Sociology 299

Key concepts, definitions and sundry research nuggets – Tausig et al. text, The Sociology of Mental Illness.

Preface

The sociological definition of mental illness: “mental illness can be described as behaviour and thought patterns that are not normative and that require control or constraint because of their potential to disrupt individual and collective arrangements” (p. xii).

Choices for dealing with disruptive behaviour: “punish” vs. “treat.”

Most mental illnesses involve violations of social norms…is therefore m.i. just a category of deviant behaviour subject to social control?

Chapter 1 – Introduction: social causes and consequences of mental illness

Source of psychological distress? Consequences for individuals of psychological problems? What connections are there between social systems and individual well-being? What happens to people labelled mentally ill?

Reviews biological, psychological and sociological perspectives; the medical model

Stress theory – the authors’ approach – terminology (p. 14)

Seeks social origins of psychological distress: ways of feeling that do not always correspond to categories of illness

Definitions:

**Distress:** feelings of an individual about his or her affective state – unhappy, anxious – uncomfortable psychologically; a psychological condition, not a m. i., but can become one…issue is degree and intensity

**Deviance:** a violation of social norms; in the case of psychological deviance, violations of social norms that do not fit other general categories and seem to stem from motives that appear incomprehensible: hence, distress is a feeling state of the individual, while deviance is a perception of others.

**Mental illness:** social categorization of observed deviant behaviour to facilitate treatment.
Chapter 2 – The stress process and mental illness

Towards a sociology of stress…it is a biological, biosocial, psychological and social phenomenon.

Biological basis of stress: stressors, like stimuli, provoke arousal and the goal of the organism is to achieve homeostasis…3 phases to stress response: alarm; resistance; exhaustion…the general adaptation syndrome…hence stress is seen as a physiological state of exhaustion due to external stimuli and the biological failure to adjust….based on the survival mechanism of “fight or flight.”

Today’s stress is not life threatening…daily stress is routine, but the body reacts as it always has in a biological/biochemical sense

Today stress disorders are seen as diseases of civilization; we face repetitive daily stresses; the biological consequences can be negative in the long-term…

But is biology the cause? No, these are consequences of the stress with social origins; clearly socially induced stress has both biological and psychological consequences.

In the biological model disruptions of life events cause stress (imbalances) and the organism seeks equilibrium; extreme social stress can lead to serious illness, even death.

Certain personality traits elevate stress: hostility; aggressiveness; time urgency.

Typical solutions: change the environment; alter perceptions of stress; change our responses to stress.

The Sociomedical Model
Includes social conditions as part of the stress to illness sequence, but social conditions are merely seen as the sources of biological stress; social aspects – gender, income, education, personal adequacy – are simply variables, not seen as causal and there is no analysis of social variations in stress.

The Sociological Model
Stress not just an individual response…certain social categories are more prone to suffer from stress because of their relationship to society and its norms (example of Durkheim’s analysis of suicide). Specific social stressors are not the only cause, but the social structure itself results in clear patterns of distribution of stress, i.e., structural arrangements (SES, gender, ethnicity, etc.) creates distress resulting from stressors.

Structural inequalities are seen as fundamental causes of psychological distress…life events can lead to chronic stress; access to resources – material and psychological – for dealing with stress is different for different social categories; exposure to strain and resulting stress is structurally differentiated; therefore the key…is to analyze how social statuses and roles directly influence the experience of stressors and the ability to cope with them.
**Linking Stress to Mental Illness**

Relationship between stress and m.i…factors include emotional and psychological resources, chronic vs. acute stressors, access to resources to cope.

**Key factors:** predictability and control: inability to control negative life events has both biological and psychological consequences; predictability allows one to anticipate and expect and to prepare. Events or situations over which we have no control are more biologically damaging; stressors can become precursors to m. i. in chronic situations out of the control of the individual…vulnerability: lack of control; lack of support; lack of mediating resources. In examining the risks and rates of m.i., social not biological factors are key.

Stress is a fact of life in the modern world, inescapable…today’s human condition is full of stress---but this stress varies in degree, severity, and frequency along clear social and economic lines; those at high risk of experiencing stress, especially severe stress, vary along a variety of social dimensions; and responses to stress vary along social lines: resiliency vs. vulnerability.
Chapter 3: Social Status: Gender

Key definitions:

Role: a pattern of behaviour, structured around specific rights and duties and associated with a particular status position within a group or social situation. A person’s role in any situation is defined by the set of expectations for his behaviour held by others and by the person himself. [Note: the Gerth and Mills definition provided in the lectures is superior, but either will be accepted on examinations.]

Status: a defined position in the social structure of a group or society that is distinguished from and at the same time related to other positions through its designated rights and obligations. Because each status position in a social structure can be viewed in terms of its superiority or inferiority (advantages, disadvantages), people tend to equate status with rank and prestige or hierarchical position. However, status in the usual sociological sense does not necessarily imply a rank or hierarchy…Each status position is expressed in terms of a role, that is, a pattern of behaviour expected of the occupant of the status. Thus status refers to a location in a system of social relationships, while role refers to the behaviour associated with that location.


Note to students: More recently sociologists have tended to roll these two concepts into a more complete definition of the role, which includes the material associated with status, allowing the term status to be used primarily to denote rank or prestige. The definition of role provided in the lectures is an example of this. But for understanding the Tausig text you should be aware the authors are using status in the way described above.

Sociology of stress: statuses and roles generate stress; they contain differential stressors which differ in kind and degree.

Clear stressors can be associated with gender roles, and studies show that gender is linked to a sense of well-being.

While sex is a biological matter, gender involves cultural expectations and obligations; a source of stress today is that gender lines have become blurred. Stress occurs due to the strain or efforts associated with one’s gender role; evidence is clear that the female gender role involves unjust burdens and hence tends to produce higher levels of stress for women compared to the stress associated with the burdens of the male gender role. But the burdens of both produce stress.

Relationships between gender and mental health

Women are at greater risk of depression and anxiety; men are at greater risk of alcoholism/substance abuse/personality disorders….can this be seen as alternative responses to stress? Both experience stress, but differ in patterns of response.

Social status explanations of distress

Since access to resources is key in one’s ability to cope with stress, those with access to more resources have both fewer stressors and more coping ability….hence, income and work status are very significant.
Women earn less than men, enjoy fewer promotions than men.

Women’s work in the labour market tends to be occupationally segregated, and these occupations typically involve low paying, non-union jobs; less job security; less flexible work; less autonomy…hence women have more stress; and if women are in the same jobs as men, they tend to have less authority and fewer opportunities for advancement.

Therefore, women, on average, work in a restricted labour market, have fewer chances of mobility, work in more stressful jobs, are more vulnerable to economic crises and hence face a higher risk of unemployment and fewer job options….therefore they face chronic job insecurity….therefore they experience more stress.

Social role explanations of distress
Role assignments for men tend to be external, economic roles, while women tend to be assigned domestic roles as wife and mother (as well as their external roles)….this is changing dramatically and has been for years, but change is slow and resistance continues. The changes and resistance causes stress for both gender roles.
Role occupancy: women’s marriage role is associated with higher rates of depression (fewer roles; fewer options/choices); stay-at-home mothers are particularly vulnerable to depression.
Role fulfillment: even married women who work for wages have elevated risks of depression, perhaps reflecting levels of role fulfillment and role satisfaction; working mothers face the same problems as all women in the work world: poor working conditions; lower pay; harassment; discrimination. Need a careful assessment of the subjective dimensions of fulfillment linked to real conditions in the roles and conflicts between them.
Multiple roles: nevertheless women who work, married, divorced and single, have better mental health than women who do not; women face role conflicts between demands of roles of wife and mother and job demands…the double burden, hence they experience more stress than men, both economic and emotional; evidence is that the role of parent causes more stress for women than men…given the pattern, the stress must reside in the role and the social structure.
Overall, women typically experience more role strain than men…role conflict; role overload, particularly due to the responsibilities women balance for home and children and the demands of paid work in the labour force…therefore, the source of this stress is clearly structural.

Interestingly, the risk of depression both for both men and women started increasing in the late 20th century due to structural changes in work and the family….adding more stress to both men and women balancing home and work…yet levels are still more elevated among women.

Definitions:
role conflict: incompatibility between two or more roles an individual is expected to perform in a given situation. The performance of one role interferes with or is antagonistic to the other.
**role demands:** the expectations of others and oneself with reference to a person playing a role in a situation.

**role discontinuity:** a lack of congruity between the expectations associated with social roles taken on consecutively by an individual.

**role primacy:** the precedence of one role over another.

**role strain:** a feeling of difficulty or stress in fulfilling the demands of one’s role obligations.

**multiple roles:** the variety of roles held by an individual at a given time, for example, wife, mother, employee, sister, daughter, etc.
Chapter 4: Social Status: Socioeconomic Status and Ethnicity

Studies on happiness: money, education, high status, good jobs, beauty, whiteness...are all positively associated with levels of happiness and well being...those with high status tend to have higher incomes; more education; fewer difficulties; access to resources; safer and more secure lives...in short, more coping resources....

SES and Well Being

Class and status correlate with mental illness...of 60 studies from 1972 to 1989, 46 reported low SES is linked mental illness...strongest: schizophrenia; personality disorders; and organic based mi; it was also strong for depression and psychological stress...

Hence, very strong evidence based conclusion: low SES (measured by income; education; and occupation) is linked to mi and psychological distress...

Explanations of link: selection or drift vs. social causation...evidence tends toward the social causation explanation...though both must be considered, and it differs by category of mi...conclusion: overall the causation model is the stronger explanation, but selection is also a factor on an individual basis

By disorder: anxiety – social causation; depression – neither was predominant; anti-social – both were factors; ADD – social selection; psychological distress – causation is best.

This is due to the socioeconomic distribution of resources: access to resources is key since it buffers individuals from stress and gives them the resources to cope with stress...

SES must be considered when assessing risk for and vulnerability to mi; and for understanding the frequency and strength of stressors.

Those with high SES tend to have more money; more education; more opportunities; better jobs; more control over their lives; higher levels of empowerment; stronger social networks providing social support...

Can money buy happiness...yes, in a very important way....see quote on page 41 (and on exam key for MT I)...

Race/Ethnicity and Distress

Non-white individuals have a higher risk of mi: “white privilege” built into the structure of society; those who are not white are exposed to more stress and are more vulnerable to stress; there is an intersection with SES: high SES lowers the negative impact but does not eliminate it completely...non-whites face stressors whites do not: discrimination; racial hostility, etc.
Chapter 5: Social Status: Age

-the age cycle – what are the best years of our lives?

-relationship between age and distress:
  -life course..what an individual must expect; pattern – stressors and resources change as we age and are differently available to each age group…both stressors and resources accumulate over our life course

-over the life course: distress decreases slowly to about 55, then begins to climb; social status and role obligations shift over the life course..education, job, career, family obligations, buy home, age, retire…key: acquisitions versus loss of social resources…most important are income and marriage, less important but still key is health

-there are key transitions in the life course that have dramatic impacts

Age, Resources and Distress

-age ranges, social stressors and ability to cope are key interacting variables

-key events: birth of first child; graduation; getting a job/career; buying a house; retirement; death of spouse; illness and decline…during this time there may be key negative events: divorce; loss of job; required support for children

Key issues for children and adolescents: poverty; parenting; divorce/separation of parents; blended families; abuse/neglect

For young adults: 20-25 a stressful time: dramatic events..transition to adulthood; low levels of resources; less control over lives…the problems decline with the acquisition of resources

For middle aged adults: highest levels of well being and lowest levels of mi

For older adults: increasing distress, for some illness and physical decline; decline in resources and control; retirement and its impact on identity and life meaning; death of spouse; less involvement with children

Cumulative nature of well-being over life course: those well positioned enjoy a cumulative advantage as the advantages add up and increase over life cycle; there is cumulative adversity for those in difficulties which increase over the life cycle..leading to a life of stress and an old age of great difficulty (childhood adversity frequently sets the stage for a life time of cumulative adversity)
Chapter 6: Social Status: Community

- community: nation; province; region; city; town; rural area; neighbourhood

- events in the community have effects on mental health

- community involves all of a physical location; a social location; and a psychological group… events like terrorism, crime, violence, natural disasters can have profound impacts on mental health

- a neighbourhood can be psychologically toxic, leading to chronic stress and heightened distress

- community-wide traumas can have strong impacts on a sense of psychological well-being… impacts life anxiety: PTSD; depression… historical evidence that depression was a common unevenly distributed aftermath of community traumas… factors in the incidence of these impacts include: those having a higher risk of distress: women; minority groups; low SES; having children… these groups faced more stress and were more vulnerable to the stress… personal loss as a direct result of the community trauma is the highest predictor of risk elevation

- toxic neighbourhoods: those that are unhealthy, socially disorganized and dysfunctional impose great stress… key to protection from impacts: social support systems
Chapter 7: Social Roles: Spouse, Parent

- important sources of strain and distress: roles/social structure; duties; expectations; obligations; sanctions

Marriage, marital roles, emotional well-being

-does marriage bring happiness?
   - married less distressed than single
   - housewives more distressed than husbands

-marriage is both a buffer/protective factor and also a cause of distress
   - marriage psychologically better for men than women
   - nature of marriage: “good” vs. “bad” marriages
   - concord with role expectations vs. clashes
   - marriage and work: higher levels of stress
   - resistance of men for wives working, bad; best when there is sharing and support

-changes in family structure and distress: see Conway’s family book

-marital status transitions: death, separation, divorce, aging

-parental roles and emotional well-being: children bring joys, but also new conflicts and burdens; these burdens are hardest for divorcee and/or separated mothers: economic burden; less time for self and spouse; life-long burden of children

-gender differences: it is very positive for women to work…they experience much less distress; sharing of loads between husband and wife is key to emotional well-being
Chapter 8: Social Roles: Worker

- work is central to our lives and identities: key factors: nature of work; enjoyment; empowerment; significance; pay levels…can be major source of distress: alienation; exploitation

- economy, labour market and distress: unemployment; economic cycles; downsizing; job distributions; shifts; factory closures; deskilling; part-time…there is clear evidence of a direct relationship between the economy and our psychological state

- job conditions and distress: demeaning work; levels of ability; freedom to meet demands; degrees of latitude; complexity; co-worker support; job security; impacts of general economy

- gender/SES/ethnicity/job conditions: bad jobs are not randomly distributed: women’s segregation in labour force; male privilege; SES; ethnicity
Chapter 9: Intersection of Statuses and Roles

- anchoring of self concept in the social structure: psychological well-being; to assess, list statuses and roles..rank the stress attached to each and note the intersections which might result in high stress levels

- key intersections; gender/work/marital status/parental status/age/ethnicity

- single mothers: very high stress: both parent roles/managing emotions/economic problems/lower economic well-being, less security/balancing multiple roles

- caregivers: another very high stress situation

- statuses and roles combine to predict distress….see chart on page 109
Chapter 10: Labelling Deviant Behaviour of MI

-when is the MI label applied?

-deviant behaviour as MI: there is a range of deviant behaviour from the trivial (bad manners) to the serious (crime)…MI is deviant behaviour that is not comprehensible, seems to lack purpose, intent or reason

-social control: MI violates social norms, therefore it is a form of deviant behaviour and the issue of social control must be addressed…MI is disturbing to others and results in strong demands for social control…both informal and formal

-labelling: MI carries a social stigma leading to social isolation and rejection; the label causes the person to redefine the self; in a sense others create MI by imposing the label, in that sense MI is a social construction

-who has the power to label? family, teachers, social workers, police, courts, mental health professionals…labelling has a strong negative impact on one’s social status.
Chapter 11: The Relationship Between Public Attitudes and Professional Labels

-negative public stereotypes of mi and the associated attitudes: poor knowledge; fear of insanity biases judgement...key views: unpredictable; dangerous; no personal responsibility

-reactions to being labelled: powerful, life changing impacts

-why a negative stereotype? media; but also our self awareness is threatened by the fear of becoming mi, of losing control, of becoming the “other” – we strive to be in command of ourselves and those who aren’t are threatening to our sense of security; our culture contains negative core concepts of mi and instructs us on how to react to those afflicted; we share common sentiments that are evoked

-professional labels: not immune from public attitudes and cultural conceptions; there is much disagreement; continuing debates of nature of mi and efforts to increase the number of categories of mi..this can be seen in the profession’s self interest...key debate: when is distress and disturbance “normal” and when is it pathologized?

-classification of mi: psychiatric classification not the same as diagnosis of physical illness..it is unscientific; value laden; based on subjective professional judgement...it differs wildly within the profession

-look at the discussion of the DSM IV and the disorders added and deleted...there is no objectivity in diagnosis, it is riddled with bias
Chapter 12: The Medicalization of Deviant Behaviour and M I

-the DSM is based on the medical model...why a medical approach to psychological problems?....see discussion of anorexia nervosa and John Hinckley

-the biomedical model seeks to explain behaviour that is incomprehensible; no clear evidence of a biological basis but we believe it to be so; psychological deviance has come to be seen as an illness; behaviour that is immoral, sinful, criminal, bizarre becomes an illness; hence social control of the deviant behaviour in this context has become medical

-deviant behaviour and its control: violations of norms and role expectations..deviant behaviour; must be socially controlled due to threats to social stability and in order to maintain social advantages...control involves reducing the chances of occurrence...first line is socialization; if that fails, the need for positive and negative sanctions

-illness as deviant behaviour: the medical system is a less obvious agent of social control; mi is a failure to fulfill roles and meet expectations; the question of responsibility: if you are responsible, you are punished; if you are not responsible, you are treated; but treatment and punishment are not always clearly distinguished (especially in the case of mi)

-medicalization of deviant behaviour: in complex societies we rely on more formal systems of control; this includes medical interventions to control behaviour; this is part of the trend of secularization as we shift from priests to doctors in our help seeking; the medical model is very legitimate, respected and authoritative; mi does not have symptoms typical of other illnesses and medical interventions that work for other illnesses are less successful with mi; the behaviour of the mi is more ambiguous

-the medicalization process: definition of behaviour as deviant; search for a medical diagnosis; claims are made by medical and non-medical interests; struggle to gain legitimacy by securing the turf for a medical approach; the institutionalization of the medical diagnosis designation

-benefits of medicalization; humane responses; less stigma; more hope for relief and cure

-costs of medicalization: ignore social conditions that lead to disorders; cloak values and biases in neutral medical terms; can lead to harmful treatments (strong drugs; surgery; etc.); establishes a biological determinism of social and psychological behaviour

-prevalence of mi in general population: deviance is defined by upper classes, imposed on lower classes; seeing deviance as mi can been seen as a method of social control; distribution of mi....30% of 15 to 54 yr. olds fit some DSM category over their lives and 50% of these undergo some kind of diagnosis, hence the types of behaviour classified as mi are wide spread...yet only 40% of these are treated...most frequently: substance abuse; depression; phobias (see p. 161)
-social distribution of mi: distributed by class, age, gender, marital status, race, rural/urban, etc.; is defining deviance as mi a measure of social control? perhaps, since mi patterns follow patterns of disadvantage

-deviant behaviour or psychological dysfunction? Key points: mi and SES; treatment depends on SES; hence social control...or is it stress, or both social control and stress?...note that much deviance including much mi is normalized by communities, but severe disorders are much higher among low SES groups; many of the mi are in prison...hence our definitions of criminal and medical seem arbitrary and class oriented

-benefits of medical model: responses tend to be therapeutic, helpful, gentler...but if seen as the responsibility of the person, then punish...the biological model shifts blame from society and the individual to biology...but we still punish and impose involuntary committals...hence the reaction of society...and its control agencies...is key in terms of the consequences for the mi
Chapter 13: History of Societal Reactions to MI

-mi is a social/historical construction of a form of deviant behaviour

definitions of deviance and social responses varies across cultures: e.g., self-starvation can be seen as anorexia nervosa; a religious observance; a political statement....it all depends on the motives and their acceptability in the culture
-views on the mind/body relationship vary across cultures
-common explanations of mi: body’s loss of a vital substance (soul, body humours, etc.); presence of a foreign body (possession, toxic chemical, germs etc.); violations of cultural and social taboos (god, guilt, social punishment); the malevolence of others (witchcraft; abuse, labelling etc).....our new science of mi provides variations on these old themes...all constitute efforts to explain, understand, and treat mi

-key issues: degree of personal responsibility; treatments and consequences of mi; debates about cause

-non-western definitions of mi and responses: often supernatural causes; treatment – magic, herbs; evil eye or possession; the work of enemies; imbalances in the body

-western culture
-ancient Rome and Greece: no mind/body distinction
-mi caused by competing external demands
-later: mental life was seen as internal and individual; separation of mind and body; more personal responsibility; mi due to internal conflicts; therapy was to develop personal insight; 4 types of madness: prophetic; poetic – seen as positive and creative; erotic; ritual – seen as negative and socially disruptive; gradually came to be seen as an illness calling for therapy not punishment
-Middle Ages: religious causes of mi; outcome – personal responsibility; change by personal effort; control of behaviour was a social concern
-industrialization, enlightenment and the need for order: Foucault – “the great confinement”...deviance controlled by secular state; age of reason: unreason was threatening and had to be managed; rounding up “problem populations” – gradually a categorization of those who had to be confined: the criminal and the mad...the growth of large public hospitals/asylums
-modern medical and psychological explanations...growth of influence of medical model
-end of hospital era...beginning in 1940s...asylums had become dumping grounds; more scientific research on mi; more differentiation of disorders; more treatments; expansion of definition of mi; recognition of stress and social conditions as causal factors
-shift to community-based care: less serious mis could be managed and treated in community rather than the asylum; issue became more one of social control and management; as disorders expanded...became more common...attitudes and treatments changed
Chapter 14: The Challenge of Community MH

-big debate today and for past 30 yrs: community-based treatment; deinstitutionalization
-failures of community-based treatment and need for institutions for some cases
-“madness in the streets” – low quality of community programs; emphasis on maintenance rather than rehab or re-integration

-“paradigm shift” re: severe disabilities from patients to service recipients to citizens with disabilities with rights to full participation and integration

-roots of community care: big transition from hospital to community-based care; mental hospitals failed; poor conditions; cost of custodial care; psychotropic drugs; much mi untreated; legal rights won for the mi

-state of public mental hospitals: overcrowded; terrible conditions; permanent dumping ground; availability of psychotropic drugs: control symptoms and behaviour making community care possible; economics of custodial care: fiscal pressures; cost savings

-mi in general community: high rates of untreated and undiagnosed mi in gen pop; these people should be served as well

-legal requirements: judicial interventions: right to treatment; to freedom; to less restriction; informed consent; no longer possible to confine people with impunity….new legal principle: “the right to treatment in the least restrictive setting”

-new philosophical orientations to treatment; growing varieties of treatment not needing a hospital setting; treatment in the community, keeping the person integrated; deinstitutionalization: release from hospitals of large numbers of patients; community based services established….despite problems with underfunding and access, some significant successes (US – 1955 to 1983: 560,000 inmates in asylums reduced to 115,000)

-psychiatric hospitals today: smaller; fewer; better staffed; length of stays reduced from years to days

-the community ideal
-“the third revolution” – see pp 188-89: first, treat rather than punish (1800-1900); second, focus on intrapsychic causes (1900-1950); third, community mental health: keep in community; normalization; save from institutionalization; return to home and community soon; maintain in community…aftercare, rehab….see pp. 188-194 for ideal and the commitment of insufficient resources….leading to persistent problems
Deinstitutionalization and Community Mental Health: Persistent Problems
- today many seriously ill receive little or no psychiatric treatment; incarcerated in jails; homeless on the streets; boarding houses or nursing homes not much better than asylums; ideal has fallen far short of its stated mission

- why such a bad failure?
  - failure to make community based treatment available
  - many of the afflicted simply transferred from large asylums to nursing homes, group homes; and general hospitals...in effect, re-institutionalized
  - major goal became to reduce costs...one example, only 6.5% of saved funds were re-allocated to community treatment...therefore funding did not follow the patients
  - governments refused to invest in needed community treatment infrastructure

- result: unmet needs; many untreated; rehospitalisation accelerated; incarceration in jails
- the community based programs that were set up focussed on those with acute short-term mis; those with chronic mi fell through the cracks
- an utter and unqualified failure; reliance on drugs to control symptoms and that’s it for most...30 to 40% of the homeless are mi....see pp. 198-199 for partial successes and major failures

- the financing of mental health services and the growth of managed care...chronic funding problems (see pp. 199-201); move to managed care in the US: goal: lower costs and increased profits

- current trends in community mental health: a good idea that will not go away; growing pressure to realize its ideals and goals; pressure to get adequate funding; growth of a powerful lobby around mi and the growth of political pressure on governments

- the family and community mental health care: 75% of chronic mi people maintain family contact; 25% live with their families; resistance to family involvement (viewed as dysfunctional and seen as part of the problem); medicalization and biological theories relieved families of much of the blame for mi; community care implies some family support, hence the family has become a major source of support and care for many among the mi

- for a review of family burdens and family reactions see pp. 204-206; for review of the growth of alternative therapies see pp. 206-208
Chapter 15: The Contribution of Sociology
- Psychological afflictions are “a personal trouble” in the Mills’ sense, hence sociology searches for explanations; understandings; and coping strategies at both the individual and social levels

-the value and limits of the sociological perspective on mi; how much sense does the sociological model make for understanding and strategies for coping and for preventing mi?

Other explanations

-the biopsychosocial model: focus on the individual: the medical gaze (Foucault): disorder is pathological, individual-centred, and treatable...an abnormal process which can be cured or managed; an “illness” requiring “active treatment” to regain normalcy

-sees the social context of social distress as peripheral in favour of individual characteristics...focus only on “proximate risk factors, potentially controllable at the individual level”

-despite lip service to multiple causation views, most focus primarily on a biomedical model and approach to explanation and treatment

-biological causation: most widely accepted; mi as physical illness in the brain: a problem with the apparatus; the brain is the organ of behaviour: behaviour results from complex brain structures and events (chemical, electrical, etc.); abnormality is due to problems with the structure or the events; brain and mind are the same; most often applied to mood disorders (depression, mania), schizophrenia, dementia, and anxiety: all seem to respond well to drug therapy, but are rarely “cured” by drugs, merely symptom relief; so far unable to locate specific biological causes of disorders; a limited role for the environment: simply impacts on brain structure and events

-psychological causation: many theories; big influence by Freud; behaviour can be explained by unconscious and/or conscious psychological processes rather than by biology; separation between mind and body; minds develop through stages and traumatic events can disrupt development; talk therapy

-psychodynamics: perspective which assumes the existence of the unconscious plus a developmental process of psychological/personality maturation; individualistic, particular psychic injuries lead to mi

-cognitive theories: focus on current conscious thought processes; errors and distortions in thought lead to abnormal behaviour; the mi have distorted, exaggerated, mistaken or unrealistic ideas about the world and the way it works; seek the sources of the errors and encourage insight

-social causation: focus on social learning and behavioural approaches to mi; behaviour (including mi) is learned responses due to conditioning; deny a role for the conscious and
unconscious psychological processes and biology as central in the production of behaviour; used to deal with specific problems – behaviour modification, based on conditioning and reward and punishment; does not seek “cures” but seeks behavioural change

The Place of Sociological Explanations
-no logical or empirical support for biopsychosocial model; few scientific studies confirming the various causal explanations or therapies; no one explanation
-sociology has provided a plausible, empirically evaluated explanation for the causes of mi, among the best tested and confirmed; stress theory goes far beyond all others in successful explanation of mi; essential insight—“the opportunities and constraints of everyday life, which are created in one’s positions in social hierarchies and the roles one assumes, can be used to predict levels of distress” (p. 217); people are both psychological and sociological beings with unique biographies, but share common social experiences in the social structure; they are not aware of these larger social influences, but are nevertheless impacted; sociology seeks to know the “social context” that creates risk factors which lead to mi; see depressed nurse example, p. 218

Social Causes of Psychological Distress
-social structure: gender; SES; power and control...big impacts on well being; structural changes could alter the rates of disorder; raises big political, economic and social policy issues; looks at social costs of mi; contextualizes the risk factors and hence raises issues of social structure and public policy; thus provokes political debate; personal troubles of mi become public issues of social structure

Societal Reactions to Mental Illness
-the sociological approach supports a better understanding of mi; the need for community approaches to mi; points to a series of possible “cures” in the social structure and social policy; needs to persuade the public and those with power to look at the evidence

The End