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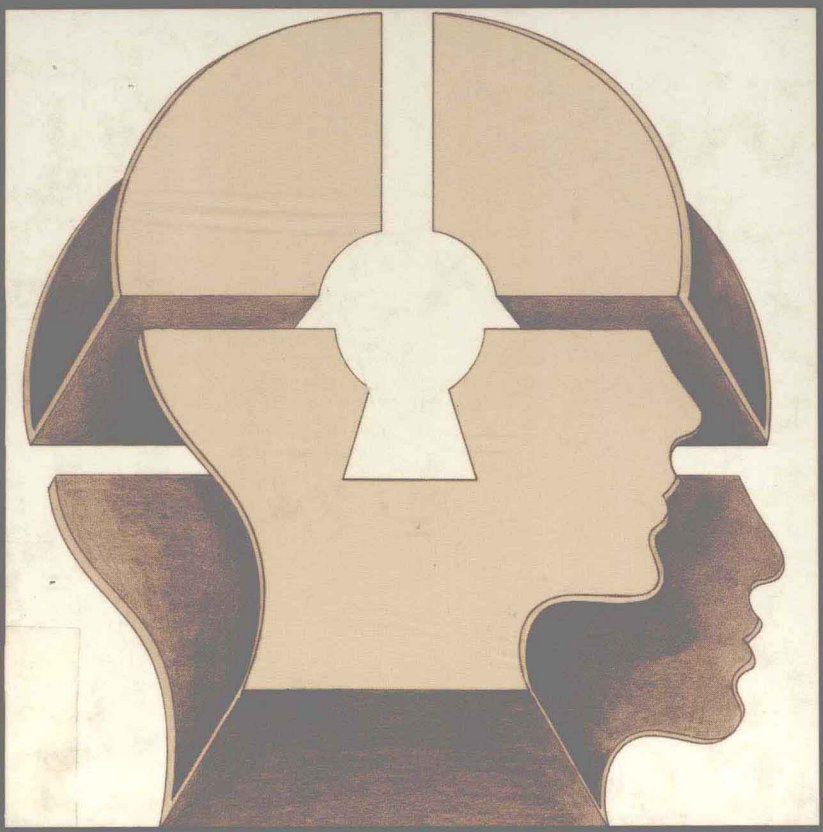
Sociology of Mental Disorder



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Sociology of Mental Disorder

Preface

This book underscores the increasing interest in the problem of mental disorder by sociologists. 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 personal attempt to accomplish that end.

While 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, McGill University; Neil J. Smelser, University of California, Berkeley; David D. Franks, Virginia Commonwealth University; and Michael Radalet, University of Florida.

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Contents

The Problem of Mental Disorder

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Mental disorder affects the lives and well-being of millions of Americans. In fact, mental disorder, more popularly known as mental illness, joins heart disease, cancer, and accidents as the greatest threats to the health of the American public. The exact number of persons who suffer from mental illness in the United States is not known because many such individuals do not come to the attention of reporting agencies and also because community investigators face a multitude of methodological problems in obtaining fully reliable data on the extent of mental disorders among noninstitutionalized populations. However, according to the National Institute of Mental Health (1985), the best current estimate suggests that 18.7 percent of the American population, about 29.4 million people, are afflicted annually by some form of mental disorder.

In economic terms, the cost of mental illness for American society is substantial. For example, the estimated cost of mental illness in the United States in 1980 was between $19.4 and $24.1 billion, based upon National Institute of Mental Health (1985) figures. The tremendous financial cost is not the most important drain on American society. What is truly the most damaging aspect of mental illness is its shattering effect on the lives of its victims and their families. Suicide, divorce, alcoholism, unemployment, and child abuse, not to mention the incalculable pain and mental anguish

suffered by those involved, are among the consequences of mental illness. In these respects, mental illness can be regarded as a terrible affliction for many people in the United States and elsewhere.

Because of its immense importance and because of the significant relationship between mental disorder and social conditions, the study of mentally disturbed behavior is a major area of sociological research and analysis. 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. Consequently, 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. The various perspectives and arguments on this matter will be reviewed in detail in Chapter 3 ("Models of Mental Disorder"), but in brief, Robert Spitzer and Paul Wilson (1975) have helped to clarify some of the issues by identifying three problem areas: (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 within 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 well-known critic of his profession, would regard any kind of human experience or behavior (for example, divorce, bachelorhood, childlessness) as mental illness if suffering or malfunction can 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, affective 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 as late as 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 the twentieth century to ancient Greece. A recent example is neurosis, which has disappeared from the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) published in 1980 by the American Psychiatric Association. What used to be called "neurosis," a middle-range (in terms of severity) and major behavioral disorder characterized by chronic anxiety, now has its various subtypes classified as affective, anxiety, somatoform, or dissociative disorders. The so-called neurotic is passing into history.

Surprisingly, neither standard textbooks in psychiatry nor the first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* 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. According to Spitzer (Spitzer & 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 personality, 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 not from the manner in which society reacts to it and that the impairment in functioning not be limited to a single form,

such as heterosexual relationships, but 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.

Even though the locus of the pathological condition is defined by Spitzer as existing within the individual, the basis for determining whether or not a person is mentally disordered includes criteria that are also distinctly sociological. To a large extent, a finding of generalized impairment in social functioning derives from an understanding of sociological concepts such as norms, roles, and status that set and give meaning to normality in particular social situations. It is the disruption or disregard of these concepts, like everyday taken-for-granted understandings of how people should conduct themselves in a particular society or social group, that causes a person's mental state to be questioned. Although mental disorder arises not from society's reaction to such a person but from within the person, as Spitzer points out, it is the expression of one's disordered psychological condition as social behavior that ultimately determines the need for psychiatric treatment.

MADNESS THROUGH THE AGES

In order to understand fully the contemporary social and psychiatric approaches to dealing with the problem of mental illness, it is useful to consider the evolution of those approaches from humankind's preliterate past up until the present. 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 their societies.

Witch Doctors

Primitive attempts by early humans to explain both physical and mental disorders were based largely upon intuition. Sometimes they 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 primitive 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 (Clements, 1932; Alexander & Selesnick, 1966; Kiev, 1964, 1972; Mora, 1985; Abel, Metraux, & Roll, 1987). All of these explanations of disease causation are clearly bound up in ideas about magic and the supernatural. Since 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 created the need for healers known as witch doctors or shamans 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 (Mora, 1985; Abel et al., 1987). Shamans can be either men or women, although men apparently are more likely to be extraordinarily successful (Murphy, 1964). This is probably so 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 (Murphy, 1964; Foster & Anderson, 1978; Abel et al., 1987).

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 often have 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 are "recruited from the ranks of neurotics and psychotics—which does indeed occur in some cultures, where mental aberration is a necessary prerequisite for becoming a leader." 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 one another. 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. 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]

Another method employed by early humans to rid the mind of evil spirits was skull trepanning. No longer performed, skull trepanning was done in the eastern Mediterranean and North Africa during the Neolithic Age some four thousand to five thousand years ago and reached its highest state of development in Stone-Age Peru one thousand to two thousand

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

years ago. This procedure consisted of boring a hole into the skull in order to liberate an evil spirit supposedly contained in the person's head. The discoveries by anthropologists of more than one hole in some skulls and the lack of erosion of bone tissue suggest that the operation was not always fatal. Some estimates are that the mortality rate from skull trepanation was as low as 10 percent in some cultures, an amazing feat considering the difficulty of the procedure and the crude conditions under which it must have been performed (Mora, 1985).

However, despite the various techniques, the shaman's major contribution to therapy appears to be that of anxiety reduction which draws upon the cultural background of his patients. The connection of treatment with the dominant values and beliefs in the community both inculcates and reinforces the patient's faith in the shaman's procedures. Many primitive people have little opportunity to develop reality-testing skills, being exposed from infancy to a system of beliefs that supports the shaman's authority and mode of treatment. Consequently, the shaman is able to foster the hope and the expectation of relief by emphasizing faith in himself, his method, and his religious orientation—all grounded in community norms and socially approved perspectives (Kiev, 1972:123).

Witch Doctors and Psychiatrists: Points of Similarity

In many ways, the shaman or witch doctor is not unlike the modern-day psychiatrist. E. Fuller Torrey, for one, in his book, *The Mind Game: Witch Doctors and Psychiatrists* (1973), suggested many similarities in both types of healers. These similarities, organized under four general categories, indicate that both witch doctors and psychiatrists: (1) provide a shared world view to the patient which makes possible the naming of pathological factors in terms understood within his or her respective culture; (2) have a *personal* relationship with the patient which makes the therapist's personality characteristics significant to the healing process (despite the attempt by some psychiatrists to keep their personality removed from therapy); (3) engender hope in the patient and raise the expectation of being cured through the therapist's reputation and the atmosphere of the therapeutic setting; and (4) share techniques of psychotherapy. In regard to the latter, witch doctors, like psychiatrists, use drug therapy, shock therapy (for example, cold water, electric eels, drug-induced convulsions), confession, suggestion, hypnosis, dream interpretation, conditioning, and group and milieu therapies.[2] In their own cultures, Torrey points out that witch

[2] An incident that serves as an amusing comparison of the similarities between witch doctors and psychiatrists was reported by psychiatrist Alexander Leighton during a stay in Nigeria:

> On one occasion a healer said to me, through an interpreter: "This man came here three months ago full of delusions and hallucinations; now he is free of them." I said,

doctors have been known to obtain sometimes striking success. "If prostitution is the oldest profession," states Torrey (1973:202), "then psychotherapy must be the second oldest."

Greeks and Romans

Like many other attributes of Western civilization and intellectual development, modern concepts of mental illness originated with the ancient Greeks and Romans. The Greeks, in particular, are noted for formulating a rational approach toward understanding the dynamics of nature and society. They replaced concepts of the supernatural with a secular orientation that viewed natural phenomena as explainable through natural cause-and-effect relationships. One of the most influential Greeks in this regard was Hippocrates, who provided many of the principles underlying modern medical practice. Whether or not there actually was a Hippocrates, who is thought to have lived around 4000 B.C., is not known. Nevertheless, the Hippocratic method which demands a rational and systematic mode of treating patients is credited to him. This method, based upon thorough observation of symptoms and a logical plan of treatment according to proven procedures, is central to contemporary medical practice.

As for mental illness, Hippocrates is believed to have introduced a radical change in the concept of madness by insisting that diseases of the mind were no different from other diseases. In other words, mental illness was not the result of divine, sacred, or supernatural influences. Instead, mental illness was due to *natural causes* that affected the mind and produced delusions, melancholia, and so forth. Although Hippocrates' logic was in advance of his time, he was clearly mistaken in attributing the cause of abnormal behavior to an imbalance in the interaction of the four so-called *humors*—blood, phlegm, black bile, and yellow bile—within the body. An excess of black bile was consistently mentioned by Hippocrates as the cause of mental illness; the recommended treatment was the administration of a purgative (black hellebore) to induce elimination of the disorder through the bowels (Mora, 1985). Also, vapors, baths, and a change in diet were sometimes prescribed.

The greatest of the Roman physicians was Galen, who lived from A.D. 130 to 200. Galen was greatly influenced by Hippocrates' notion of the four

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"What do these words 'hallucination' and 'delusion' mean? I don't understand." I asked this question thinking, of course, of the problems of cultural relativity in a culture where practices such as witchcraft, which in the West would be considered delusional, are accepted. The native healer scratched his head and looked a bit puzzled at this question and then he said: "Well, when this man came here he was standing right where you see him now and thought he was in Abeokuta" (which is about thirty miles away), "he thought I was his uncle and he thought God was speaking to him from the clouds. Now I don't know what you call that in the United States, but here we consider that these are hallucinations and delusions!" (Ciba Foundation Symposium, 1965:23)