to nonpsychiatric, medical-surgery illness. Although there were no new studies to substantiate the paradigm shift, it reflected tendencies to standardized patients' complaints and to make problems amenable to insurance companies' needs to bureaucratize the process of covering mental health treatment.

There were relatively few "illnesses" in the first two editions of the DSM. Beginning with DSM-III, the number of diagnoses greatly expanded, and the definition of mental illness changed accordingly. In the DSM-IV

> *A mental disorder is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated*

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with present distress or disability or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

But just a few years later, the APA created a quite different definition in its DSM-V, clearly making the claim that mental illness has biological origins:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

The change was resisted by many outside psychiatry. As psychologist Eric Maisel wrote in *Psychology Today* (2013), "the very idea that you can radically change the definition of something without anything in the real world changing and with no new increases in knowledge or understanding is remarkable."

The point here is that defining mental illness is daunting. Some definitions treat mental disorders as categorical and discrete medical entities, while others avoid medical language altogether. One school of psychiatry, the so-called anti-psychiatry movement, along with some sociologists, denies the existence of mental illness, stating that mental illness is merely the creation of the psychiatric industry to justify its treatments and theories. Most sociologists, however, generally agree that odd, distressing, or even bizarre behavior exists, but the argument is over how to understand and define them (Eaton 2001).

To add to the confusion, we can certainly observe behavior that is strange and unusual, but the people eliciting the behavior do not necessarily see themselves as mentally ill. Their friends and family may not think of them as mentally ill either (Aneshensel et al. 2013).

The problem, as Horwitz (2002) states, is that we notice behavior that is different from what is expected, which means behavior that is considered normal. Social values and behavioral norms constitute the basis of "normal" by specifying the standards of right and wrong, good and bad, desirable, and undesirable. Norms and values, of course, are subjective and vary by social group and place in time.

Therefore, how mental illness is defined in society is a target of sociological investigation. Indeed, many sociologists working in this area focus on how mental health and illness are defined, exploring patterns of which social groups promote a particular definition and how people understand behaviors, thoughts, and emotions contradict what they consider "normal."

Outside sociology, definitions of mental illness typically fall into three categories: (1) a statistical deviation from behavioral norms; (2) any condition treated by a mental health professional; or (3) conditions associated with biological disadvantages (Houts 2001). Each of these definitions, however, has significant problems that limit their utility in helping us understand mental health.

First, let's look at mental illness as statistical deviation from the norm. As Houts states, this approach has a great deal of appeal because it is relatively simple and straightforward: a statistical range defines normality, and those falling out of that

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range are identified as abnormal. In other words, what people usually do is considered normal and therefore healthy.

There are significant limitations in defining mental illness this way. First, what is the standard for tolerated deviation? At what point does the behavior change from normal to abnormal? Such thinking implies that normalcy is a matter of degree, but the exact point that a behavior crosses a statistical line to become abnormal is arbitrary. A second problem with this perspective is that there is no reason to believe that all statistical variations are bad. From your high school days, you may remember classmates who excelled academically and some who performed well under the class average. Both sets of students were deviating from the statistical norm set by all students in the class. Most likely only one group, the poor performers, was judged to be a problem. But what about those who are below the norm in one area yet excel in another? Perhaps the academically underperforming student is a brilliant musician. Plus, there are times when we all feel "not normal," not our usual selves. Most people, at some point in time, have intervals in their lives when they would meet the criteria of a disorder. Statistics and bell curves are of little use in these situations.

What is normal and abnormal, therefore, implies a judgment based on the values of the groups rendering the judgments (see Box 1.1 for an example). In societies with cultural diversity, people in minority groups may be considered "crazy" because their cultural practices deviate from the dominant cultural standards of the society. When conceptualized in this way, mental health is often equated with conformity.

Box 1.1 The Teachings of Don Juan

In his famous book, *The Teachings of Don Juan* (1968), anthropologist Carlos Castañeda discusses his relationship with Don Juan, a priest in a traditional culture of northern Mexico. Though not necessarily portrayed accurately by Castañeda, the teachings of the traditional Yaqui religion center on the practice of ingesting hallucinogenic plants such as peyote and jimsonweed. Once a person can tolerate the chemicals in these plants, the practitioner then learns to experience the mind-altering effects of the plant in religious and spiritual terms. When Don Juan consumed one of the hallucinogenic plants in a ritual, he believed he literally transformed into a crow and could fly and "see" an otherwise hidden view of the spiritual world that heightened his insights into understanding himself and human nature. Traditional western cultural standards, on the other hand, would lead many to label the priest as a drug addict or psychotic. In Yaqui culture, however, Don Juan was held in high esteem, and the visions he had while under the influence of peyote or jimsonweed were treated as having great spiritual value. During his apprenticeship, Carlos consumed jimsonweed and had the experience of flying, but he challenged Don Juan about his actual physical metamorphosis into a bird and flying above the ground. Carlos persisted, asking: "if I had tied myself to a rock with a heavy chain" would I have flown? Don Juan, increasingly frustrated with Carlos' questions, replied, "The trouble with you is that you understand things in only one way" (1968: 147–8). Don Juan insisted that Carlos "flew" and that the difference in flying physically or metaphysically does not matter. What is important is the experience. The point of the fictionalized story is that reality and truth are relative to one's socio-cultural sensibilities and interpretations.

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The second way mental illness is commonly defined considers anything treated by mental health professionals to be a disorder. Mental illness in this case is based on what defines people called "patients" (Houts 2001). The problem with this definition is that it lacks objectivity and consistency. Decisions to seek care can be voluntary or involuntary, arbitrary, and costly. Those who enter psychological or psychiatric care, as we shall see later, are largely a self-selecting group, a process rife with bias. Clients, furthermore, bring a wide array of problems to mental health professionals, so virtually anything can become a disorder. Spouses who are upset because their partner had an affair or a person has developed chronic anxiety because they recently received a serious medical diagnosis, for example, are "mentally ill" the same as someone suffering from chronic, debilitating schizophrenia. This definition of mental illness lacks sufficient objective diagnostic criteria and puts nonparallel types of conditions and problems into one category of mental illness.

Third-party payment plans reinforce this approach. For a practitioner or patient to file for insurance to cover therapy sessions and treatments, the insurance company requires a diagnosis recognized in the DSM and represented by a code number. Because insurance companies will not pay without a code, the practitioner must enter a diagnosis. The patient now "has" a psychiatric disorder.

One surgeon-general's report (New Freedom Commission 2003: 4–5) exemplifies this category of definition:

> *Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination therefore) associated with distress and/or impaired functioning.*

Third, mental illness has been defined as an outcome of biological disadvantage. In recent times, many studies on mental illness have searched for damaged physiologic functions that lead to distressing thoughts, emotions, and behaviors. These theories and definitions have gained interest because they are assumed to be value-free, organic, and objective and contend that people with psychological and psychiatric problems have a discrete naturalistic disadvantage that hinders their ability to engage in normal activities.

This approach, known as the **medical model**, remains the dominant approach in psychiatry. Comparable to nonpsychiatric medicine in form, the medical model organizes psychological complaints into discrete categories. These clusters of symptoms are then classified as disorders that are presumed to have a physical cause. Another way to say it is that psychological problems are symptoms of an underlying bio-medical disorder. For example, depressive symptoms such as prolonged sadness, feelings of hopelessness and guilt, and thoughts of suicide are the expression or consequence of brain chemistry or perhaps genetic inheritance. Once a diagnosis is made, a disorder is treated with drugs prescribed by a physician.

This definition falls short of providing the definitive explanation of mental illness. First, as Houts suggests, any time human activity is compared to a model of "normalcy," the question of what constitutes normalcy arises. As in the case of the Yaqui, as shown in Box 1.1, "normal" may be a function of social and cultural

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conformity, being in the right social group at the right time, or judgments of what is right and wrong. Despite the organic approach's claims to scientific objectivity, saying that deviation from normalcy is a "disease" that causes deficiencies in functioning efficiency is a value-laden position.

Second, there is the problem of lack of evidence. Despite considerable public and professional opinion, there is little solid, science-based evidence to connect biological dysfunctions with mental illness in a direct and causal way. While there is some indication that biology may play a part in some cases, biological correlates of mental illness are not necessarily predictive. In addition, the range of conditions that fall into the category of mental illness is quite broad, making a singular explanation of all of them unlikely.

A Sociological Definition of Mental Disorder

Sociology provides a fourth way to approach mental illness. In attempting to avoid the pitfalls of the other definitions discussed, many sociologists classify mental illness as a type of deviant behavior in which people behave in ways social standards define as inappropriate (Horwitz and Scheid 1999). Horwitz' definition of mental disorder, for example, states that psychological disorders are "internal dysfunctions" that social standards label as inappropriate (2002: 35). These dysfunctions are emotions, thoughts, motivations, and behavior that are not as they should be, according to social conventional norms and values. As Horwitz says, only those internal dysfunctions that are also seen as deviant are considered mental disorder.

Rather than studying intra-psychic or physical pathology, these sociologists focus on the social processes that create social expectations, define who or what violates those rules, and under which conditions deviance from those rules is labeled illness. Symptoms of distress, such as feelings of depression and anxiety, and nonconforming behaviors, in this view, are interactive and connected to a social environment that promotes them, not indicators that something biological is "broken."

In the sociological approach, mental illness is an **ascribed status**, which implies that it is a status bestowed by a social agent, such as a mental health professional, on individuals. This social agent has reassigned the meaning of the behavior from simple rule-breaking to illness. But which dysfunctions are labeled an illness varies from one psychiatrist or psychologist to another. Many, and perhaps most, mental health professionals do not rush to give a diagnosis to everyone who enters their doors; others, however, claim to the ability to identify a disorder in virtually everyone within a few minutes of an assessment interview.

From this perspective, mental illness is a complex, multidimensional concept. Individuals can be ascribed mental illness status unwillingly via the judgment of others who are distressed or threatened by a person's behavior, thoughts, or emotions. Or individuals can accept the label because their internal feelings of discomfort lead them to believe something is wrong. The second category includes distressed individuals who subjectively see themselves as ill or disordered, or at least make themselves available for diagnosis and treatment. The sufferer may contend that the deviance occurs as abnormal or undesirable behavior, thoughts, or

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emotions, and there is usually agreement from a mental health care worker to validate the mental illness status.

Despite the attractiveness of this approach, it, too, has certain limitations. First is the problem separating causality from association. Establishing direct causal links in the social sciences is a risky exercise. Because human behavior is neither linear nor mechanical, many socio-cultural, individual, and biological factors impact what people do and how they think. Sociological research often reveals patterns of association, two or more things happening together in a meaningful, logical way. Does this mean one factor directly acts upon the other forcing a change in its previous state? For example, we know that people with higher levels of educational achievement have better overall mental health compared to people with lower levels of schooling. Mental health is not directly taught in school, and psychological therapy is not a requirement for a college degree. Educational success, however, often translates into economic success, which in turn makes life more comfortable and less stressful. Education also facilitates self-awareness and the ability for insight. Despite this pattern, it is not a strict one-to-one relationship. Many people with very high academic attainment have severe mental health problems, while many with low levels of education are free from psychological distress. Nonetheless, we can say with certainty that education and mental health are associated because people with higher levels of educational achievement have a far lower probability of mental illness than people with lower levels of education. But is it a causal relationship in the same sense that natural phenomena are causally connected? Finding the answer is not easy.

Sociology, as a science, is based on the calculation of probabilities rather than linear determinism. We look for the chances of a particular outcome given the presence of certain predicting or causal conditions. We usually cannot say if or when a particular event will happen, but we can calculate the likelihood of the event occurring. Because of the complexities of human behavior, we devise theories to explain the relationships that we observe. Theories argue for causal relationships, but typically do so in terms of explaining patterns of probabilities rather than specific, linear causal effects.

Second, the definition ignores the role biology may play in explaining differences in human behavior. There is no question that biological factors account for some individual differences between people. If you've been around newborns and young babies, you probably observed that they already have a temperamental style about them. In just the first few weeks and months of life, infants begin to act in ways unique to their own character. Some are quiet and calm from the beginning, while others are more vocal and active. As you follow the children into adulthood, you may begin to notice consistency in those styles that were first seen in infancy. Biology likely accounts for these styles of temperament that form a baseline or foundation of personality by providing basic predispositions of taste and certain talents. But do inheritable factors account for mental illness? The answer right now is that we don't know. There are measurable characteristics in brain and neurological functioning among some categories of mental illness that differ from "nonill" groups; however, these biological markers of disorder are not consistent, and it is not known which came first—the so-called ill behavior or the biological condition. Biologists are now

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exploring ways that stimuli from the social environment affect brain structure and function. This research demonstrates the value of biologists and sociologists working together.

A third criticism of this approach is the discipline's traditional reliance on the study of behavior. Much psychological distress is experienced as disturbing thoughts and emotions, but the sufferer can cope behaviorally. Many can put on such strong public faces that emotional and cognitive unease are masked from others. Intra-personal dynamics are not necessarily expressed in outward, observable behavior, but can nonetheless be very distressing. In response to this criticism, however, we could argue that distressing thoughts and emotions constitute deviance because of the way they are presented in clinical settings. Usually someone with such intra-personal stress will frame upsetting emotions or thoughts as not normal or wrong, as if they were deviant behavior. These "abnormalities" are just as real to sufferers as externalized behavior.

Social Construction of Psychiatric Illness

One of the main problems in creating definitions of mental illness has been establishing validity; that is, does the definition match the actual phenomenon being defined? It would be a mistake to presume that all people who are labeled mentally ill believe they are ill. They may neither feel that their behavior is an indication of a mental problem nor seek treatment voluntarily. Still, some authority in society such as parents, teachers, health care workers, or the police, has defined that person as psychiatrically disordered partly because they have control over what is and what is not termed "sick" behavior and because they have the social power to enforce the label on the person. An interesting example from the former Soviet Union comes to mind. The leaders and ideologues of the Soviet Union contended that the soviet socialist system was the idyllic form of social organization. The ideals of this society proclaimed that all people in the Union of Soviet Socialist Republics (USSR) lived equally, received what they needed to flourish as human beings, and were free from the wrongs committed by all other types of society. One would have to be crazy to find fault in this system, and that is what Soviet psychiatry believed! Many people who were critical of the Soviet state were labeled insane and sent to psychiatric facilities to "re-cover." The only symptoms these patients had were political opinions.

In this sense, we can say that mental illness is socially constructed. Social interactions shape the concepts of mental health and illness and set the boundaries of what is and what is not a disorder. The categories of disorders are determined more by social rules than biologic conditions (Busfield 2000). The **social construction** view of psychiatric disorders also contributes to our understanding of the biases inherent in the various concepts and definitions in health and illness (Brown 1995). A social constructionist perspective furthers a richer understanding of cultural differences in mental illness patterns. Socio-cultural systems produce diagnoses and treatments unique to their particular norms and values. What mental illness is and how symptoms are perceived may dramatically differ from culture to another.

While it is not uncommon for different cultures to recognize clusters of symptoms as co-occurring, western and nonwestern cultures often offer quite different explanations for the same set of symptoms. The symptoms of what we call

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depression, for example, are recognized similarly across cultural lines, yet where westerners might view depression as an illness or maladaptive response to something in the social environment, others, such as the Jiri people in Nepal, are likely to claim that persons with those symptoms are suffering because they ate the wrong foods or are possessed by a demon (Tausig et al. 2000). The Jiris' explanations are just as valid to them as bio-psycho-social explanations are real to many westerners. Differences in cultural history and knowledge patterns accounts for the difference. The social construction concept, therefore, gives us insight into the social processes that provide definitions of behavior as illness.

While social construction provides insights into how we define certain behaviors, thoughts, and emotions, this perspective does not explicate the sources of distress. As stated earlier, many people indeed feel psychological distress and emotional pain and relate to them as a problem in carrying out their everyday lives or just trying to enjoy their lives. In the absence of definitive theories of causality, in this book we will assume an interactive approach to studying mental illness. We will approach mental disorder sociologically, yet also make note of neurological and other biological mechanisms when they apply. The direction many contemporary biologists and sociologists are taking is to show that social conditions may trigger certain biological responses and lead to structural changes in the body. The basic question then is: How do the social environment, psychological well-being, and biology interact with each other?

I'm sure by now the age-old "nature versus nurture" debate has come to mind. Scholars and laypersons alike have argued forever over whether personality is made (nurture) or in-born (nature). The argument has been between two discrete, nonoverlapping choices: either human personality was totally inherited and was established at birth or was the sum of the individual's contact with the world. Now we know that this debate is moot, a throwback to old ways of thinking, and factually in error. The processes of nature and nurture are reciprocal not discrete and oppositional (Eisenberg 1995). The key question today is how the social environment and biology intersect. In short, it is not "nature versus nurture," but "nature *and* nurture."

Let's look at a couple of examples that show the advantages of integrating biology and sociology. When acquired immunodeficiency syndrome (AIDS) was first identified as a discrete disease, many theories to account for its origins were posed. Eventually, the human immunodeficiency virus (HIV) was discovered and linked to AIDS as the direct causal mechanism. If a person had the virus, its actions would eventually destroy the immune system and lead to AIDS. After several years had passed, researchers noticed social patterns in the distribution of HIV/AIDS. Higher AIDS rates were associated with certain social problems such as poverty, intravenous drug use, and sex work. Poor countries in Africa, for example, began to develop such high rates of AIDS that the disease threatened their demographic and economic stability. With this knowledge, questions of what caused AIDS began to change. Yes, the virus is the mechanical trigger of biological AIDS, but the psychosocial conditions of deprivation, exclusion, and alienation play a causal role too. To have the full picture of AIDS means more than understanding the biochemistry of the virus that causes AIDS; it also requires understanding the nonrandom, social climate that organizes the way HIV is transmitted.

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Lead poisoning in children is another situation in which the value of integrating biological and social factors is evident. The element lead is considered a cumulative toxicant, which means that its toxicity accumulates over time. It affects several organs, particularly the brain, and is stored in teeth and bones. Children are especially harmed by lead because they absorb the element four to five times as much as adults and are more likely to ingest it. Mass lead poisonings resulting in many deaths have occurred in western Africa due to lead-contaminated soil, dust from battery recycling, and mining.

Lead poisonings are not relegated to developing countries; in 2017 over 500,000 US children are believed to have toxic concentrations of lead in their blood (Mayans 2019). As an important side note, there is no safe level of lead in the body.

After lead was banned from gasoline and paints in the 1970s, ingesting the element has become less common; however, there is reason to believe it has increased recently. Today, about 70 percent of exposure in children comes from old paint and house dust comprised of old paint and lead-contaminated soil. The remaining 30 percent comes from lead-based water pipes used for drinking water and imported goods including candies, pottery, and herbal remedies. Most of the toxicity found in children originates from old houses in disrepair. The lead in the paint has a sweet taste and the dust gets on children's fingers, which often go into their mouths.

Exposure to lead is linked to several negative mental health outcomes such as phobias, depression, mania, and schizophrenia, in addition to developmental disorders and behavioral problems.

The distribution of lead contamination is not equally distributed in the US population. Poor families and children are more likely to live in old houses that are not properly maintained or updated. These houses may still have lead paint and pipes. Researchers in Wisconsin (Christensen et al. 2019), found that children enrolled in Medicaid were three times the risk of lead poisoning than children not registered with Medicaid. In addition, because lead is more easily absorbed when other nutrients such as calcium and iron are deficient, malnourished children are more susceptible to the effects of lead. Since these health outcomes have connections to social interactions and a person's location in society, poverty can be considered a causal factor in lead poisoning, and consequently mental illness.

Social Forces and Mental Illness

How society influences mental health is another major area of interest of sociologists of mental health.

In his famous book, *The Sociological Imagination*, C. Wright Mills asked readers to look beyond their individual life spaces to think about and analyze their lives in the context of broader society. The secret to understanding much of what happens to us, according to Mills, is connecting our lives to what is happening in the larger society, a process known as the **sociological imagination**. For example, Mills recognized that divorce feels like a personal trouble because it is often accompanied by emotions such sadness, guilt, grief, fear, and shame. If only one couple divorced

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each year, then it would indeed be a problem, likely a psychological one, in one or both partners of the couple that made it hard for them to live together. However, roughly half of all marriages in the United States end in divorce, and that means it is a little harder to argue that half of married people have a psychological problem unique to themselves. Instead, Mills proposed that a better explanation is that social conditions have made it challenging for people to live together as a married couple. Indeed, in the last 50 years expectations of marriage have changed from a focus on following social expectations of tradition-based status and a gendered division of labor, to expectations of emotional fulfillment, which are much tougher to maintain over time. Also, increased educational and economic opportunities for women have made marriage less critical for women's identity and life satisfaction. Though it may have psychological outcomes, divorce is actually a social issue, a problem that is rooted in social, not psychological, dynamics.

While some sociologists who work in the mental health and illness area focus on how society defines mental illness, others explore patterns of psychological distress in society. Many decades ago, we learned that psychological problems do not occur randomly in society, and studies consistently report predictable patterns in the distribution of distress. These patterns mean that something sociological is happening and that sociological theories and research can offer insight into understanding them.

Sociologists use the term **social forces** to describe external patterns of behavior, emotions, and thinking typical to a society or group that coerce or direct individuals to act in certain ways. Outside the scope of individual people, social forces take the form of social structures and cultural norms and values that influence action and thinking. Social forces are the activities of the social environment that act upon individuals and to which individuals must respond. That response can be conscious or unconscious. The patterned activities of the education system, a group's morality code, and a family's household rules are among the countless examples of social forces that constantly envelope and shape us.

Social forces exert strong influence in the onset, maintenance, and diagnosing of mental illness. In this regard, the sociological approach to the study of mental illness in a population, in general, asks two types of questions. First, what is the role of social forces in the etiology or cause of mental disorder? And second, how do social forces influence who is at higher or lower risk of psychological problems in a given population? We will address these questions as we go along, but let's look at a couple of ideas now that will "set the table" for discussions in later chapters.

Social forces are those social things that act upon individuals, and many have been empirically linked to the incidence and prevalence of mental illness in populations. Many sociologists propose that mental distress is largely a consequence of social forces that conflict with individuals' psychosocial needs and interfere with psychological development and well-being. The volumes of data on this question seem to support this proposition, and recent changes in social patterns may explain observations that rates of mental illness are increasing (Nikelly 2001).

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Meaningful human associations and close satisfying relationships are essential for mental health and are barriers to psychological and psychiatric problems. Social integration, attachments to community, voluntary participation in civic and religious organizations have been shown to reduce anxiety (Bergeman and Wallace 1999). Research further indicates that improvement in the symptoms of severe and persistent mental illness and depression is facilitated largely by sufferers' enhanced social environment, active participation in the community, healthy living conditions, satisfying and meaningful employment, and the therapist's interpersonal style and personal characteristics that demonstrate warmth, hope, and acceptance (Nikelly 2001: 306).

Sociologists have identified three sets of broad social forces that include both antecedents to mental health problems and facilitators to recovery from them. These forces are culture, social structure, and the dynamics of social interaction.

Cultural Factors

Several social critics see contemporary culture as rife with chaotic and confusing references and changing in ways that make the development of psychological health difficult. The intrusion of rationality into everyday life, rampant materialism and consumerism, individual gratification, bureaucratized labor, surveillance technologies, and the commodification of sacred culture are examples of socio-cultural forces that have led individuals to withdraw from a broader social life and to a narrow social milieu. Individualism and the mentality of "if it feels good, do it," furthermore, sends signals that life primarily centers on individual gratification and that social obligations and responsibilities are in some way negotiable. A retreat from the social arena, which can be seen in studies that report we are less involved in voluntary groups, know less about politics, and know fewer of our neighbors than ever before, may offer protection from the perceived threatening world around us, but may have injurious consequences for psychological health.

Cultures socialize their individual members in their own particular way. The values of a culture provide the contextual basis upon which individuals interpret their experiences, objects, and social roles. Culture is like a perceptual lens that people use to understand the world around them, and the interpretations an individual makes of the social environment have considerable implications for mental health (Simon 2002).

Although self-actualization seems the ultimate humanistic achievement, it comes with a price. According to Christopher Lasch (1979), contemporary western culture has become a culture of narcissism. A culture that rewards individualism and self-gratification, de-values intrinsic meaning, stresses "feel good" activities and products, and equates success with individual achievement, force us to retreat from society and dive more deeply into ourselves. A culture organized around the glorification of the individual creates psychological distress because individuals also face demands to conform, follow rules, and care for others. Narcissism and social obligations, to a large extent, are antagonistic forces. One cannot fully attend to the responsibilities of raising a child, for example, when the needs of the parent compete with the needs of the child. These pressures toward isolation and individualism make

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forming attachments with others difficult. Consequently, unstable marriages and children who are disconnected from their parents are commonplace.

Retrenching to our individual private worlds, and being alienated from society, disenchanted with its institutions, and cynical about its intentions, hinders the ability to ground one's sense of self. Communities are often viewed with suspicion where once they were seen as the foundation of social life and the primary provider of identity. These cultural forces contribute to problems of depression and anxiety, and existential dilemmas over our places in society and our identities.

Social Structural Factors

Social structure, which refers to the organization of societies and groups and the ways wealth and social resources are distributed, has a dramatic impact on psychological health. As Carol Aneshensel (1992) argues, psychosocial stress is an inevitable consequence of social organization because social systems create tensions between the needs of individuals and needs of the system. Ordinary people often experience stressful, yet normal and usual social practices with distressing emotional consequences (Aneshensel 1992).

Society is organized in such a way that individuals and groups have different levels of vulnerability to the risks of mental health problems and varying access to the social resources needed to ameliorate those problems. The harmful effects of poverty on mental health in particular are among the most established hypotheses in all mental health studies (Perry 1996). Economic marginality (as well as comfort) infiltrates all aspects of personal and family life. Because money is tight and opportunities are poor, life can be very stressful for those on the economic edges. For those who are economically disadvantaged or in working class jobs, work is not only more repetitive and meaningless but also less reliable as well. Seasonal, temporary employment and greater vulnerability to layoffs are common among lower income strata. The small social networks, marital discord, and economic dependence that frequently evolve out of living on the economic fringe magnify the stress of having little income. Repeated exposure to these stressors through one's life increases dramatically one's risk for mental illness, depression, and anxiety (Wandersman and Nation 1998) and to behavioral expressions of these conditions such as crime, divorce, and alcoholism, among many others (Nikelly 2001).

In addition to social class, other arenas of social structure have influence on mental health. Family, work, and peer environments where conflict and tension are present and poorly handled promote chronic stress. Violent and abusive families, racism, sexism, and struggles for valuable necessities create stressful environments and have negative implications for psychological health.

These social forces impact individuals' psychological well-being in several ways. Mirowsky and Ross (2012) contend that seven social factors contribute to depression in the US population: economic hardship, education, gender, age, personal control, social support, and mistrust. Their research found that half of all symptoms of depression are caused by these social factors in large part because of inequities in wealth, power, and access to important resources.

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Most people who are exposed to stressful life events and conditions, however, fail to develop psychological and psychiatric problems (Kessler et al. 1985). Having a supportive social support system of friends, family, and community resources, few conflicts, and confrontations at work, can ameliorate and vary the severity of stress (Kessler et al. 1985; Pearlin 1989). Therefore, social structure can also provide barriers to and relief from psychological distress.

Interaction Factors

Concurrent with the socio-cultural forces and changes described previously are changes in the rules of personal, day-to-day interactions. Wheaton (2001) argues that recently measured increases in mental illness may reflect the consequence of social changes that have altered the basic meaning of social life at the interpersonal level.

The first of these social changes, according to Wheaton, is an increase in the rate of regulation of daily interaction. With the emergence of bureaucratization as the dominant form of social organization, regulation occurs at virtually all levels of social life. Many sociologists contend that the bureaucratic rationalization of social institutions has spread to the regulation of interpersonal relations. As traditional family functions are replaced by nonfamily agencies and as communication technologies have penetrated most aspects of personal activity, private life has become increasingly public. Daily living, which is often organized around informal social rules, is becoming formalized. One important example is Arlie Hochschild's (1985) concept of **emotional labor**, a term that describes the management of emotions to create a publicly observable facial and bodily display within the context of employment. The goal of emotional labor is to produce the proper state of mind in others. Whereas traditional physical labor in industrial societies required the coordination of mind and body, which is working with one's hands to run a machine, make a product, or perform some other manual task, emotional labor requires the coordination of mind and feelings. Emotional labor involves dividing the self, whereupon one must create a sense of "emotional elation" on the job despite one's true emotional condition at the time. Workers that Hochschild studied talked about the smiles *on* them, not *of* them. They were required to be cheerful continuously and to disguise fatigue and irritation. Hochschild concluded that emotional labor demands lead workers to feel detached from their own emotions in order to present the emotions demanded by their employers in interactions with customers. Cynicism and the depersonalization of others were also consequences of emotional labor. An important trend in contemporary society is to present a certain "public face" when interacting with others; this false presentation of self is often out of sync with the intentions of the social actor (Wheaton 2001).

A second social force having an impact on mental illness is the spread of mistrust of others, which has become a regular feature of daily interpersonal interaction (Wheaton 2001). The anxiety of managing risk, the erosion of tradition authority, and the increase in perception of interpersonal betrayal, have contributed to a culture of mistrust that has bred social disengagement and hostility. For an example, see Box 1.2.

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Box 1.2 Understanding Society through Self-Reflection

We become uncomfortably aware of the integration of this "culture" into our psyche when we travel to other countries where this sense of distrust is absent. I have personally experienced this intra-personal conflict during my travels in Nepal, an Asian country where I have conducted research and traveled for pleasure. As a rule, the people of Nepal are uncompromisingly friendly; many will do things for you out of feelings of simple kindness and an obligation to help others that we have learned not to expect in our own country. During my research work in the former Hindu Kingdom, I relied upon Nepalis for various services ranging from transportation to typing to translating. Many of these services were offered to me without charge. I contended that this activity was work, not pleasure, and that the assistants should be compensated. Still many refused payments, saying they were honored to help. The first few times this occurred, I admit, with guilty feelings, my first reaction to myself was, "OK, what is this guy going to want from me later? What's the catch?" I soon realized what was happening. I was exporting a conditioned cultural sense of distrust on to people who had no intention of conning or taking advantage of me. Their culture is based upon trust and social cooperation, especially to strangers. I felt ashamed, but it was a strong lesson in how cultural processes affect the mind and the meanings of action with other people.

Third, Wheaton describes an increase in the negative labeling of others in day-to-day life. Changes in the nature of interaction patterns have resulted in more rejection, condemnation, and avoidance of others. As Wheaton says, in interpersonal interaction people often judge others as guilty until proven innocent. These judgments are made without evidence to substantiate them. Interaction based on negative projections makes engaging with other people difficult and can lead to a retreat into the self.

The Search for Meaning

The tension between psychosocial needs and the social environment has generated a desperate revolution in the search for meaning. "Bottom-line" economic practices and scandals by political, religious, and economic leaders have undermined traditional institutions that historically provided emotional succor and guidance for personal living. Much of the meaning revolution is not fought in mainstream religious houses or the halls of science, but on the vanguard of alternative thought and practices. Eastern religions and disciplines, notably Buddhism and yoga, so-called new age health practices, and therapeutic pseudo-psychologies not concerned with data-based conclusions (George 2006), are the directions many people are turning in their quest for the meaning of life. Similarly fanatical and extremist religious and hate groups are increasingly attractive because they preach a message of acceptance, belongingness, and identity in an age of ambiguity. These unconventional

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strategies are mechanisms in which people are utilizing to fight the existential battles brought on by changes in the social order.

We also seem to know less about ourselves, so we seek the guidance of psychologists, psychiatrists, social workers, gurus, and psychics; we sleep on crystals, attend "harmonic convergences," and chant mantras in languages we don't understand, all in an attempt to "find ourselves" within a social environment that is perceived as disenchanting and aimless.

Society has created new challenges for people in recent years. Few resources, however, have been presented that are adequate to cope with them, and the result has been a rise of existential and psychological complaints. The social "ocean" in which we "fish" swim and live has radically changed. New social forces have altered the rules of behavior and the definitions of what is expected and what is sane.

Despite the strong evidence that social factors have a considerable impact on mental health, sociological explanations of mental health problems have largely been underestimated (Nikelly 2001) and biological explanations remain popular and receive the lion's share of funding and media attention.

In our culture of individualism, we assume individuals are responsible for their own lot in life. This ideology presumes that personality and personal achievement are the result of rational-based decision-making and that we choose, without influence from the outside world, everything we are and will become. If something is wrong, therefore, it is not due to the social environment, but to bad morals or choices or biological impairment. Biological reductionism fits extant cultural norms and values well.

Biological reductionism also fits current industrial demands. The pharmaceutical industry has invested heavily in this ideology and has developed medications that, as some critics say tongue-in-cheek, are looking for a disease to cure. Despite the lack support that drugs are a panacea for psychological problems, the research and development and marketing of these treatments continue not only to be a multibillion-dollar industry, but a power in reinforcing the ideology that mental illness is a function of physiopathology. From a sociological viewpoint, biological reductionism itself is a social force that influences thought and behavior and facilitates the creation of mental illness.

About the Quote

Rosenberg's twelve words sum up sociology's perspective on mental health and illness. In our discipline, mental well-being is viewed as the result of an interactive, or social, process that evolves over time amid a sea of dynamic interpersonal relationships, institutional practices, and ideologies about authority and power. His quote reminds us that normality is not inherent: someone else has to tell people they are mentally ill or healthy. We are neither until a social "something" gives us the label and the label has social meaning.

A sociological study of mental health and illness essentially lies in two points. First, there is no agreement on what constitutes mental illness. Definitions change over time and vary by culture, and the criteria for defining a condition as a discrete

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mental illness are fluid and subject to interpretation. Therefore, the processes that are exercised to define a condition as a disorder or an illness are social constructions. In the absence of concrete biological evidence that, as shall be seen later, predicts and explains mental illness conditions, the void is often filled by ideology, mysticism, theories, and various other explanations of why people behave and feel the way they do. The very act of labeling behaviors and emotions as illness is a sociological phenomenon and subject to social theory.

Second, the distribution of cases of mental illness is not randomly dispersed in any population—there are predictable social patterns in the distribution of psychological distress. Social forces at the cultural, structural, and interactive levels have been linked to these trends and may either intersect with biological conditions or serve as separate causes of mental ill-health. Because disorders and treatments follow social patterns, sociological theories are applicable and relevant to discussions on the causes of these mental illness.

In sum, social forces can make us psychologically distressed and determine that we are mentally ill—one of us has to behave in a way that someone else thinks is psychotic. In other words, there is no mental illness unless another person says so.

DISCUSSION QUESTIONS

1. What have you learned about the definition of mental illness after having read this chapter? Why is mental illness so difficult to difficult to define?
2. Think about the social forces that impact your own life. Using your sociological imagination, how have these forces shaped your emotions, thinking, and behaviors? What social forces have been positive or negative emotionally for you?

KEY TERMS

Ascribed Status 8
Diagnostic and Statistical Manual 4
Emotional Labor 16
Health Disparities 3
Medical Model 7
Social Construction 10
Social Forces 13
Sociological Imagination 12
Sociology in Medicine 3
Sociology of Medicine 2

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