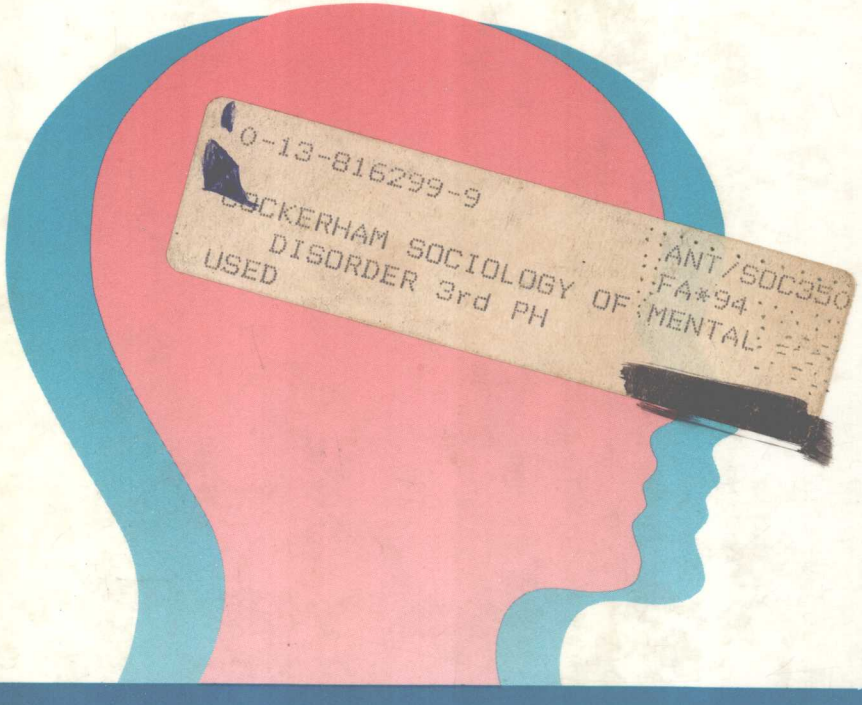
Third Edition

SOCIOLOGY OF MENTAL DISORDER



William C. Cockerham

Sociology of Mental Disorder

Third Edition

WILLIAM C. COCKERHAM
University of Alabama at Birmingham

PRENTICE HALL, Englewood Cliffs, New Jersey 07632

Library of Congress Cataloging-in-Publication Data

COCKERHAM, WILLIAM C.
Sociology of mental disorder/William C. Cockerham.—3rd ed.
p. cm.
Includes bibliographical references and index.
ISBN 0-13-816299-9
1. Social psychiatry. 2. Mentally ill—Social conditions.
I. Title
RC455.C57 1991
616.89—dc20 91-37229
CIP

Editorial/production supervision
and interior design: Kari Callaghan Mazzola
Acquisitions editor: Nancy Roberts
Cover design: Barbara Singer
Prepress buyer: Kelly Behr
Manufacturing buyer: Mary Ann Gloriande

To Bruce
"Le Brave des Braves"

Printed in the United States of America
10 9 8 7 6 5 4 3 2 1

ISBN 0-13-816299-9

PRENTICE-HALL INTERNATIONAL (UK) LIMITED, *London*
PRENTICE-HALL OF AUSTRALIA PTY. LIMITED, *Sydney*
PRENTICE-HALL CANADA INC., *Toronto*
PRENTICE-HALL HISPANOAMERICANA, S.A., *Mexico*
PRENTICE-HALL OF INDIA PRIVATE LIMITED, *New Delhi*
PRENTICE-HALL OF JAPAN, INC., *Tokyo*
SIMON & SCHUSTER ASIA PTE. LTD., *Singapore*
EDITORA PRENTICE-HALL DO BRASIL, LTDA., *Rio de Janeiro*

Sociology of Mental Disorder

Preface

This book underscores sociologists'increasing interest in the problem of mental disorder. A contents analysis of the American Sociological Association's *Journal of Health and Social Behavior* for the past few years would disclose that nearly as many articles are published on some aspect of mental health as are published on physical health. Increase in the number of sociologists and the amount of sociological research oriented toward mental disorder has meant a corresponding increase in the number of courses taught on the subject in American colleges and universities. Yet it has only been since the mid-1960s that a substantial body of literature has emerged to establish firmly the sociology of mental disorder as a major subfield. It is appropriate that an effort be made to summarize and analyze the direction of the field. This book represents a continuing personal attempt to accomplish that end.

Although the conclusions expressed in this book are solely the responsibility of the author, other individuals provided extremely helpful comments. A note of appreciation is due to the following colleagues who read all or part of the manuscript: Norman Denzin, University of Illinois; Sharon Guten, Case Western Reserve University; Stephan P. Spitzer, University of Minnesota; Raymond M. Weinstein, University of South Carolina; Paul M. Roman, Tulane University; Robert Emerick, San Diego State University; R. Blair Wheaton, University of Toronto;

Neil J. Smelser, University of California, Berkeley; David D. Franks, Virginia Commonwealth University; Michael Radalet, University of Florida; Michael Hughes, Virginia Polytechnic Institute and State University; and Hugh Floyd, University of New Orleans.

William C. Cockerham
Birmingham, Alabama

Contents

— 1 —

The Problem of Mental Disorder

Mental disorder affects the lives and well-being of millions of people throughout the world. The exact number of persons who suffer from some form of it is not known, because many afflicted people do not come to the attention of reporting agencies. Moreover, community investigators face a multitude of problems in obtaining fully reliable data on the extent of mental disorders in noninstitutionalized populations. But enough data are available in advanced societies to make relatively accurate assessments, and it is clear that mental disorder is a major social problem. For example, in the United States, approximately 15 to 20 percent of the total population has some type of mental disorder, ranging from relatively mild psychological difficulties to severe cases of highly disabling mental abnormalities.

The extent of mental disorder and the high social and economic costs associated with it are substantial in most advanced societies. But what is truly the most damaging aspect of mental illness is its shattering effect upon the lives of its victims and their families. Suicide, divorce, alcoholism and drug abuse, unemployment, child abuse, damaged social relationships, and wasted lives, not to mention the incalculable pain and mental anguish suffered by those involved, are among the consequences of mental illness. In these respects, mental disorder can be regarded as a terrible affliction for many people in the United States and elsewhere.

With increasing numbers of studies uncovering a significant rela-

tionship between social factors and many psychiatric conditions, the study of mentally disturbed behavior has become an important area of research in sociology. Unlike psychiatrists and clinical psychologists, who usually focus on individual cases of mental disorder, sociologists approach the subject from the standpoint of its collective nature; that is, they typically analyze mental disorder in terms of group and larger societal processes that impact on people and their mental state.

In a social context, mental disorder is seen as a significant deviation from standards of behavior generally regarded as normal by a majority of people in a society. The relevance of this perspective for our understanding of mental disorder is that, even though a pathological mental condition is something that exists within the mind of an individual, the basis for determining whether or not a person is mentally ill often involves criteria that are also sociological. A psychiatric finding of generalized impairment in social functioning requires an understanding of such sociological concepts as norms, roles, and social status that establish and define appropriate behavior in particular social situations and settings. It is the disruption or disregard of the taken-for-granted understandings of how people should conduct themselves socially that causes a person's state of mind to be questioned. Consequently, it is the overt expression of a person's disordered thinking and activity as social behavior that ultimately determines the need for psychiatric treatment in most cases.

This situation has attracted sociologists to the study of mental disorder and has led to its development as a specialized area of sociological research. The sociology of mental disorder is generally viewed as a subfield of medical sociology, which itself is a fairly new field. In fact, it was the funding and encouragement of the National Institute of Mental Health during the late 1940s that stimulated the development and rapid expansion of medical sociology in the United States. Therefore, from its most important beginnings, the sociology of mental disorder has been linked to medical sociology. But despite its status as a subfield within medical sociology, the sociology of mental disorder has acquired an extensive literature containing significant theoretical concepts and applied knowledge of the human condition. It is the purpose of this book to provide an overview of that knowledge for students, sociologists, health practitioners, and others interested in and concerned with the social aspects of mental disorder.

DEFINING MENTAL DISORDER

Before proceeding we first should define mental disorder. This is no easy task, as there is considerable disagreement over what constitutes mental disorder, even among mental health professionals. Robert Spitzer and

Paul Wilson (1975) helped to clarify some of the issues by asking (1) whether certain mental conditions should be regarded as undesirable; (2) how undesirable these mental conditions should be to warrant being classified as mental disorders; and (3) even if undesirable, whether the conditions in question should be treated within the domain of psychiatry or by some other discipline.

Some psychiatrists define mental disorder very broadly as being practically any significant deviation from some ideal standard of positive mental health. This view, as pointed out by Thomas Szasz (1974), a psychiatrist and critic of his profession, would regard any kind of human experience or behavior (for example, divorce, bachelorhood, childlessness) as mental illness if mental suffering or malfunction could be detected. Other psychiatrists, in contrast, subscribe to a more narrow definition of mental disorder, which views the condition as being *only* those behaviors that clearly are highly undesirable. Behaviors that are merely unpleasant would not be mental illness. This narrower definition would encompass those mental abnormalities like schizophrenia, mood or anxiety disorders, or an antisocial personality, which Spitzer and Wilson (1975:827) describe as "manifestations which no one wants to experience—either those persons with the conditions or those without them." This latter approach appears more realistic.

The problem of defining mental disorder is further complicated by the fact that concepts of mental disorder often change and are even changing now. For example, homosexuality was considered a mental disorder by American psychiatrists until the early 1970s but is not considered such today. Terms like melancholia (depression), amentia (mental retardation), hysteria (conversion disorder), and moral insanity (for people who were not truly insane but were thought to be perverted, such as nymphomaniacs) are no longer used. Yet they were major classifications of mental disorders at one time or another during periods ranging from ancient Greece to the twentieth century. A recent example is neurosis, which used to be a major behavioral disorder characterized by chronic anxiety, but now has its various subtypes classified under mood, anxiety, somatoform, or dissociative disorders.

Surprisingly, neither standard textbooks in psychiatry nor the first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) generally defined mental disorder. Spitzer, a research psychiatrist who headed the American Psychiatric Association's Task Force on Nomenclature and Statistics charged with developing DSM-III, addressed this problem (American Psychiatric Association 1980). According to Spitzer (Spitzer and Wilson 1975:829), mental disorder can be defined as follows: (1) It is a condition that is primarily psychological and that alters behavior, including changes in physiological functioning if such changes can be explained by psychological concepts, such as per-

sonality, motivation, or conflict. (2) It is a condition that in its "full-blown" state is regularly and intrinsically associated with subjective stress, generalized impairment in social functioning, or behavior that one would like to stop voluntarily because it is associated with threats to physical health. (3) It is a condition that is distinct from other conditions and that responds to treatment.

Of the three criteria described above, the first separates psychiatric from nonpsychiatric conditions. The second specifies that the disorder may be recognizable only in a later stage of its development ("full-blown") and that its identification depends upon consistent symptomatology ("regularly associated with"). Spitzer also says that the disorder must arise from an inherent condition and that the impairment in functioning must not be limited to a single situation, but should include an inability to function in several social contexts ("generalized impairment in social functioning"). The second criterion also includes "behavior that one would like to stop voluntarily," for instance, compulsive eating or smoking. The third criterion places the definition within a medical perspective by limiting it to distinct treatable conditions.

MADNESS THROUGH THE AGES

Throughout history, people have attempted to cope with the problem of behavior that was irrational, purposeless, and unintelligible. Ideas about the nature of mental illness have been intrinsic to ideas about the nature of human beings and their mode of civilization. What people have thought about mental illness has revealed what they have thought about themselves and the world they lived in. In order to better understand contemporary approaches to the problem of mental disorder, it is useful to review the evolution of those approaches from humankind's preliterate past up to the present. Present measures on the part of human societies to cope with mental disorder as a social problem are grounded in the experiences of the past.

Witch Doctors

Primitive attempts to explain both physical and mental disorders were based largely upon intuition. Sometimes early humans noted a cause-and-effect relationship between taking a certain action and alleviating a certain symptom or curing a wound. Primitive people could certainly understand the effect caused by striking someone with a spear or a large rock. The effect could be death. Most often an illness, however, especially if its cause could not be directly observed, was ascribed to supernatural powers. In essence, primitive medical practice was primi-

tive psychiatry, as humans applied subjective notions about their environment to ailments whose origin and prognosis were beyond their comprehension.

In most preliterate cultures, an illness would be defined as a problem brought on because those who were sick (1) had lost a vital substance (such as their soul) from their body, (2) had had a foreign substance (such as an evil spirit) introduced into their body, (3) had violated a taboo and were being punished, or (4) were victims of witchcraft (Abel, Metraux, and Roll 1987; Kiev 1964, 1972; Mora 1985). All of these explanations of disease causation are clearly bound up in ideas about magic and the supernatural. Because there was so much that was mysterious about the world around them and the functioning of their own bodies, primitive humans attempted to explain the unexplainable by applying human motivations to the unknown. Yet, as Ari Kiev (1972) observes, these etiological concepts were not random ideas but were derived from linking particular symptoms to particular beliefs and customs prevalent within a society. Widely held taboos among primitive groups, for example, are murder and incest. Violations of these taboos are thought to have deleterious effects on the mind of the perpetrator. Thus, in this situation, insanity is believed to be a form of punishment by God, or whatever deities are common to that society, for misdeeds that violate collective morals. According to Kiev (1972), taboo violations seem to be universally a primitive explanation for mental illness.

Another example is found in Haiti, where the belief still prevails among some superstitious persons that a sorcerer can force the soul from a victim's head through the use of magic and replace it with the soul of an animal or an insane dead person. This act is thought responsible for the victim's then disordered behavior. There is also a belief that a curse can cause death. Here one is dealing with a cultural belief that a curse is "real." The result can be a state of extreme anxiety on the part of the person cursed, who eventually dies from shock induced by prolonged and intense emotion associated with believing in the reality of the curse. This reaction is reinforced by the response of others who seek to avoid contact with the person who has been cursed. Such an event demonstrates the possible psychological leverage that a group can have over an individual in certain circumstances and the significance of the role assigned to that person. According to local customs, being cursed might result in interaction that could hasten a person's death. Of course, this is dependent on the belief of all concerned, especially the victim, that the curse is fatal.

If evil spirits and *black* magic are believed to cause death and illness, then it is perfectly permissible to employ *white* magic to counter the work of the evil person or supernatural entity causing the suffering. This belief created the need for healers known as witch doctors or sha-

mans, who work at producing a cure by applying magical arts grounded in folk medicine and prevailing religious beliefs. The most commonly held image of a shaman is that of a medicine man who is susceptible to possession by spirits and through whom the spirits are able to communicate (Abel et al. 1987; Mora 1985). Shamans can be either men or women, although men apparently are more likely to be extraordinarily successful (Murphy 1964). This is probably because men can "act" more violently during rituals and thereby appear more powerful. Advanced age, high intellect, and sometimes sexual deviance, such as transvestism and homosexuality, are characteristics of shamans. Also, being an orphan, being physically disabled, or even being mentally ill is not uncommon.

The most important equipment for a shaman is a strong imagination, for the shaman theoretically gains his strength by mentally drawing upon power that he believes exists outside himself in nature or in the cosmos. He tries to accomplish this through deep concentration while engaging in a mind set stimulated by chants, prayers, drugs, drinking, ritual dancing, or perhaps sex. The shaman works himself into a frenzy until he senses he has become the very force he seeks; when this happens he projects his supposedly powerful thoughts out of his mind toward the intended target. The extent of his influence depends upon the belief that other people have in his ability to conjure up and control supernatural forces for either good or evil.

Although witch doctors have often had considerable power and prestige among their fellows, they by no means have always occupied a desirable role in society. They may have been viewed as deviant and odd, a condition perhaps reinforced by the need to work with undesirable people and matter (for example, snakes, insects, human organs, and excretion). Kiev (1972:99) notes that primitive shamans were often recruited from the ranks of the mentally disturbed. Skill in performance is apparently the most significant criterion in shamanism, rather than heredity or special experience, although the latter can be particularly important. In this occupation, a degree of craziness can be an advantage for the performer.

Typically, the shaman's performance reflects certain principles of magic, such as similarity or "sympathetic magic" and solidarity or "contagious magic." *Sympathetic magic* is based upon the idea that two things at a distance can produce an effect upon each other through a secret relationship. That is, two things that look alike affect each other through their similarity because the shared likeness places them in "sympathy" with each other. Thus, "like" is believed to produce "like." A well-known example of this notion comes from voodoo and is the sticking of pins into a doll made in the image of a certain person in order to inflict pain on that individual. In healing, a shaman might act out a sick person's

symptoms and recovery, supposedly to "orient" the illness toward recovery. An example of sympathetic magic in relatively recent times comes from the Shona tribe living in southern Zimbabwe in Africa. Here a usual practice of witch doctors is to administer the shell of a tortoise in some form to a patient to give that patient a general feeling of strength and security; or a portion of bone removed from a python's back may be used to try to restore strength in a patient's back by having the patient eat the bone fragments.

Contagious magic is based on the idea that things that have once been in contact continue to be related to each other. Hence, a shaman might use a fingernail, a tooth, or a hair as the object of a magical act to affect the source of that part in some way. Among the Shona, all shamans practice contagion. A member of the Shona group might, for example, obtain some article of clothing that an enemy has worn close to his or her body, take it to a shaman who can produce a spell on it, and supposedly cause the enemy to become ill (Gelfand 1964).

Other measures used by witch doctors include the prescription of drugs made from parts of people, animals, or plants and prepared secretly according to a prescribed ritual. Sometimes an evil spirit might be forced to leave a body by inducing vomiting, through bloodletting, or as bodily waste. For instance, the following ritual is used by Yoruba witch doctors in Nigeria for treating a psychosis diagnosed as being due to a curse (*epe*) or sorcery (*asasi*):

> The patient's head is shaved. Shea butter, palm oil, pap, and banana are kneaded together and then generously plastered on the scalp; next juices of certain leafy plants are squeezed into a pail of water to make a cooling shampoo. This shampoo is used to wash off the oily plaster. Finally, a series of shallow razor cuts is made over the scalp in the form of a cross. Into these cuts is rubbed a medicine composed of certain roots, the filings of a human tooth, and a small quantity of fluid collected from a putrifying human corpse. The oily mixture soothes the patient's agitation, while the shampoo cools his overheated brain. The medicine enters the patient's blood through the cuts, "fights" with the toxic agents caused by the *epe* or *asasi*, and expels them into the feces and urine. This technique of cutting to introduce substances into the blood is widely used. The cuts are made near the seat of the trouble, that is, in the case described above, in the head; in cases of visual hallucinations or the nightmares of children, they are made under the eyes; for auditory hallucinations, they may be made in front of the ears.[1]

[1] Raymond Prince, "Indigenous Yoruba Psychiatry," in *Magic, Faith, and Healing: Studies in Primitive Psychiatry Today*, ed. A. Kiev (Glencoe, IL: Free Press, 1964), pp. 100–101.