SOC 3290: Deviance:

Lecture 29: Mental Disorder I:

It can be very scary to a person when they sense that something is wrong with them. One's life can seem to be going nowhere and one can turn inward. Plans can come and go, one can become agitated, and jobs never seem to last. One can want relationships and a family but have no real friends. Then something can snap and one can do something outrageous - like push someone under a train under the influence of urges, forces, or "voices" beyond one's control.

Even though this is an extreme example, such agitation and irrational behaviour happens to people. Schizophrenia affects 1-2% of the population, and, if other, far less serious psychiatric problems are considered, mental disorder is indeed very common. A recent survey indicates that nearly 50% of adult Americans have experienced at least one episode of psychiatric disorder in their lifetime (30% in the past year). Indeed, most of us have been mentally ill at one time or another, just as we have been physically sick (e.g. mild depression "the common cold of mental illness").

Yet, because a strong social stigma is attached to mental illness, most people associate it with the most severe forms such as schizophrenia and major depression. Thus, if we feel down and call in sick we tend to say "I'm ill," not mentally ill. The boss would assume one is physically ill - not dying from cancer, but sick. If we said "I'm mentally ill," however, the boss would think we're nuts.

While the general public equates "mental illness" with only the relatively severe and uncommon forms of mental disorder, most other forms that occur every day are far from severe and quite common. These are basically the problems of everyday life, ranging from being sad, anxious, irritable or antisocial to being dependent on drugs, alcohol, or coffee to doing poorly in reading, writing and math as a kid. Psychiatrists define all such problems as mental disorders, but we would not if we associate mental illness with only its relatively serious forms. Tonight we will discuss a number of popular myths about mental disorder, take a look at its various types, and examine a number of the social forces behind mental disorder. Then we will follow up with a film about the myths of mental illness.

Some Popular Myths:

The mentally ill are popularly believed to be very weird. In reality, most are far from greatly disturbed. Only a few institutionalized patients spend their time screaming and yelling, coloring with crayons, talking to people who aren't there, hearing voices, etc. Even among schizophrenics the flamboyant symptoms of hallucinations and delusions are not the most important characteristics of their disorder - the less demonstrative symptoms of apathy and inertia are the core.

Secondly, mental illness is commonly regarded as hopeless - as essentially incurable. Indeed, even after discharged as recovered, many view individuals with suspicion. In reality, the majority (70-80%) of hospitalized mental patients can recover and live relatively normal lives if their treatment has been adequate and received in time. Even many schizophrenics can eventually recover. According to studies, about half of all schizophrenics spontaneously get better over 20 years, and professional treatment with support from family and friends further makes the recovery easier and faster.

A third misconception is that there is a sharp, clear distinction between "mentally ill" and "mentally healthy." This is only true if we compare the few, most seriously disturbed patients with average "normal" people. Most of the time even a psychiatrist cannot clearly differentiate the vast majority of the mentally ill from the healthy. Thus, the dividing line is extremely arbitrary. This is not only because the behavior of different people ranges by imperceptible degrees from normal to abnormal, but also because an individual can shift at different times to different positions along that range - appearing normal at one time and abnormal at another.

Fourthly, the mentally ill are often portrayed in the media as crazed, violent people. In fact, the great majority (90%) of mental patients are not prone to violence and criminality, and are more likely to harm themselves than others. Although they have a higher risk of violence than the general population, they are still less violent than alcoholics, drug abusers and young, lower class men.

Finally, the fifth popular myth is about midwinter depression, which psychiatrists call SAD (seasonal affective disorder). Many people assume that we are more likely to become depressed in the winter due to the relative cold and dark. Research has actually shown that depression is more likely to strike people in the summer - presumably because we spend less time with our loved ones than we do in the winter (?)

Types of Mental Disorder:

Psychiatry has two opposing views on what constitutes a mental disorder. One is the medical view, which defines mental disorder chiefly as a biologically caused disorder - similar to physical disease. This view dominates psychiatry today, as expressed in the DSM. The other view of mental disorder is psychoanalytic, which defines mental disorder primarily as an emotional problem that is psychological in origin. This view dominated in the 1950's and '60's, but is less popular today.

Traditional Classification:

In the traditional classification system, mental illness is divided into organic and functional disorders. Both may show the same symptoms (e.g. hallucinations), but they can be differentiated on the basis of their underlying causes. Organic disorders are caused by damage to the brain by any variety of factors (e.g. head injury, infection, old age, drug abuse). Functional disorders, on the other hand, are believed to result from psychological and social factors (e.g.

unpleasant childhood experiences, interpersonal conflict or social stress). Functional disorders constitute a much larger category than organic disorders, and most researchers are primarily interested in these.

Functional disorders can be further divided into three major categories: psychosis, neurosis and personality disorder. In general, psychosis is typified by losing touch with reality, and neurosis by an inability to face reality. Since psychotics have lost contact with reality, they don't realize they are mentally ill and have no desire to seek treatment. Neurotics, conversely, still know what reality is, keenly feel their suffering, and consciously wish to get well. Their problem is an inability to accept reality for what it is, causing them to be unreasonably worried about it. As for the third category, personality disorders tend to involve individuals who are basically self-absorbed, unsociable or antisocial. Each of these will be discussed in a bit more detail.

Beginning with psychosis, we must recognize that this is more serious than the other two types of disorder. Because it involves losing touch with reality, the patient cannot go to school, work, or do other things that "normal" people do. There are many types of psychosis, but we will only discuss two here: schizophrenia and manic depression.

Schizophrenia is the most common form of psychosis. Such individuals think and talk in unconventional, illogical or ambiguous ways. They express emotions inappropriately (e.g. laughing or crying at unusual times), withdrawing from others into their inner selves - often becoming totally unresponsive to their surroundings. They may simply sit mute, motionless and emotionless, sunk in deep apathy. They have delusions of grandeur and delusions of persecution. They have hallucinations, hearing voices where there is only silence and seeing things that do not exist. They will talk to themselves, or scream loudly to voices only they can hear. While some of these things occur to normal people, psychiatrists would not consider us schizophrenic unless these occur so frequently that our lives and activities are severely disrupted. Because of the severe nature of their disorder, many schizophrenics are thought to require hospitalization.

Manic depressive disorder (a.k.a. bipolar disorder), in contrast, involves fluctuating between two opposite extremes of mood. One, called mania, is characterized by great elation, exuberance, confidence, or excitement. Here, individuals are constantly joking, laughing, or making speeches, though far from happy or content. They are always on the move, driven by a powerful tension within. In this hyperactivity they are enveloped by grandiose delusions of superiority. After going through this manic phase, however, they suddenly find themselves at the other extreme of depression - where they feel an overwhelming despair, delusions of worthlessness, and consider suicide. In turn, they lose the desire to talk, move, eat and sleep, and spend much time crying.

Moving on to neurosis, this category of functional disorders generally is less severe than psychosis. There is little distortion of reality and most neurotics are able to appear normal and do most of the things that the rest of us do (e.g. work, go to school, and keep family relations). The

only problem is that their symptoms prevent them from being as happy as they'd want. There are various types of neurosis.

One is known as anxiety reaction. This is a vague, freely floating apprehension where the object of the apprehension can't be identified. While normal people occasionally experience anxiety (e.g. before an exam), the anxiety experienced by neurotics is more serious (e.g. panic attacks, accompanied by a feeling of impending doom, coming on for no apparent reason).

If neurotics can identify a specific object for their anxiety, they are said to suffer from a phobia. Phobic neurotics may, for example, have an extreme unreasonable fear of closed spaces (claustrophobia), open spaces (agoraphobia), or a variety of other specific fears. Another type of fear is social phobia brought on by the presence of other people. The neurotic with social phobia cannot speak before an audience, eat in restaurants, or even write his or her own name when someone else is around.

The second type of neurosis is a combination of obsession and compulsion. Obsession involves some bothersome idea that keeps interrupting one's train of thought (e.g. fear of germs, or that the door was left unlocked). A compulsion involves some ritualistic action that neurotics feel they must perform (e.g. washing one's hands repeatedly, checking the door over and over). The more they do these things, however, the more anxious they become.

The third type of neurosis is depressive reaction. Neurotic depression can be distinguished from psychotic depression - which is much more severe in degree and duration. Milder, neurotic depression is characterized by a feeling of sadness, dejection, and self-depreciation. While possibly lasting for weeks or months, it usually either clears up - or intensifies into psychotic depression.

The final type of neurosis is psycho-physiologic disorder (a.k.a. psychosomatic illness). Its symptoms range from minor to severe, including headaches, ulcers, amnesia, and paralysis. These symptoms have no actual basis in physical injury or nerve damage: they represent the neurotic's way of solving a psychological problem (e.g. wanting to get out of the army but fearing being seen as a deserter or a coward).

We move on, finally, to the third traditional category of functional disorders: personality disorders. This is a general category for all sorts of deviant behaviour the psychiatrist can describe but cannot diagnose as either psychotic or neurotic. These have also been termed character disorders, psychopathic or sociopathic disorders. The most prominent feature is blatant disregard for society's rules. It is thought to be caused by a lack of moral development - failure to develop conscience, acquire true compassion or learn how to form meaningful relationships (e.g. con-men, pimps, unprincipled businesspeople, etc.) Some of these come across as merely self-centred nonconformists rather than as seriously disturbed.

Overall, this traditional classification system provides insight into the characteristics of

various types of mental disorder by explaining in some detail how they differ. It also encourages psychiatrists to analyze their patient's life in order to find and eliminate the causes of their mental disorder. However, to more medically oriented psychiatrists, this traditional system is too broadly and ambiguously defined. Disorders cannot be precisely identified in terms of specific symptoms. Moreover, this approach presents only a small number of disorders, thereby missing a large number of more specific ones that have emerged.

Thus, a much greater number of mental disorders (over 300) can be found in the DSM-IV. Each mental disorder therein is defined as having a list of specific symptoms (e.g. panic disorder is characterized by shortness of breath, dizziness, heart palpitations, trembling, sweating, choking, nausea, chest pain and fear of dying). By checking a patient against a specific list of symptoms like this, psychiatrists can determine what mental disorder their patient is possibly suffering. Using this mechanical, routine method of diagnosis, they can dispense with the time-consuming psychoanalysis required by the traditional classification system. More importantly, by using this parallel with how doctors diagnose physical illnesses, psychiatrists can also efficiently collect payment for their services from insurance companies or government health plans - both of which insist that the DSM be used.

Yet the scientific value of the DSM falls short. One issue is that this manual is merely descriptive, describing various disorders through lists of symptoms without explaining how they differ from one another (see chart on p.178 for list of major types). It also arbitrarily defines disorders in terms of a specific number of symptoms (e.g. at least 3 out of a list of 7 for mania). This doesn't explain why 3, not 5 or 6 is required. Further, the focus on symptoms inevitably encourages psychiatrists to eliminate the symptoms rather than the underlying cause of the patient's problem. Influenced by the view of mental disorder as a biologically caused disease, the elimination of symptoms often involves prescribing medication - but the disorder usually persists because its non-biological cause remains.

Since its first edition in 1952, the DSM has been criticized for promoting the medical view of mental disorder as a biologically caused disease. But in its more recent editions, psychiatrists are encouraged to see social factors as possibly additional causes of mental disorder. Thus, after identifying the symptoms and disorder, users of DSM-IV are instructed to question whether the patient has suffered any "environmental" problems in their social context (e.g. unemployment, divorce). Still, the main emphasis remains on diagnosing mental disorder as a disease with specific symptoms.

DSM-IV has also been criticized for defining too many ordinary problems in our lives as mental disorders (e.g. the "disorder of written expression" in poor writing). It's possible that some students who have this trait are mentally ill, but not all of them - they just write poorly. Other examples include "oppositional defiant disorder" in children who are difficult or uncooperative. While in a heated moment some parents may say their unruly kids are mentally ill, but most would merely think that's part of being a kid.

Social Factors in Mental Disorder:

In contrast to the primarily psychological and biological positions elucidated by psychologists and psychiatrists, sociologists have long emphasized the influence of various social factors on mental disorder.

The first of these is social class. This has been clearly and consistently demonstrated by studies to be related to mental disorder. More specifically, those from the lower classes are more likely than those from other classes to be mentally ill. Although mental illness among the lower classes is more likely to be reported to the authorities, surveys on random samples of the population have consistently found a greater percentage of lower class people suffering from psychiatric symptoms.

There are two conflicting explanations of this. One, called social causation, suggest that lower class people are more prone to mental disorder because they are more likely to experience social stress (e.g. unemployment, divorce), to suffer from psychic frailty, infectious diseases, neurological impairments, and to lack good medical treatment, coping ability and social support. Through an accumulation of these problems, and the stresses that result, low social status becomes a cause of mental illness. The other explanation emphasizes social selection or drift. This suggests that mentally ill people from higher social classes often drift downward into the lower class areas, helping to increase the rate of mental illness in such neighbourhoods. This explanation suggests that being lower class is a consequence of mental illness among formerly higher status individuals. Both explanations may be true to some extent.

The next social factor associated with mental illness is gender. There are conflicting findings as to which gender is more likely to become mentally ill. In most studies women are found to have a higher rate of mental disorder, but some others find men to more predominant or no difference between the sexes.

These conflicting findings, however, refer to mental illness most generally. Studies on specific types of disorders, however, do indicate gender differences. These usually show that women predominate in depression and anxiety disorders, while men more commonly have antisocial personalities, paranoia, drug and alcohol abuse disorders. How can we explain this?

Most sociologists attribute this difference to differences is gender roles. The female role is relatively restrictive and oppressive, likely to confine the woman to her inner self, such that she tends to keep her frustration and anger to herself rather than aggressively pour it out on others. Hence women are more likely to fall victim to depression and anxiety. Men, on the other hand, have a more liberated role, and they are encouraged to be bold, assertive and aggressive in social relations. If frustrated and angry, they are more likely to take it out on others - behaving as antisocial and paranoid individuals. In Durkheimian terms, women respond as they do because they are more socially integrated and regulated; men because they are less so.

Research has also suggested that the female role has taught women to value emotional attachment to others and be sociable, while the male role has encouraged men to be emotionally detached and aggressive. Women, therefore, become more vulnerable to social losses such as the death of a loved one, while men are more vulnerable to material loss such as unemployment. Yet, as more women enter the competitive, male workforce, they will suffer less depression and anxiety like men. Similarly, with the relative decline in mens' employment over the last 30 years, there has been a rise in anti-social personality disorders among men. Hence, the traditional gender difference in psychological distress has narrowed over time.

A third social factor in mental disorders is race and ethnicity. Like gender, these have not been consistently found to be related to mental illness in general. While many studies have shown higher rates of psychiatric stress among minorities, the standard explanation has been that these groups experience more social stresses stemming from discrimination, poverty and cultural conflict. On the other hand, there are studies showing no significant difference in psychiatric problems between minorities and whites. An equally plausible explanation emerges for this finding: minority group identification, group solidarity, or social networks protect them against these social stresses. The same explanation has been proffered to account for the lower rate of mental illness among British minorities.

More consistent data are available on the relationship between race or ethnicity and specific forms of mental disorder. In the U.S., Puerto Ricans and African Americans are more likely than Irish or Jewish Americans to have sociopathic inclinations or paranoid tendencies. Jewish Americans, in contrast, tend more to manifest depressive disorders. In addition, Americans of Korean ancestry, have more depressive symptoms than whites.

A fourth social factor implicated in mental illness is the urban environment itself. Community surveys indicate higher rates of mental disorders in urban areas, particularly the inner city, than in rural areas, including the suburbs and small towns. It is argued that the urban environment produces a lot of mental problems because it generates an abundance of physical and social stresses (e.g. traffic congestion, noise, population density, tenuous social relations, loneliness and lack of social support).

Some community studies also reveal a link between urban living and specific psychiatric problems (e.g. neurotic and personality disorders). In contrast, more serious psychotic conditions are more prevalent among rural and small town residents. This could be explained by the argument that rural and small-town residents find their lives too restrictive, and they are not able to express frustration and anger in the presence of others - who may easily find out who the troublemakers are. By suppressing their frustration, they may get deeper and deeper into themselves until they become psychotic. In contrast, urban dwellers can get away from family and friends, are freer to express frustration in the midst of strangers, and tend more to tolerate unconventional behaviour. If they persist in doing so, urbanites may become neurotics, who, unlike psychotics, retain their grip on conventional reality. Otherwise, they may develop an antisocial psychopathic personality, which is essentially an "acting out" disorder.

The final social factor that has been associated with mental disorder is young age. Studies conducted before the 1980's suggested that older persons were more likely to suffer mental disorders. This was attributed to societal neglect of the elderly eventually resulting in institutionalization - where the neglect can continue. Yet, more recent studies in the 1980's and 1990s show that the elderly are the least likely among all age groups to become mentally ill. A 1994 U.S. survey found that relatively young people (25-34) actually have the highest rate of mental illness. Another study also found significant increase in major depression among the younger generations, especially over the last several decades. In diverse countries successive generations have been growing more vulnerable to depressive disorders. People born after 1955 are more than three times as likely as their grandparents to have a major depression. Among Americans, about 6% born after 1955 have become severely depressed by age 24, while only 1% of those born before 1905 have suffered similar depression by age 75.

The increasing prevalence of depression among younger people can be attributed to changes in modern society: an increase in social stresses coupled with a decrease in social resources for dealing with them. Most of these stresses come from family problems (e.g. divorce, child abuse, or parental indifference). The difficulty in coping comes largely from the loss of the extended family and close-knit village-like community in modern society. Research has shown, for example, that lack of parental love and affection, divorce, and other factors can significantly contribute to the development of depression, anxiety, or other types of mental disorder.

Next class, we will continue our discussion by looking at various societal responses to mental disorder and some of the major perspectives that have attempted to explain it.