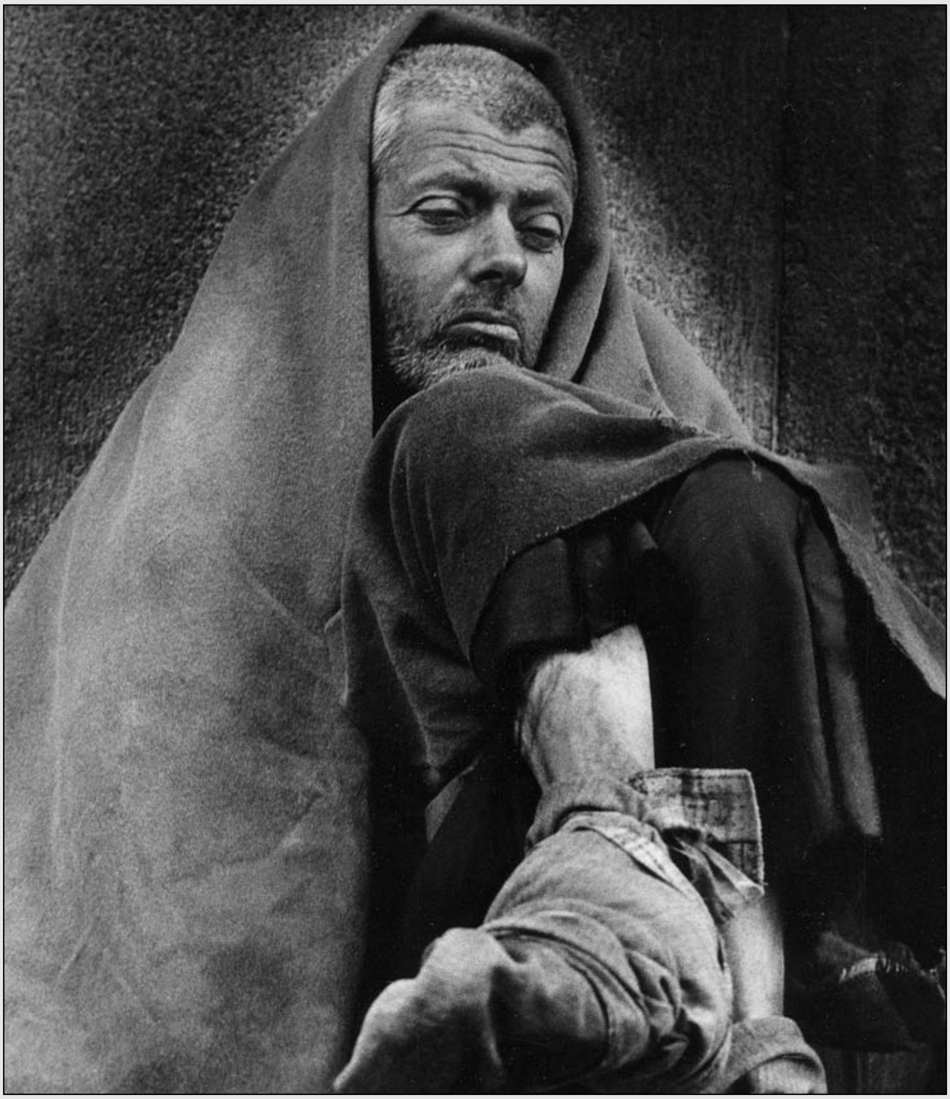
CHAPTER 7



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The Sociology of Mental Illness

At the age of 18, Susan Kaysen was committed to a private mental hospital, where she spent the next two years. In her book *Girl, Interrupted,* she describes her experience in making the transition from mental hospital to the outside world:

> *The hospital had an address, 115 Mill Street. This was to provide some cover if one of us were well enough to apply for a job while still incarcerated. It gave about as much protection as 1600 Pennsylvania Avenue would have.*
>
> *"Let's see, nineteen years old, living at 1600 Pennsylvania Avenue—Hey! That's the White House!" This was the sort of look we got from prospective employers, except not pleased.*
>
> *In Massachusetts, 115 Mill Street is a famous address. Applying for a job, leasing an apartment, getting a driver's license: All problematic. The driver's license application even asked, Have you ever been hospitalized for mental illness? Oh, no, I just loved Belmont so much I decided to move to 115 Mill Street.*
>
> *"You're living at One Fifteen Mill Street?" asked a small basement-colored person who ran a sewing-notions shop in Harvard Square, where I was trying to get a job.*
>
> *"Uh-hunh."*
>
> *"And how long have you been living there?"*
>
> *"Oh, a while." I gestured at the past with one hand.*
>
> *"And I guess you haven't been working for a while?" He leaned back, enjoying himself.*
>
> *"No," I said. "I've been thinking things over."*
>
> *I didn't get the job.*
>
> *As I left the shop my glance met his, and he gave me a look of such terrible intimacy that I cringed. I know what you are, said his look. (Kaysen, 1993: 123–124)*

As Susan Kaysen's story suggests, mental illness is a social as well as a psychiatric condition, and mental hospitalization has social as well as psychiatric consequences. We begin this chapter by considering the extent and distribution of mental illness. We then examine contrasts between the medical model of mental illness, which views mental illness as an objective reality (if subjectively experienced), with the sociological model, which views mental illness as largely a social construction. Finally, we look at the history of treatment and the experience of mental illness.

The Epidemiology of Mental Illness

The importance of understanding mental illness becomes clearer once we realize how many people are affected. The following section discusses research on the extent, distribution, and causes of mental illness.

The Extent of Mental Illness

Since the 1920s, social scientists have tried to ascertain the extent of mental illness. These researchers essentially have adopted medical definitions of mental illness (which, as we will see later in this chapter, are problematic). However, whereas doctors and other clinicians have focused on how biological or psychological factors can foster mental illness, social scientists have focused on how *social* factors can do so.

Over the years, researchers using a variety of methods have reached two consistent conclusions regarding the extent of mental illness. First, all societies, from simple to complex, include some individuals who behave in ways considered unacceptable and incomprehensible (Horwitz, 1982: 85–103). Second, symptoms of mental disorder are fairly common. According to the National Comorbidity Survey Replication (NCS-R), the largest national survey on the topic based on a **random sample** (R. Kessler et al., 2005a), during the course of a year approximately 31 percent of working-age adults experience a diagnosable mental illness, with 20 percent experiencing a moderate or severe disorder. The most common illnesses are major depression and problems with alcohol use, reported by 17 percent and 13 percent respectively. These estimates, however, are probably high, because they are based on reports of symptoms, not medical diagnoses of illnesses (Horwitz, 2002). Survey researchers can't know, for example, if someone has lost weight because of depression or because they are getting ready for a wrestling match.

Social Stress and the Distribution of Mental Illness

So far we have seen how common mental illness is across the population. But mental illness does not burden all social groups equally. In this section we look at how ethnicity, gender, and social class affect rates of mental illness.

Why do some social groups experience more mental illness than others do? For many sociologists, the answer lies in their different levels of exposure to social stress.

In the past, sociologists interested in the link between mental illness and stress largely focused on the **acute** stresses of **life events,** such as divorce, losing a job, or a death in the family. Researchers looked not only at the sheer number of life events individuals experienced but also at the *meaning* life events have for people and the *resources* individuals have for dealing with those life events. For example, an unplanned pregnancy means something quite different to an unmarried college student from a poor family than it does to a married, middle-class housewife. Similarly, some individuals have resources that can reduce the stresses of life events (such as money, social support networks, and psychological coping skills), whereas others lack such resources (Ensel and Lin, 1991; Pearlin and Aneshensel, 1986). For example, a person whose marriage fails but who has enough income to maintain his or her current lifestyle, close friends to provide companionship and social support, and good stress management skills will probably experience less stress than will someone whose economic standing following divorce plummets, who has few friends, and who responds to stress by drinking.

As we saw in Chapter 2, recent research finds that **chronic** stress is more important than acute stress for predicting poor *physical* health. Similarly, researchers have shown that acute stresses like life events often mask the more powerful impact that chronic stresses have on mental illness, as well (Turner and Avison, 2003). As is true for research on physical illness, one important line of research in this field explores how mental illness can result from the chronic stresses of **role strain** (Pearlin, 1989). Role strain refers to problems such as unwanted roles, rapidly changing roles, roles that exceed a person's resources and abilities, and conflicting roles (such as lacking the time to be both a successful college student and a good parent). Currently, however, the main focus of research in this field looks at how exposure to chronic social stress may explain ethnic, gender, and social class differences in rates of mental illness.

The Impact of Ethnicity: Social Class or Discrimination?

Researchers have uncovered few significant ethnic differences in rates of schizophrenia or other major mental illnesses. Compared to non-Hispanic whites, African Americans seem less likely to develop anxiety or mood disorders but more likely to report psychological distress, which overlaps with but is not the same as diagnosable mental illness (R. Kessler et al., 2005a). The former remains unexplained, but the latter is not surprising, because exposure to chronic stress is significantly higher among African Americans than among whites (Turner and Avison, 2003). African Americans report higher levels of distress than white Americans do at all income levels, although these differences taper off as income rises. Researchers theorize that psychological distress among African Americans results from the chronic daily stresses of living with racism and declines at upper income levels because those with higher incomes can better shield themselves from at least some of the effects of racism (R. Kessler and Neighbors, 1986).

Little recent research is available on psychological distress among other U.S. minority groups, and studies are divided as to whether Hispanics experience more or less distress than non-Hispanic whites or African Americans do (Rogler, 1991). However, Hispanics are less likely to develop anxiety disorders, mood disorders, or substance abuse problems (R. Kessler et al., 2005a). The largest study available (as of 2005) on Mexican Americans found that new immigrants' rate of mental disorders initially is half that of U.S.-born Mexicans, but after immigrants live in the United States for 13 years or more, the two rates converge (Vega et al., 1998).

The researchers hypothesize that the Mexican culture's strong emphasis on extended families protects immigrants from mental illness by offering social support and thus reducing chronic stress among persons who are single, childless, less educated, or employed in low-prestige jobs. As Mexicans integrate into American culture, they lose these protections.

The Impact of Gender: Socialization Effects

The impact of gender on mental illness is at least as complex as the impact of ethnicity. Gender has no consistent effect on the rate of schizophrenia or other major psychiatric illnesses. However, men consistently display higher rates of substance abuse problems and personality disorders (conditions characterized by chronic, maladaptive personality traits, such as compulsive gambling or antisocial tendencies), whereas women consistently display higher rates of anxiety disorders and of depression (R. Kessler et al., 2005a).

These differences in mental illness parallel differences in gender roles. Consistently, men display higher rates of disorders linked to violence, such as paranoid schizophrenia and antisocial personality disorder. As a result, some researchers hypothesize that these forms of mental illness occur when men become "oversocialized" to their gender roles. The symptoms of antisocial personality disorder (listed in Box 7.1), for example, essentially parallel expectations within lower-class communities for male behavior. Within these communities, men who meet these expectations are typically considered dangerous but not mentally ill, because their behavior is comprehensible. Although they might be labeled criminal, they are unlikely to be labeled mentally ill unless they somehow come to the attention of doctors from outside their communities.

Similarly, many sociologists hypothesize that depression results when traditional female roles cause chronic stress by reducing women's control over their lives (Horwitz, 2002: 173–179). Research has found that rates of depression are considerably higher among those women with the least control over their lives: nonworking women and married mothers. By the same

Box 7.1 *Diagnostic Criteria for Antisocial Personality Disorder*

A. There is a pervasive pattern of disregard for the rights of others since age 15, as indicated by three (or more) of the following:
    (1) failure to conform to social norms with respect to lawful behavior . . .
    (2) deceitfulness . . .
    (3) impulsivity or failure to plan ahead
    (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults . . .
    (5) reckless disregard for the safety of self or others
    (6) consistent irresponsibility such as repeated failure to honor financial obligations
    (7) lack of remorse at having hurt, mistreated, or stolen from another
B. The individual is at least age 18 years.
C. Before age 15, a history of three or more of the following:
    (1) often bullied, threatened, or intimidated others
    (2) often initiated physical fights
    (3) used a weapon that could cause serious physical harm . . .
    (4) was physically cruel to other people
    (5) was physically cruel to animals
    (6) stole while confronting a victim . . .
    (7) forced someone into sexual activity
    (8) deliberately engaged in fire-setting
    (9) deliberately destroyed others' property . . .
    (10) was often truant from school, beginning before age 13 years
    (11) often lied
    (12) stole without confronting a victim . . .
    (13) often stayed out at night despite parental prohibitions, beginning before age 13 years
    (14) ran away from home overnight at least twice . . .

Source: *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (Arlington, VA: American Psychiatric Association, 2000), pp. 98–99, 706.

token, depression is especially common among men who have less power than their wives do, have little control over their work, or lose their jobs.

The Impact of Social Class: Social Stress or Social Drift?

Of all the demographic variables researchers have investigated, social class shows the strongest and most consistent impact on mental illness. As social class increases, the rate of both diagnosable mental illness and psychological distress decreases (Eaton and Muntaner, 1999; R. Kessler et al., 1994). But does lower social class status cause mental illness, or does mental illness cause lower social class? In other words, do the social stresses associated with lower-class life lead to greater mental disorder, or do those who suffer from mental disorder drift downward into the lower social classes? These two theories are referred to, respectively, as **social stress** versus **social drift.**

Researchers interested in social class have focused primarily on schizophrenia, the disease that shows the most consistent relationship to social class; studies have found that schizophrenia and related disorders occur two to five times more often among those who have not graduated from college compared with those who have. Those who favor the social drift argument have shown that, at first admission to a mental hospital, schizophrenic patients hold jobs lower in social class than one would expect given their family backgrounds. This suggests that mental problems caused these individuals to drift downward in social class (Eaton and Muntaner, 1999).

Those who favor the (more commonly held) social stress theory, on the other hand, argue that instead of looking at the jobs schizophrenic patients held at first *admission* to a mental hospital, we should instead look at their first *jobs.* When researchers do this, they find no difference in educational attainment or in prestige levels of first jobs between schizophrenic patients and comparable others in their communities (Link, Dohrenwend, and Skodol, 1986). Therefore, these researchers argue, whatever causes downward social drift occurs *after* a person completes his or her education and obtains a first job but *before* first admission to a mental hospital. They further note that compared with the general public, a higher proportion of schizophrenic patients have worked in unusually noisy, hazardous, hot, cold, smoky, or humid environments, leading researchers to conclude that the chronic social stress of these working conditions precipitated mental disorder in vulnerable individuals. Similarly, other researchers have found that mental health problems increase among workers laid off because of plant closings, again suggesting that the chronic stresses of unemployment and lower-class status lead to mental disorder, rather than mental disorder leading to lower-class status (R. Kessler, House, and Turner, 1987). These findings are bolstered by research showing that chronic stress is significantly higher among lower-class persons and is a strong predictor of depression (Turner and Avison, 2003).

Defining Mental Illness

As with **disability** and physical illness, doctors and sociologists typically have very different ways of thinking about mental illness. In this section, we look at the contrasts between the medical model of mental illness and the sociological model. Neither of these models is absolute, however, for both sociologists and doctors often blend elements from each in their work. Nevertheless, the contrast between these two “ideal types” provides a useful framework for understanding the broad differences between the two fields.

The Medical Model of Mental Illness

To doctors and most other clinicians in the field, mental illness is an illness essentially like any other. To understand what this means, it helps to understand the history of medical treatment for syphilis, the disease that first demonstrated the power of medicine to control mental illness and that in many ways established the frame through which doctors would understand all mental illnesses.

Since the fifteenth century, doctors had recognized syphilis as a discrete disease. Because of its mild initial symptoms, however, only in the late nineteenth century did doctors realize the full damage syphilis can inflict on the nervous system, including blindness, deformity, insanity, and death. Unfortunately, doctors could do little to help those with syphilis. The best available treatment consisted, essentially, of poisoning patients with arsenic and other heavy metals in the hopes that these poisons would kill whatever had caused the disease before they killed the patients.

In 1905, scientists first identified the bacterium *Treponema pallidum* as the cause of syphilis. Five years later, Paul Ehrlich discovered the drug salvarsan as a cure for syphilis. Salvarsan, an arsenic derivative, was the first drug that successfully targeted a specific microorganism. As such, it opened the modern era of medical therapeutics. Doctors now could cure completely those who sought early treatment for syphilis, whereas people who put off treatment risked irreversible neurological damage and a horrible death.

The history of salvarsan and syphilis provided ideological support for a **medical model of mental illness.** This medical model is composed of four assumptions about the nature of mental illness. These are (Scheff, 1984):

1. Objectively measurable conditions define mental illness, in the same way that the presence of a specific bacterium defines syphilis.
2. Mental illness stems largely or solely from something within individual psychology or biology, even if researchers (like those who studied syphilis before 1905) have not yet identified its sources.
3. Mental illness, like syphilis, will worsen if left untreated, but may diminish or disappear if treated promptly by a medical authority.
4. Treating mental illness, like treating syphilis, rarely harms patients, and so it is safer to treat someone who might really be healthy than to refrain from treating someone who might really be ill.

The Sociological Model of Mental Illness

The sociological model of mental illness questions each of these assumptions (see Key Concepts 7.1). Perhaps most important, sociologists argue that definitions of mental illness, like the definitions of physical illness and disability discussed in Chapters 5 and 6, reflect subjective social judgments more than objective scientific measurements of biological problems.

What do we mean when we say someone is mentally ill? Why do we diagnose as mentally ill people as disparate as a teenager who uses drugs, a woman who hears voices, and a man who tries to kill himself? According to sociologist Allan Horwitz (1982), behavior becomes labeled mental illness when persons in positions of power consider that behavior both unacceptable and inherently incomprehensible. In contrast, we tend to define behavior as crime when we consider it unacceptable but comprehensible; we do not approve of theft, but we understand greed as a motive. (The judgment of not guilty by reason of insanity falls on the border between crime and mental illness.) Similarly, we might not understand why physicists do what

Key Concepts 7.1

Models of Mental Illness

The Medical Model	The Sociological Model
Mental illness is defined by objectively measurable conditions.	Mental illness is defined through subjective social judgments.
Mental illness stems largely or solely from something within individual psychology or biology.	Mental illness reflects a particular social setting as well as individual behavior or biology.
Mental illness will worsen if left untreated but may improve or disappear if treated promptly by a medical authority.	Persons labeled mentally ill may experience improvement regardless of treatment, and treatment may not help.
Medical treatment of mental illness can help but never harm.	Medical treatment for mental illness sometimes can harm patients.

they do, but we assume that those with appropriate training find their behavior comprehensible.

According to Peggy Thoits (1985), behavior leads to the label of mental illness when it contravenes **cognitive norms, performance norms,** or **feeling norms.** Someone who thinks he is Napoleon, for example, breaks cognitive norms (that is, norms regarding how a person should think), whereas someone who can't hold a job breaks norms regarding proper role performance. Thoits argues that the last category—breaking feeling norms—accounts for most behavior labeled mental illness. Feeling norms refer to socially defined expectations regarding the "range, intensity, and duration of feelings that are appropriate to given situations" and regarding how people should express those feelings (Thoits, 1985: 224). For example, laughing is highly inappropriate at a Methodist funeral but perfectly acceptable at an Irish wake, and feeling sad that your pet cat died is considered reasonable for a few days but unreasonable if it lasts for a year.

Different social groups consider different behaviors comprehensible and acceptable. The friends of a drug-using teenager, for example, might consider drug use a reasonable way to reduce stress or have fun. Their views, however, have little impact on public definitions of drug use. Similarly, members of one church might consider a woman who reports talking to Jesus a saint, whereas members of another church consider her mentally ill. The woman's fate will depend on how much power these opposing groups have over her life. The definition of mental illness, then, reflects not only socially accepted ideas regarding behavior but also the relative power of those who hold opposing ideas.

Researchers who use this sociological definition of mental illness do not mean to imply that emotional distress does not exist or that people do not feel real pain when they cannot meet social expectations for thought, behavior, or emotions. Nor do these researchers mean to imply that biology has no effect on behavior or thought. They do, however, question the purpose and consequences of using medical language to describe such problems and question why we label certain behaviors and individuals but not others.

Not all sociologists raise these questions, however. Many, especially those working in health care settings and in **epidemiology,** employ a **sociology *in* medicine** approach and use essentially medical definitions of mental illness in their research and writing. Nevertheless, sociologists are united in assuming that mental illness, like physical illness and disability, stems at least partially from social life rather than solely from individual psychology or biology. For example, beginning in the 1960s the number of young women diagnosed with eating disorders such as anorexia and bulimia skyrocketed (Brumberg, 1997). Those who use a medical model trace these disorders to biological defects such as endocrine or biochemical imbalances or to psychological factors such as poor adjustment to normal life changes, a need for personal perfection, poor relationships with parents, and adolescent identity crises (see, for example, T. Costello and J. Costello, 1992: 151–152). In contrast, those who use a sociological model of mental illness argue that eating disorders have mushroomed partly because of the increased cultural pressures on women to be slim (Brumberg, 1997). Thus, sociologists shift the focus from individual biology and psychology to the social context.

The Problem of Diagnosis

The sociological model of mental illness gains credibility when we look at research on the problems with psychiatric diagnosis. These problems became a political embarrassment for psychiatrists (medical doctors who specialize in treating mental illness) following a well-publicized experiment by psychologist David Rosenhan (1973). Rosenhan and seven of his assistants had presented themselves to twelve mental hospitals and complained of hearing voices, but otherwise had acted normally. The hospitals diagnosed all eight "pseudopatients" as mentally ill and admitted them for treatment. Once admitted, all behaved normally, leading 30 percent of the other patients to identify them as frauds. None of the staff, however, noticed anything unusual about these pseudopatients. It took an average of 19 days for them to win their release, with their symptoms declared "in remission."

When these results were published, psychiatrists objected vociferously that the results were some sort of fluke. In response, Rosenhan agreed to send pseudopatients to another hospital and challenged the staff at that hospital to identify the pseudopatients. During the three months of the experiment, the staff identified 42 percent of their new patients as pseudopatients, even though Rosenhan really had not sent any!

These two experiments vividly demonstrate the subjective nature of psychiatric diagnosis and its susceptibility to social expectations. Within the context of a mental hospital, staff members quite reasonably assume patients are ill and interpret everything patients do accordingly. When, for example, one bored pseudopatient began taking notes, a worker officially recorded this "note-taking behavior" as a symptom. Conversely, when staff members expected to find pseudopatients, they interpreted similar behaviors as signs of mental health.

The problems with diagnosis are particularly acute when therapist and patient do not share the same culture. With the rise in immigration to the United States over the last generation, doctors increasingly must diagnose and treat patients whose symptoms do not appear in Western textbooks (Goleman, 1995). For example, whereas Americans sometimes fear that their bodies will embarrass *them,* Japanese people sometimes experience disabling fears (known as "taijin kyofusho") that their bodies will embarrass *others.* Malaysian men may be stricken by "koro," the sudden and intense fear that their penises and testicles will recede into their bodies and kill them, and Latin Americans by "boufee delirante," characterized by sudden outbursts of excited, confused, violent, or agitated behavior. In response to growing concerns about cross-cultural misunderstandings, the American Psychiatric Association (APA) in 1995 adopted new guidelines that recommend psychiatrists consider cultural and ethnic factors in their work and require psychiatric training programs to cover cross-cultural issues.

The Politics of Diagnosis

To reduce the problems with diagnosis, psychiatrists over the years have attempted to refine the definitions of illnesses in the ***Diagnostic and Statistical Manual of Mental Disorders (DSM).*** Since the APA first published the *DSM* in 1952, virtually all psychiatrists have relied on this manual for assigning diagnoses to patients. So, too, do most other clinicians, because insurers usually require a *DSM* diagnosis before they will reimburse clinicians for treating a patient. *DSM* and the subsequent *DSM-II,* published in 1968, instructed clinicians to reach diagnoses based on the clinicians' inferences about such intrapsychic processes as defenses, repression, and transference. Because clinicians cannot measure these processes, the same behavior often elicited quite different diagnoses from different clinicians (Helzer et al., 1977).

Partly because of these problems, the APA in 1974 announced its decision to revise *DSM-II* (Spitzer, Williams, and Skodol, 1980). Ironically, although the resulting *DSM-III,* published in 1980, was designed to quiet questions about the ambiguities of psychiatric diagnosis, it instead illuminated those ambiguities because its writing became an overtly political battle, involving active lobbying by both professional and lay groups (Kirk, 1992). This battle revealed wide differences among clinicians regarding what behaviors signified mental illness, what caused those behaviors, who should treat them, and how they should be treated.

These differences already had surfaced during earlier and openly contentious battles regarding homosexuality (Conrad and Schneider, 1992).

DSM-I and *DSM-II* had listed homosexual behavior and desires as conclusive evidence of mental illness. By the early 1970s, however, gay rights activists had begun challenging this definition of the situation, arguing instead that homosexuality was a natural human variation. Active lobbying by gay activists and sympathetic professionals led the APA to hold a referendum in 1974, in which its members voted to drop homosexuality from *DSM-II.* This decision was based as much on political and moral considerations as on new scientific evidence.

The battle over the meaning of homosexuality began again with the writing of *DSM-III.* In the end a compromise was reached, declaring only "ego-dystonic" homosexuality a mental illness. Ego-dystonic homosexuality referred to individuals whose homosexuality caused them emotional pain and who had proved unsuccessful in changing their sexual orientations. This compromise did not end differences over treatment, for those who considered homosexuality merely an alternative sexual orientation treated ego-dystonic homosexuality by helping individuals become comfortable with their sexuality, whereas those who considered homosexuality pathological treated it by trying to change individuals' sexual orientation. DSM-IV, published in 1994, was the first edition that included neither the diagnosis of egodystonic homosexuality nor its symptoms under another name.

Debate over other diagnoses revealed equally divergent views on causation and treatment (see, for example, Scott, 1990). Clinicians trained in Freudian psychiatry (described later in this chapter) traced the roots of mental illness to unresolved childhood sexual conflicts and favored treating it with intensive psychoanalysis. Other clinicians traced mental illness to problematic interpersonal relationships, inappropriate social learning, or biological defects and favored treating it with, respectively, psychotherapy, behavioral conditioning, or drug therapies.

To encourage support for *DSM-III* and to avoid open political battles among psychiatrists, its authors decided to stress symptomatology and avoid discussing either causation or treatment (Kirk, 1992). In addition, to increase the odds that clinicians would use *DSM-III,* the authors described the various diagnoses based not on available research but, rather, on the consensus among practicing psychiatrists. These two strategies, they hoped, would produce a widely used and highly reliable document. **Reliability** refers to the likelihood that different people who use the same measure will reach the same conclusions—in this case, that different clinicians, seeing the same patient, would reach the same diagnosis. Yet even this modest goal was not achieved, for studies continue to find high rates of disagreement over diagnosis (Kirk, 1992; Mirowsky and Ross, 1989). Moreover, reliability in the absence of validity is not particularly useful. **Validity** refers to the likelihood that a given measure accurately reflects what those who use the measure believe it reflects—in this case, that persons identified by *DSM-III* as having a certain illness actually have that illness. As Phil Brown (1990: 393) notes, "anyone can achieve interrater reliability by teaching all people the 'wrong' material, and getting them to all agree on it. . . . The witch trials [of earlier centuries] showed a much higher degree of interrater reliability than any DSM category, yet we would not impute any validity to those social diagnoses."

Finally, even if the diagnostic categories used by clinicians are reliable and valid, clinicians will not necessarily apply them in an objective fashion. Research suggests that ethnicity and gender of both patient and clinician affect diagnosis. For example, Marti Loring and Brian Powell (1988) asked 290 randomly selected psychiatrists to diagnose two cases based on a brief description. Both cases had experienced hallucinations and extreme anxiety, had symptoms severe enough to damage their family lives, and had proved unable to keep a job. Both also met the *DSM-III* definition of undifferentiated schizophrenic disorder with a dependent personality disorder, a serious psychiatric illness with roots in childhood or adolescence.

The case descriptions the psychiatrists received were identical except for the descriptions of the cases' sex and ethnicity. When sex and ethnicity either were not given or matched those of the psychiatrist, the psychiatrists' diagnoses matched those of the researchers. In the other situations, however, bias seemed to affect the diagnoses. Male psychiatrists proved more likely to diagnose the female cases as having either depression or histrionic personality disorder, a diagnosis given to individuals with a long-standing tendency to express emotions intensely, act charmingly and seductively, feel helpless and therefore act dependent, and engage in romantic fantasies. Both depression and histrionic personality disorder fit stereotypical notions of female psychology and are diagnosed more often in women. In addition, white clinicians and, to a lesser extent, African American clinicians, more often diagnosed African Americans as paranoid schizophrenics. Paranoid schizophrenia is characterized by violence and is considered extremely difficult to treat, and so is considerably more serious than the researchers' diagnosis.

Only nineteen psychiatrists could not reach a diagnosis based on the information they had received. Of these, almost two-thirds (63 percent) had not received information about sex or ethnicity, further suggesting that psychiatrists base their diagnoses at least in part on social stereotypes of gender and ethnicity rather than on symptoms.

Despite all these problems, *DSM-III* and *DSM-IV* gained great support among clinicians because they served a variety of political needs (Horwitz, 2002). By stressing (even if inaccurately) the "objective" nature of diagnosis, clinicians were able to gain respect in the medical world, access to reimbursement from insurance companies, and funding from agencies that sponsor research. By assigning discrete diagnoses to all the different client groups and combinations of symptoms treated by different types of clinicians, they could gain widespread acceptance of the system from both clinicians and clients; *DSM-IV* contains almost 400 different diagnoses. Finally, a system that emphasized diagnosis and symptoms rather than underlying causes of illness both stemmed from and was reinforced by the increasing reliance on psychotropic medications as the main treatment for mental illness.

A History of Treatment

The history of treatment for mental illness further reveals the role social values play in medical responses to problematic behavior. In this section we trace the treatment of mental illness from the prescientific era to the present.

Before the Scientific Era

Although the concept of mental illness is relatively new, all societies throughout history have had individuals whose behavior set them apart as unacceptably and incomprehensibly different. However, premodern societies more often could find informal ways of coping with such individuals (Horwitz, 1982). First, premodern societies could offer acceptable, low-level roles to those whose thought patterns and behaviors differed from the norm. Second, because work roles rarely required individuals to function in highly structured and regimented ways, many troubled individuals could perform at marginally acceptable levels. Third, in premodern societies, work occurred within the context of the family, whether at home or in fields or forests. As a result, families could watch over those whose emotional or cognitive problems interfered with their abilities to care for themselves. These three factors enabled families to **normalize** mental illness by explaining away problematic behavior as mere eccentricity. As a result, unless individuals behaved violently or caused problems for civil authorities, their families and communities could deal with them informally.

In some cases, however, individuals behaved too unacceptably or incomprehensibly for their communities to normalize. In these cases, and as is true with all illnesses (as described in Chapter 5), communities needed to find explanations to help them understand why such problems struck some people and not others. Such explanations helped to make the world seem more predictable and safe by convincing the community that such bad things would never happen to "good people" like themselves.

Until the modern scientific age, societies typically viewed disturbing behavior as a punishment for sin or for violating a taboo; a sign that the afflicted individual was a witch; or a result of evildoing by devils, spirits, or witches. Therefore they assigned treatment to religious authorities—whether shamans, witch doctors, or priests—who relied on prayer, exorcism, spells, and treatments such as bloodletting or trepanning (drilling a hole in the skull to let "bad spirits" out). Religious control of socially disturbing behavior reached a spectacular climax with the witchcraft trials of the fifteenth to seventeenth centuries, during which religious authorities brutally killed at least 100,000 people, including some we would now label mentally ill (Barstow, 1994).

As a capitalist economy began to develop, both religious control and informal **social control** began to decline (Horwitz, 1982; Scull, 1977). Under capitalism, work moved from home and farm to workshops and factories, making it more difficult for families to care informally for problematic relatives. In addition, a capitalist economy could less readily absorb those whose productivity could not be scheduled and regimented. At the same time, widespread migration from the countryside to cities weakened families and other social support systems, as did migration from Europe to the United States in subsequent centuries. Meanwhile, other changes in society weakened religious systems of social control.

These changes fostered a need for new, formal institutions to address mental illness. By the end of the eighteenth century, however, only a few hospitals devoted to treating the mentally ill existed, along with a few private "madhouses" run by doctors for profit. Instead, most of those we would now label mentally ill were housed with the poor, the disabled, and the criminal in the newly opened network of public **almshouses,** or poorhouses.

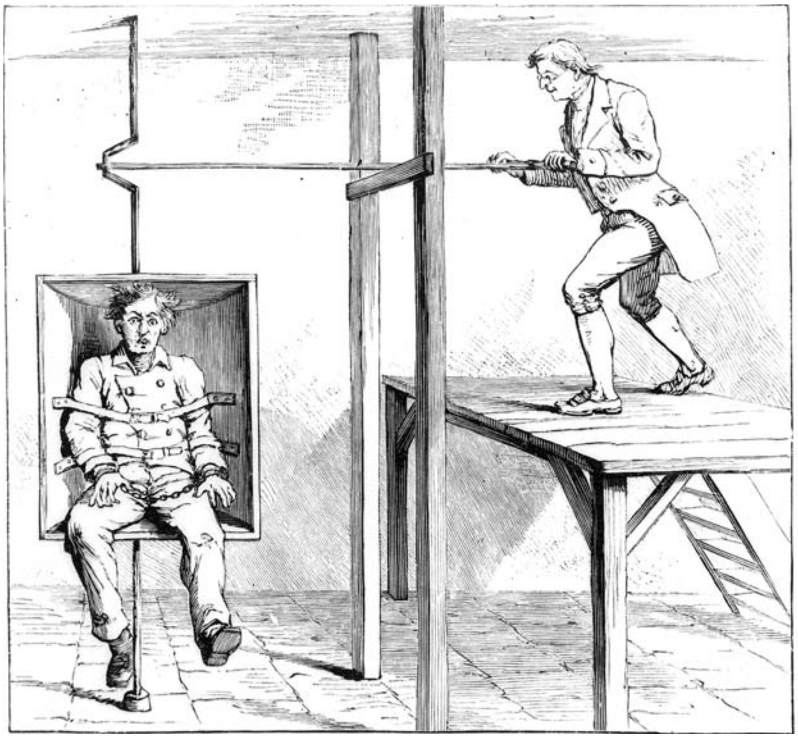
Conditions in both almshouses and madhouses were generally miserable, but they were especially bad for those considered mentally ill. Doctors and the public typically considered that persons with mental illness were incurable and essentially animals. As a result, institutions treated the mentally ill like animals—chaining them for years to basement walls or cells, often without clothing or proper food, and beating them if they caused problems.

The Rise and Decline of Moral Treatment

By the late eighteenth century, however, attitudes toward persons with mental illness began to moderate (Scull, 1989: 96–117). In place of punishment and warehousing, reformers proposed **moral treatment:** teaching individuals to live in society by showing them kindness, giving them opportunities to work and play, and in general treating mental illness more as a moral than a medical issue. The stunning successes that resulted convinced the public that mental illness was curable. The first American hospital designed to provide moral treatment, the Friends' (or Quakers') Asylum, was founded in 1817.

Despite this strong beginning, moral treatment in the end could not compete with medical models of mental illness (Scull, 1989: 137–161). Because those who promoted moral treatment continued to use the language of medicine, talking of illnesses and cures, medical doctors could argue successfully that only they should control this field. In addition, because moral treatment required only kindness and sensitivity, which theoretically any professionals could offer, no professional group could claim greater expertise than that of doctors. As a result, by 1840, doctors largely had gained control over the field of mental illness both in the United States and Europe.

As care gradually shifted from laypersons to doctors, custodial care began to replace moral treatment. This shift reflected that communities



Bettmann/CORBIS

Benjamin Rush, the "Father of American psychiatry," invented this device to treat mental illness through removing distractions from the patient.

were more interested in controlling problematic individuals than in treatment, especially when those individuals were poor, nonwhite, or immigrants. It also reflected the growing belief that illness was genetic and untreatable.

By the 1870s, moral treatment had been abandoned. Yet the number of mental hospitals continued to grow exponentially (D. Rothman, 1971). Historians refer to this change, and the similar but earlier developments in Europe, as the **Great Confinement.**

The rise of institutions reflected the need to respond to public **deviance.** The Great Confinement drew energy from the well-meaning efforts of reformers—most notably, Dorothea Dix—to close down the brutal and anarchic almshouses and to provide facilities specifically designed to care for the mentally ill, instead of warehousing them with criminals, disabled persons, and the poor (Sutton, 1991). Because no agreed-upon definitions of mental illness existed, however, families and communities found it relatively easy to move troublesome relatives into the newly established mental hospitals. Indeed, a substantial proportion of those found in these new hospitals suffered primarily from old age and poverty coupled with a lack of relatives who could or would care for them (Sutton, 1991). So, except for those wealthy enough to obtain care in small, private mental hospitals, most of those labeled mentally ill continued to find themselves housed with others whom society had rejected. The only difference was that instead of residing in institutions filled with a varied group of deviants, they now lived in large institutions officially devoted to the "care" of the mentally ill.

Freud and Psychoanalysis

By the beginning of the twentieth century, then, doctors controlled the mental illness field. Yet medicine was torn by internal divisions. From the nineteenth century to the present, although doctors overwhelmingly traced mental illness to sources internal to individuals, some emphasized the emotional roots of mental illness while others emphasized physical causes.

This split grew wider with the rise of Freudian psychiatry. According to Sigmund Freud, a Viennese doctor, to become a mentally healthy adult one had to respond successfully to a series of early childhood developmental issues. Each issue occurred at a specific stage, with each stage linked to biological changes in the body and invested with sexual meanings. For example, during the oral stage, infants and toddlers derived their greatest satisfaction from sucking a breast or bottle. Those who did not learn how to signal and fulfill those needs, Freud concluded, would later develop traits such as dependency and narcissism.

The phallic stage (between about ages 3 and 6) plays an especially important role in Freud's model because that is when the **superego**—that portion of the personality that has internalized social ideas about right and wrong—is hypothesized to develop. During the phallic stage, according to Freud, children start noticing and responding to their genitalia. They begin experiencing sexual attraction toward the opposite-sex parent and viewing their same-sex parent as a rival. When boys first learn that girls do not have penises, however, they naturally (according to Freud) conclude that girls have been castrated by their fathers as punishment for some wrongdoing. Fearing the same fate, boys abandon their attraction to their similarly castrated mothers and identify with their fathers, whose love they try to obtain by adopting their fathers' values. Through this process, boys develop a strong superego.

But what of girls, who lack penises? According to Freud, once they realize they lack penises, girls immediately recognize their inferiority (1925 [1971] 241–260:). They descend into jealousy and narcissism, which they can relieve only partially and only by marrying and having baby boys who vicariously give them penises of their own. Thus, girls can never develop strong superegos because they lack the fear necessary for their development.

Freud based this theory on his interpretations of the lives and dreams of his upper-middle-class patients; no scientific data underpin this theory. Looking back at this theory from the present, it is hard to comprehend how anyone could have believed in such notions as three-year-olds lusting after their parents or girls naturally feeling jealous of boys' penises (rather than feeling jealous of the social power maleness confers). Yet Freudianism's long-standing popularity should not surprise us. Freudianism both reflected and supported contemporary cultural notions holding that men's anatomy, intellect, and moral capabilities naturally surpassed women's, that women lacked the necessary maturity and selflessness to hold positions of authority in society, and that women were destined to become wives and mothers. These notions have not been totally abandoned; although no longer widely used in its pure form and rarely used by modern psychiatrists, Freud's conception of human nature and of mental illness continues to permeate American culture and vocabulary and to affect ideas about both normal and abnormal psychology.

For those who accepted Freud's theory, the only way to cure mental illness was to help patients resolve their developmental crises. To do so, Freud and his followers relied on psychoanalysis, a time-consuming and expensive form of psychotherapy geared to patients without major mental illnesses. In psychoanalysis, patients recounted their dreams and told a largely silent therapist whatever came to mind for the purpose of recovering hidden early memories and understanding their unconscious motivations.

Because psychoanalysis was so costly, most mental patients during the first half of the 1900s instead received far cheaper physical interventions (Valenstein, 1986). Insulin therapy became immediately popular from its inception in 1933, followed by electroconvulsive (shock) therapy in 1938. These therapies caused comas or seizures, which psychiatrists believed improved mental functioning. Neither therapy had received scientific testing before becoming popular, nor did later studies find evidence of their effectiveness. Similarly, lobotomies—operations that permanently destroy part of the brain—became popular during the 1940s and 1950s. An estimated 50,000 Americans received lobotomies, and the procedure's originator, Dr. Egas Moniz, received the Nobel Prize in Medicine in 1949. Yet the only proven effects of lobotomies are diminished memory, intelligence, creativity, and emotional capacity (Valenstein, 1986). At any rate, therapy of any sort occupied only a minuscule proportion of patients' time in mental hospitals. Instead, patients spent their days locked in crowded wards with little other than radio or, later, television to ease their boredom.

The Antipsychiatry Critique

By the middle of the twentieth century, mental hospitals had become a huge and largely unsuccessful system (Mechanic, 1989). Patients with mental illnesses occupied half of all hospital beds in the United States. Virtually all (98 percent) were kept in public mental hospitals; insurance rarely covered mental health care, so private hospitals had no interest in the field. At their peak in 1955, public mental hospitals held 558,000 patients, most of them involuntarily confined, for an average of eight years.

Beginning in the 1960s, many voices would challenge this system. Civil rights, antiwar, and feminist movements all brought issues of individual rights to the forefront and stimulated a broader questioning of authority and social arrangements. These ideas contributed to a growing critique of mental health treatment by sociologists, psychologists, and even some psychiatrists such as R. D. Laing (1967) and Thomas Szasz (1970, 1974).

One of the most powerful critiques of large mental institutions appeared in a classic study by sociologist Erving Goffman (1961). Goffman's work fell within the tradition of **symbolic interactionism** theory. According to this theory, individual identity develops through an ongoing process in which individuals see themselves through the eyes of others and learn through social interactions to adopt the values of their community and to measure themselves against those values. In this way, a **self-fulfilling prophecy** is created, through which individuals become what they are already believed to be. So, for example, children who constantly hear that they are too stupid to succeed in school might conclude that it is senseless to attend classes or study. They then fail in school, thus fulfilling the prophecies about them.

Goffman used symbolic interactionism theory to analyze mental hospitals and the experiences of mental patients. He pointed out that mental hospitals, like the military, prisons, and monasteries, were **total institutions**—institutions where a large number of individuals lead highly regimented lives segregated from the outside world. Goffman argued that these institutions necessarily produced **mortification** of the self. Mortification refers to a process through which a person's self-image is damaged and is replaced by a personality adapted to institutional life.

Several aspects of institutional life foster mortification. Persons confined to mental hospitals lose the supports that usually give people a sense of self. Cut off from work and family, these individuals' only available role is that of patient. That role, meanwhile, is a **master status**—a status considered so central that it overwhelms all other aspects of individual identity. Within the mental hospital, a patient is viewed solely as a patient—not as a mother or father, husband or wife, worker or student, radical or conservative. According to Goffman's observations, and as in Rosenhan's (1973) experiment, all behavior becomes interpreted through the lens of illness. In addition, because each staff member must manage many patients, staff members necessarily deal with patients en masse. In these circumstances, patients typically lose the right to choose what to wear, when to awaken or sleep, when and what to eat, and so on. Moreover, all these activities occur in the company of many others. Individuals thus not only experience a sense of powerlessness but also can lose a sense of their identity—their desires, needs, personalities—in the mass of others. As a result, patients experience **depersonalization**—a feeling that they no longer are fully human, or no longer are considered fully human by others. At the same time, the hierarchical nature of mental hospitals reinforces the distinctions between inmate and staff and constantly reminds both parties of the gulf between them. Consequently, patients can avoid punishment and eventually win release only by stifling their individuality and accepting the institution's beliefs and rules.

Table 7.1 ***Average Daily Census of Adult Mental Patients, by Type of Organization, 1969–1988***

TYPE OF FACILITY	1969	1975	1979	1983	1986	1988
Inpatient, public mental hospitals	414,800	225,500	167,300	136,500	128,200	119,400
Inpatient, private psychiatric hospitals or wards	29,400	34,800	37,000	50,800	57,800	65,600
Outpatient facilities	6,240	10,989	11,026	20,970	19,670	19,673

Source: Manderscheid and Sonnenschein (1992: 26).

These forces producing mortification are so strong that even Rosenhan's pseudopatients—knowing themselves sane and hospitalized only briefly—experienced depersonalization.

Implicit in Goffman's work is the idea that mental hospitals may be one of the worst environments for treating mental problems. Later research supports this conclusion. A review of ten **controlled** studies on alternatives to hospitalization, including halfway houses, day care, and supervised group apartment living, found that all could boast equal or better results than those of traditional hospitalization, as measured by subsequent employment, reintegration into the community, life satisfaction, and extent of symptomatology (Kiesler and Sibulkin, 1987).

Deinstitutionalization

By the time the anti-psychiatry critique appeared, the Great Confinement already had begun to wane. Beginning in 1955, the number of mental hospital inmates declined steadily, as treatment shifted from **inpatient** care (in hospitals) to **outpatient** care (see Table 7.1). This process of moving mental health care away from large institutions, known as **deinstitutionalization,** gained further support during the 1970s, as mental patients successfully fought in the courts against involuntary treatment, against hospitals that provided custodial care rather than therapy, and for the right to treatment in the "least restrictive setting" appropriate for their care.

Explaining Deinstitutionalization

Those who adopt a medical model of illness typically assume that deinstitutionalization resulted from the introduction, beginning in 1954, of drugs known as phenothiazines. These drugs, such as chlorpromazine (Thorazine), significantly reduce severe symptoms such as hallucinations in many patients. To these drugs would later be added antidepressants and antianxiety drugs such as diazepam (Valium). Yet the number of patients in public mental hospitals did not fall rapidly until more than a decade after these drugs were introduced.

Although phenothiazines did facilitate deinstitutionalization by making mental patients compliant enough for communities to tolerate their release, financial changes more fully explain this shift (Mechanic and Rochefort, 1990). Increasingly during the 1960s and 1970s, private insurers covered the costs of mental health care, making the treatment of mental illness profitable for private hospitals. As a result, these hospitals began aggressively developing psychiatric facilities and admitting patients who in the past would have gone to large public hospitals (Mechanic, 1999; Mechanic and Rochefort, 1990). Table 7.1 shows the growth in private facilities for treating mental illness. General hospitals also sought psychiatric patients as a means of filling beds emptied during the 1950s and 1960s by the overbuilding of general hospitals and during the 1980s by pressures from insurers to control costs by releasing patients quickly (P. Brown, 1985: 116–117; Gray, 1991).

Changes in public benefit programs played an even more important role in fostering deinstitutionalization. With the establishment in 1965 of the federal health care programs **Medicare** and **Medicaid, nursing homes** realized they could now receive federal funds for caring for chronically mentally ill persons and began aggressively seeking this market. States happily supported this shift, because public mental hospitals were largely funded through state tax dollars but Medicare and Medicaid were largely paid for by the federal government. During the same years, Social Security increased the monthly benefits it paid to persons with chronic mental illness, making it possible for mental hospitals to release patients who previously would have been unable to support themselves. Three-quarters of the reduction in the total number of mental hospital patients occurred after these changes in Medicare, Medicaid, and Social Security, suggesting that these changes were the most important factor behind deinstitutionalization.

Finally, deinstitutionalization also stemmed from the rise of **individualism**—a set of "sociocultural beliefs and practices that encourage and legitimate the autonomy, equality and dignity of individuals" (Horwitz and Mullis, 1998: 122). In past generations, individuals' identities depended on their places within family or community. Because families and communities were far more important social units than were individuals, laws typically upheld the right of these groups over any rights of the individual. Thus, for example, until about 1900, parents had near-absolute rights to discipline their children without interference from the law. Similarly, most psychiatric inpatients were committed by their families, and most requests by families to commit individuals were honored (Horwitz and Mullis, 1998).

During the last few decades, however, this "moral sovereignty" of the family has weakened; families are no longer assumed to know what is best for their members, and family ties of all sorts have weakened. In its stead, individualism has become dominant. Although families still are the most common source of requests for commitment, they now must demonstrate that commitment is in the best interest of the individual. Similarly, mental hospitals now must demonstrate that an individual needs continued treatment rather than the individual having to demonstrate that he or she does not.

Perhaps more important, as family ties have weakened, increasingly families simply abandon their more problematic members, rather than either caring for them or arranging for them to be cared for by others. At the same time, now that laws increasingly protect the right of individuals to dress and behave in unusual ways, communities no longer police unusual public behavior so closely. For both these reasons, the rise of individualism has resulted in fewer commitments to mental hospitals.

The Consequences of Deinstitutionalization

Following deinstitutionalization, persons with mental illness no longer found themselves locked for years in the often brutal conditions of large mental institutions. Yet the promise that deinstitutionalization would herald a new era in which individuals would receive appropriate therapy in the community, avoiding the **stigma,** degradation, and mortification of mental hospitalization, has been met only partially. Unfortunately, individuals who were released from hospitals to the community found few services available to help them with their continuing problems. The situation worsened further beginning in the 1980s, when the federal government began cutting funding for Medicaid and Medicare, the federal health care programs that are supposed to help disabled and poor Americans. As a result, many chronically mentally ill persons could no longer afford treatment. According to the NCS-R, less than half (40 percent) of those with serious mental illnesses currently receive even minimally adequate treatment (R. Kessler et al., 2005b).

During the same years that government funding for the nation's health care system declined, funding for the criminal justice system dramatically *increased* (Butterfield, 1999). As a result, public mental hospitals now find that the best way to pay their bills is to accept for treatment persons sent to them by the criminal justice system: mentally ill prison inmates, people found innocent by reason of insanity, and violent offenders who under new "sex predator" laws can be involuntarily confined even after finishing their prison sentences. For example, at California's Napa State Hospital, almost 75 percent of patients during 1999 came from the criminal justice system (Kligman, 1999).

Simultaneously with these changes, the federal government also reduced funding for low-income housing. As a result, many mentally ill persons who cannot afford treatment also cannot find housing. Consequently, many persons with chronic mental illness now cycle between homelessness, brief jail stays when they prove too troublesome for local authorities who lack other alternatives, and acute episodes in public mental hospitals; a report released by the U.S. Department of Justice in 1999 estimated that 16 percent of jail and prison inmates have a mental illness (Butterfield, 1999). Despite these severe gaps in our mental health system, however, observers generally agree that deinstitutionalization improved the quality of life for most seriously mentally ill persons, whether they live in nursing homes, board and care homes (residential facilities that provide solely assistance in daily living), with relatives, or on their own (Grob, 1997; Horwitz, 1999).

The Remedicalization of Mental Illness

The last 20 years have seen an increasing **remedicalization** of mental illness (P. Brown, 1990). Psychiatrists have developed new techniques for diagnosis and treatment and new theories of illness etiology that link mental illness to individual abnormalities in biochemistry, neuroendocrine functioning, brain structure, or genetic structure and downplay the effects of social factors.

The data for this "biological revolution" consist primarily of simple correlations between biological abnormalities and some serious mental disorders (P. Brown, 1990); no studies have uncovered significant biological differences between those who have minor mental disorders and those who do not. None of this research adequately sorts out other factors that might account for these correlations (such as differences in nutrition or in the use of various drugs) or determines whether either the mental disorders or treatment for them might have caused, rather than resulted from, biological abnormalities.

Despite these weaknesses in the biological model of mental illness, most psychiatrists have adopted it. As a result, psychiatrists now present a more united front in their struggles for control against other mental health occupations such as psychology and social work. In addition, they have increased their political power relative to these other occupations because, having declared mental illness a biological problem, they now can argue that only persons trained in medicine can properly diagnose and treat it (P. Brown, 1990).

Reflecting this medical model, doctors now rely primarily on psychoactive drugs not only to treat mental illness but also to diagnose it. In a process first brought to public attention by psychiatrist Peter Kramer (1993) in his popular book, *Listening to Prozac,* doctors now "listen to drugs," assuming that the reaction to a drug tells us something basic about an individual's mental state. So if Prozac (fluoxetine hydrochloride) or another selective serotonin reuptake inhibitor (SSRI), which increases levels of the neurotransmitter serotonin in the brain, somehow makes an individual feel less depressed, then physicians conclude that lack of serotonin must have caused the depression. Yet as Kramer points out, pneumonia is not caused by a lack of antibiotics nor headaches by a lack of aspirin, but both drugs make ill people feel better. Similarly, doctors increasingly decide whether a patient is clinically depressed based not on whether that patient meets standard criteria for that diagnosis but on whether the patient responds favorably to SSRIs. Yet most people feel better when they take a mood-enhancing drug, whether it is Prozac or cocaine. As a result, during 2001 Americans spent more than $11 billion on SSRIs (Sills, 2002).

Most of the drugs now used to treat mental illness fall into one of three main categories: antipsychotics, mood stabilizers, and antidepressants. Psychiatrists use antipsychotic drugs, such as Clozaril and Risperdal, to help control severe symptoms in persons with major mental illnesses such as schizophrenia. These drugs are considerably less likely than are older drugs such as Haldol and Thorazine to produce loss of alertness and a condition known as "tardive dyskinesia" (uncontrollable, severe, and sometimes permanent muscular spasms). To control anxiety, obsessions, compulsions, and the severe mood swings of bipolar disorder, doctors commonly use mood stabilizers such as Tegretol and Depakote. Finally, psychiatrists use antidepressants to alleviate depression. Unlike previous generations of antidepressants, SSRIs and other new drugs have fewer side effects and cannot be taken to commit suicide, although they are no more effective than the older drugs and increase the odds that individuals will in fact commit suicide. Because drug companies proved successful at both marketing the benefits of SSRIs and downplaying their problems, the use of SSRIs has exploded (Abramson, 2004), primarily among persons who suffer only from minor depression.

The Rise of Managed Care

Beginning in the 1990s and in response to consumer pressure, insurance coverage for mental illness became considerably more common. Still, most insurers offer less coverage for mental illness (especially chronic illness) than for physical illness (R. Frank and McGuire, 1998; Mechanic, 1999: 128–132). Increasingly, too, that coverage is offered through **managed care organizations (MCOs).** Managed care is described more fully in Chapter 8, but essentially refers to any system that controls health care spending by closely monitoring where patients receive health care, what sorts of providers patients use, what treatments they receive, and with what consequences.

It is too soon to fully assess the impact of managed care on either the cost or quality of care. However, early research suggests that managed care may be able to reduce the costs of mental health treatment, at least for less severe illnesses, by encouraging shorter rather than longer inpatient stays, outpatient rather than inpatient care, conservative rather than aggressive interventions, and use of lower-level clinicians (such as social workers) rather than psychologists or psychiatrists (Mechanic, 1995; Mechanic, 1999: 160–162). According to David Mechanic, probably the most influential sociologist in the area of mental health care, it also may be able to improve the quality of care:

> By reducing inpatient admissions and length of stay, managed care programs potentially make available considerable resources for substitute services and other types of care. Managed care provides incentives to seek closer integration

> between inpatient and outpatient and primary and specialized services to achieve cost-effective substitutions.
>
> Managed care also offers the potential to bring . . . science-based mental health care into the mental health system more quickly than traditional programs. . . . Many individual practitioners resist practice guidelines and scientific findings, preferring their own clinical experience, but managed care can put systems in place to measure performance and to enforce adherence to established standards. (1997: 45–46)

But managed care also carries risks. The emphasis on cost containment inherent in managed care has affected who offers mental health services, for how long, and of what type (Scheid, 2001). MCOs encourage the use of clinicians who charge less per hour, preferring those with master's degrees to those with doctorates and preferring those with doctorates to those with medical degrees. To further restrain costs, MCOs press clinicians to restrict care to short-term treatment of immediate problems, rather than longer-term treatment of underlying problems. As a result, therapists increasingly prescribe medications, even if they believe "talking therapies" would be more useful. This shift probably makes sense for most patients who are dealing with mild "problems in living" but is problematic for those with more severe mental problems (Luhrmann, 2000).

Managed care also has affected how mental disorders are diagnosed. One way managed care controls costs is by determining in advance, based on outcome studies of past patients, how much and what type of care patients with specific diagnoses should receive. For this system to work, clinicians must assign a diagnosis to each patient. This in turn reinforces the medical model of mental illness and the idea that every person who seeks mental health services has a specific, diagnosable mental illness.

At the same time, to contain costs, MCOs are trying to curtail the breadth of the diagnostic system (Horwitz, 2002). Because each successive edition of *DSM* has included more diagnoses than its predecessor has, with each edition more individuals have become eligible for mental health care. For this reason, MCOs often oppose new diagnoses or any loosening of the criteria for existing diagnoses. For example, some MCOs deny treatment to individuals who have fewer than five symptoms on a depression checklist, even if individuals' listed symptoms are severe and even if they have other, unlisted symptoms. Box 7.2 describes the National Alliance on Mental Illness, which, among other things, fights for better access to care.

For all these reasons, it remains unclear whether the benefits of managed care will outweigh the disadvantages.

The Experience of Mental Illness

The previous sections described the nature, causes, distribution, and history of mental illness. Next, we look at the experience of mental illness.

Box 7.2 ***Making a Difference: The National Alliance for the Mentally Ill***

The National Alliance for the Mentally Ill (NAMI) is a nonprofit, national organization that aids individuals with severe mental illnesses, their friends, and their families. NAMI has several primary missions.

First, NAMI works to increase insurance coverage for mental illness and access to the best treatments. To this end, NAMI's volunteers and staff engage in political advocacy, using NAMI-funded research reports that document both the social costs of untreated mental illness and the ways communities suffer when mental illness is not adequately treated. Second, NAMI works with communities to develop appropriate housing options for persons with severe mental illness and works with employers to develop appropriate jobs. Third, to gain public support for better treatment, housing, and job opportunities, NAMI focuses on fighting the stigma of severe mental illness.

In its fight against stigma, NAMI has used a variety of tactics. For example, each month, NAMI members nationwide are asked to report instances in which national media (television, radio, Internet, etc.) portrayed persons with mental illnesses accurately or inaccurately, demeaningly or sympathetically. These reports are then sent along with the names and addresses of those responsible for these portrayals to the almost 20,000 NAMI members who have volunteered to participate in its StigmaBusters E-mail Alert. Participants are asked to send letters of complaint or commendation, as appropriate, to the responsible parties. State and local NAMI chapters have similar structures to deal with their local media. The flood of email and letters generated by these alerts has helped to reduce ignorance and prejudice and foster more accurate images of mental illness in the mass media.

Becoming a Mental Patient

As already noted, in any given year 31 percent of working-age adults experience a diagnosable mental illness, but only 40 percent of these receive even basic treatment (R. Kessler et al., 2005a, 2005b). Ironically, as the stigma among the middle class against seeking counseling for minor problems has diminished and insurance has increased, levels of treatment have increased among basically well-functioning individuals who experience situational stress, sadness, or lowered self-esteem (R. Kessler et al., 2005b). Nearly half of those who receive outpatient treatment have no mental disorder that can be identified through surveys, although some of these might have disorders that could be identified by clinicians (R. Kessler et al., 2005b). What explains this discrepancy between experiencing symptoms and receiving treatment?

According to Allan Horwitz, "Symptoms of mental disorder are usually vague, ambiguous, and open to a number of varying interpretations. . . . Labels of 'mental illness,' 'madness,' or 'psychological disturbance' are applied only after alternative interpretations have failed to make sense of the behavior" (1982: 31). The key question, then, is how does this happen?

Self-Labeling

Regardless of how others define their situation, at least initially individuals usually define themselves as mentally healthy, using a process Whitt and Meile (1985) refer to as **aligning actions,** or actions taken to align one's behavior with social expectations. If individuals' problems increase, however, these aligning actions become less convincing. In a process Whitt and Meile refer to as **snowballing,** each additional problem becomes more difficult to deal with than the previous one, so a person with four problems experiences more than twice the difficulty of a person with two problems. As this snowballing occurs, individuals become more likely to define themselves as mentally ill and to seek care.

Peggy Thoits (1985) has provided a more detailed model of how self-labeling works among those—the majority—who experience only acute or mild problems. Her model, like that of Erving Goffman, draws on the theory of symbolic interactionism. Thoits applies this to mental illness by hypothesizing that well-socialized individuals sometimes label themselves as mentally ill when their behavior departs from social expectations, even if others do not consider their behavior disturbed or disturbing.

Because individuals recognize the stigma attached to mental illness, however, they work to avoid this label. According to Thoits, and as described earlier, most of the behavior that can lead to the label of mental illness involves inappropriate feelings or expressions of feelings. To avoid the label of mental illness, therefore, individuals can attempt to make their emotions match social expectations, through what Arlie Hochschild (1983) refers to as **feeling work.**

Feeling work can take four forms. First, individuals can change or reinterpret the situation that is causing them to have feelings others consider inappropriate. For example, a working woman distracted from her work by worries about how to care for an ill parent—and distracted while with her parent by worries about her work—can quit her job. Second, individuals can change their emotions physiologically, through drugs, meditation, biofeedback, or other methods. The woman with the ill parent, for example, could drink alcohol or take Prozac to control anxiety. Third, individuals can change their behavior, acting as if they feel more appropriate emotions than they really do. Fourth, individuals can reinterpret their feelings, telling themselves, for example, that they only feel tired rather than anxious.

When feeling work succeeds, individuals can avoid labeling themselves mentally ill. This is most likely to happen when the situations causing the emotions are temporary and brief and when supportive others legitimize their emotions. If, for example, the woman with the ill parent has similarly situated friends who describe similar emotions, she might conclude that her emotions are understandable and acceptable. If, on the other hand, her colleagues do not sympathize with her concerns and continually tell her to put her work first, her attempts at feeling work could fail, and she might conclude that she has a mental problem.

Ironically, some individuals label themselves mentally ill or are labeled by others because they succeed too well at feeling work. For example, those who rely too heavily on drugs to manage their feelings can lose control of their lives, and those who consistently reinterpret their emotions—telling themselves that they are not angry, for example, even while punching a wall or a spouse—can find that others label them crazy when their emotions and behavior don't match. In addition, those who consistently engage in feeling work can lose the ability to interpret their feelings accurately and experience them fully. The resulting sense of numbness and alienation eventually can lead individuals to define themselves as mentally ill.

Labeling by Family, Friends, and the Public

Like individuals, families only reluctantly label their members mentally ill (Horwitz, 1982). Instead, families can deny that a problem exists by convincing themselves that their relative's behavior does not depart greatly from the norm. If they do recognize that a problem exists, they can convince themselves that their relative is lazy, a drunkard, "nervous," responding normally to stress, or experiencing physical problems rather than mental illness. Finally, families might recognize that their relative is experiencing mental problems but define those problems as temporary or unimportant.

Two factors explain how and why families can ignore for so long behavior that others would label mental illness. First, those who share cultural values, close personal relationships, and similar behavior patterns have a context for interpreting unusual behavior and therefore can interpret behavior as meaningful more easily than outsiders could. Second, families often hesitate to label one of their own for fear others can reject or devalue both the individual and the family. As a result, families have a strong motive to develop alternative and less stigmatizing explanations for problematic behavior.

Surprisingly, strangers as well as intimates tend to avoid interpreting behavior as mental illness. In one study, for example, researchers had subjects read vignettes describing individuals who met the criteria for various psychiatric diagnoses (D'Arcy and Brockman, 1976). The researchers found that the proportion of subjects who defined the described individuals as mentally ill declined from 70 percent for the vignettes of paranoid schizophrenics to 34 percent for the vignettes of simple schizophrenics, 25 percent for the vignettes of alcoholics, and less than 10 percent for the vignettes of neurotics (that is, persons who experience psychological distress but are in touch with reality and able to function). This evidence suggests that the public applies the label of mental illness only when disordered behavior is public, violent, dramatic, or otherwise unignorable.

Moreover, even when relatives and other intimates define an individual as mentally ill, they do not necessarily bring the individual to treatment. Instead, they can continue to protect the individual against social sanctions through a process Lynch (1983) refers to as **accommodation.** Accommodation refers to "interactional techniques that people use to manage persons they view as persistent sources of trouble" and to avoid conflict (Lynch, 1983: 152).

Based on analyzing essays in which college students described how they handled family members, workmates, fraternity brothers, and others whom they regarded as disturbed, Lynch identified three forms of accommodation. First, students could minimize contact with problematic individuals—avoiding them, ignoring them when they could not be avoided, or restricting interactions to a minimal and superficial level when they could not be ignored. Second, students could limit the trouble individuals could cause through such actions as taking over the individuals' responsibilities or humoring their wishes and beliefs. Third, they could manage the *reactions* to the problematic individual through such actions as providing excuses when the individual did not meet social expectations or hiding the individual from others' view—for example, keeping a "crazy" fraternity brother out of sight when outsiders were present during parties.

Nevertheless, despite these attempts to normalize and accommodate mental illness, families and friends may eventually conclude that an individual needs treatment. At that point, they must either get the individual to agree or coerce the individual into getting treatment despite his or her active resistance. One study of all persons seeking care for a serious mental illness for the first time found that 42 percent had actively sought care and 23 percent had been coerced (Pescosolido, Gardner, and Lubell, 1998). Coercion was most common among those with bipolar disorder, who often enjoyed the "highs" of mania even though others regarded them as seriously disturbed, and among those with large, tight social networks. In another 31 percent of cases, families "muddled through"; either the individuals went along with treatment decisions made by others without accepting or rejecting those decisions, or no one in the family seemed to have been in charge of the decision-making process.

Labeling by the Psychiatric Establishment

Once individuals enter treatment, a different set of rules applies, for whereas the public tends to normalize behavior, mental health professionals tend to assume illness. First, because the medical model of mental illness stresses that treatment usually helps and rarely harms, it encourages mental health workers to define mental illness broadly. Second, because mental health workers see prospective patients outside of any social context, behavior that might seem reasonable in context often seems incomprehensible. This is especially likely when mental health workers and prospective patients come from different social worlds, whether because they differ in gender, ethnicity, social class, or some other factor. Third, mental health workers assume that individuals would not have been brought to their attention if they did not need care. Finally, because normalization and accommodation are so common, mental health workers often do not see individuals until the situation has reached a crisis, making it relatively easy to conclude that the individuals are mentally ill.

The Post-Patient Experience

Research on the post-patient experience has focused on the sources, consequences, and extent of stigma experienced by former patients. This is a critical issue, for it challenges the medical model's assumption that psychiatric treatment is benign.

Those who support a medical model of illness point to several studies suggesting that the public stigmatizes only those former patients who continue to engage in problematic behavior (Link et al., 1987). Yet nationally representative surveys continue to find that persons with mental illnesses evoke substantial fear and social rejection from others (Link et al., 1999).

To explain why some studies find high rates of stigma toward former mental patients and others do not, Bruce Link and his colleagues (1987) asked a random sample of survey respondents to fill out questionnaires regarding their attitudes toward persons with mental illness and to respond to a description of a person whose behavior met the definition of mental illness. None of the respondents was told that the person was mentally ill, but half were told that he was a former mental patient. Respondents who believed mentally ill persons are dangerous proved *more* likely to reject a person who was described as a former mental patient, whereas those who believe persons with mental illness are generally harmless proved *less* likely to reject the former patient. The authors conclude that previous studies found no evidence of stigma because they unintentionally had combined these two groups.

In two further studies, Link and his colleagues argued that labeling an individual mentally ill has negative effects not only because of how the general public responds but also because of how the labeled individual responds (Link, 1987; Link et al., 1989). According to these studies, former patients believe that most people devalue and reject former mental patients. As a result, former patients devalue themselves, which damages their self-esteem and their work performance. In addition, because former patients expect rejection, they often engage in defensive behaviors such as secrecy and emotional withdrawal, which further harms their social relationships.

These findings, of course, do not necessarily mean that the hazards of stigma outweigh the benefits of treatment. Substantial evidence suggests that both psychotherapy and drug treatment can reduce symptoms and prevent relapse, at least in the short term (Link et al., 1997). Other research, however, suggests that the negative effects of stigma coexist with the benefits of treatment, partially canceling each other out (Link et al., 1997; Rosenfield, 1997). These results led Bruce Link and his colleagues to conclude that

> stigma has important effects, effects that remain even when people improve while participating in treatment programs. Health care providers are therefore faced with the challenge of how to address stigma in its own right if they want to maximize the quality of life for those they treat and maintain the benefits of treatment beyond the short term. (1997: 187)

Box 7.3 *Ethical Debate: Confidentiality and the Duty to Warn*

In the fall of 1969, Prosenjit Poddar entered outpatient psychotherapy at the University of California–Berkeley Student Health Center. During the course of therapy, he told his therapist, Dr. Lawrence Moore, that he planned to kill his girlfriend, fellow student Tatiana Tarasoff.

Therapists, like medical doctors and clergy, always have regarded their discussions with patients as privileged communication in which, both legally and morally, confidentiality must be safeguarded. In a situation such as this one, however, therapists must weigh the danger to their patients if they breach confidentiality against the danger to others if they do not.

Dr. Moore's first response was to consult with his two supervisors. All three concurred that Poddar needed to be hospitalized for observation. Moore's supervisor then notified the campus police and asked them to bring in Poddar. When the police detained and interviewed him, however, they concluded that he was rational and not dangerous. As a result, Moore's supervisor rescinded the original commitment order.

Not surprisingly, Poddar felt betrayed by his therapist's breach of confidence and broke off therapy. Two months later, when Tarasoff returned from a long trip, Poddar killed her.

After Tarasoff's death, her parents learned that Poddar had told his therapist of his intentions. In Tarasoff v. Regents of the University of California *(131 California Reporter 14, July 1, 1976), the parents successfully sued Dr. Moore and the university on the grounds that therapists must abandon confidentiality when another life is endangered and that, specifically, they must inform intended victims as well as legal authorities.*

At first reading, the message of the *Tarasoff* case seems obvious: If a therapist reasonably suspects a client is dangerous, the therapist must warn both the legal authorities and the intended victims. This same reasoning has been applied to clients who tell their therapists of suicidal thoughts. More recently and in a somewhat different vein, some have argued that health care workers must breach confidentiality when they learn of **HIV**-infected clients having unprotected sex without informing their sexual partners of their infection. The codes of ethics of both the American Medical Association and the American Psychiatric Association, as well as various legal

The potential for stigmatizing mental patients and the problems that arise when the interests of mental patients conflict with the interests of others are discussed in this chapter's ethical debate (Box 7.3).

Conclusion

In this chapter we have compared the sociological and medical models of mental illness. As with the medical models of physical illness and disability discussed in Chapters 5 and 6, the medical model of mental illness asserts that mental illness is a scientifically measurable, objective reality, requiring decisions, declare that doctors must breach confidentiality when the health or welfare of either a client or others in the community is endangered.

A closer look at the *Tarasoff* case, however, reveals some of the difficulties of reaching any simple conclusion. On the one hand, it could be argued that if Tatiana had been informed, she could have protected herself. Yet women are killed daily who know full well that their husbands or lovers want to kill them. Police often offer little protection to these women, and the women often can do little to protect themselves.

In addition, in the *Tarasoff* case, the one documented result of informing the police was that Poddar ended therapy. It could be argued, therefore, that far from protecting the intended victim, breaching confidentiality placed her in greater danger by convincing Poddar to end therapy, thus reducing the chances that he would find a nonviolent way of managing his anger.

Finally, the argument that therapists must breach confidentiality regarding dangerous clients assumes that therapists know which clients are dangerous. Yet, as various studies have shown and as the American Psychiatric Association and several other professional organizations argued in briefs filed on behalf of the therapists in the *Tarasoff* case, this assumption is far from true. Moreover, if psychiatrists wrongly conclude that clients are dangerous and therefore breach confidentiality, they can subject the clients to substantial stigma, sometimes with permanent consequences. Indeed, with the growth of large, all-too-accessible, computerized data banks of medical records and the growth in access to those records by insurers, peer review organizations, and the like, the more serious issue facing therapists in the future may be how to *protect* confidentiality, not when to breach it.

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in this policy? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests are served by the different sides of this issue?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?
4. What are the intended consequences of this policy? What are the unintended social, economic, political, and health consequences of this policy?

prompt treatment by scientifically trained personnel. As such, this model downplays the role of social and moral values in the definition and treatment of mental illness and the effect of mortification and stigma on those who receive treatment.

Entering the twenty-first century, we find ourselves facing a situation uncomfortably similar to that of past centuries. As in the years before the Great Confinement, thousands of persons who have mental illnesses now live on the streets and support themselves at least partly by begging. Many more—along with others who experience social rejection—are confined in nursing homes, board and care homes, or prisons, in the same way that earlier societies confined persons with mental illness in almshouses along with the poor, the disabled, and those without families. Although drugs largely have replaced shackles, society still allocates far too few resources to provide humanely for those who suffer mental illnesses. We can only hope that, in the future, with a greater understanding of the nature of mental illness and of the social response to it, we can develop more compassionate and effective means of coping with mental illness.

Suggested Readings

Goffman, Erving. 1961. *Asylums.* Garden City, NY: Doubleday. The classic text on the nature of mental hospitals and other total institutions. Still fascinating reading.

Kaysen, Susan. 1993. *Girl, Interrupted.* New York: Random House. A memoir of mental illness and its treatment.

Wagner, Pamela Spiro, and Carolyn S. Spiro. 2005. *Divided Minds: Twin Sisters and Their Journey Through Schizophrenia*. New York: St. Martin's Press. Two sisters, one who has fought a lifelong battle with schizophrenia and the other a psychiatrist, offer their joint memoir of how schizophrenia has affected their lives and relationship.

Getting Involved

American Civil Liberties Union. 132 W. 43rd Street, New York, NY 10004.

(212) 944-9800. www.aclu.org. Among other things, works for the civil rights of mental patients.

Bazelon Center for Mental Health Law. 1101 15th Street NW, Suite 1212, Washington, DC 20005. (202) 467-5730. www.bazelon.org. Works to advance and preserve the rights of people with mental illnesses and developmental disabilities. Provides extensive information about current issues and late-breaking news in this area.

MindFreedom Support Coalition International. 454 Willamette, Suite 216, PO Box 11284, Eugene, OR 97440. (877) MAD-PRIDE. http://mindfreedom.org. A grassroots organization of self-described survivors of psychiatric treatment, which, among other things, has led campaigns to end involuntary electroshock and psychiatric drugging.

National Alliance for the Mentally Ill. 2107 Wilson Blvd., Suite 300, Arlington, VA 22201. (703) 524-7600. www.nami.org. The nation's leading grassroots, self-help, and family advocacy organization devoted to improving the lives and treatment of persons with severe mental illnesses. Supports the medicalization of mental illness.

Review Questions

How and why do ethnicity, gender, and social class affect rates of mental illness?

What is the relationship between life events and mental illness?

What are the differences between the medical and sociological models of mental illness?

What are the problems embedded in psychiatric diagnoses?

What was moral treatment, and why did it fail?

What was the antipsychiatry critique?

What were the sources and consequences of deinstitutionalization?

What is the remedicalization of mental illness?

How is managed care affecting the treatment and experience of mental illness?

How do individuals become mental patients?

What are the consequences of labeling an individual mentally ill?

Internet Exercises

1. Browse the website for the National Alliance for the Mentally Ill (NAMI) (www.nami.org), the major organization promoting the interests of persons with mental illness and their families. What is NAMI's approach to mental illness? How is it similar to or different from the perspective presented in this chapter?

2. To ascertain the extent to which Freudian ideas now permeate American culture, obtain access through your library or the Internet to *Periodical Abstracts,* the *Readers Guide to Periodical Literature,* or another index of popular magazine articles. Then search for all English language articles from the last two years that use the word *Freudian.* In what ways is the term now used, by what sorts of persons and organizations, and for what purposes?