S/A 4071: Social/Cultural Aspects of Health and Illness:
Class 12: Social Psychological Factors & Health 2: Mental Disorder

* Today we review the Stolzman article on mental disorder, concentrating on:

(1) Social factors in psychiatric diagnosis;
(2) Contextual factors and psychiatric assessment;
(3) The contributions and limits of the labeling approach; and
(4) Social patterns of stress and patterns of mental disorder.

(1) Social factors in psychiatric diagnosis:

* Accurate diagnosis of mental disorders not straightforward

* Anti-psychiatric critics of 1960's-70's claimed:

- diagnostic standards reflected power structure of society
- scientific objectivity a sham
- mental illness a “myth”

* Rosenhan study:

(1) Fake patients couldn’t be detected as sane after gaining admission to mental hospitals

(2) In subsequent incident, professionals claimed to detect fake patients when none were sent

* This draws attention to contextual factors in psychiatric diagnosis that are external to the patient (unlike physical illness). These include:

- social standards
- cultural norms

* Officially ruling out such factors by scientific rhetoric acts as a cover, and they enter through the “back door”

(2) Contextual factors and psychiatric assessment:

* Psychiatrists assume only 2 variables at play in diagnosis:

(1) Patients either have/don’t have mental disorder
(2) Psychiatrists either have/don’t have accurate diagnostic ability

* Rosenhan pointed to significance of a third variable: contextual factors

* These include:

(1) The social system of mental health care (doctors, nurses, orderlies, administrators, etc.)
(2) Unquestioned assumptions built into context (e.g. people there because they have mental disorders, don’t want to be patients, seek admission genuinely, etc.)
(3) Medical decision rules: (“when in doubt, diagnose illness”)
(4) Fads and fashions (e.g. cultural variations in using schizophrenia as a catchall category)
(5) Extra- scientific contingencies (e.g. insurance coverage, research funding, being paid to give expert testimony).

* Psychiatrists pin blame on humanistic/ psychoanalytic legacy, claiming that DSM now more “rigorous” and “scientific

* Critics reply that DSM criteria more style than substance

(3) The contributions and limits of the labeling approach:

* Scheff's labeling approach suggests:

    (1) Mental illness = residual rule breaking
    (2) Labeling someone mentally ill has consequences for them

* Case in point: Stouffer's (1949) study of "battle" fatigue in WWII: soldiers hospitalized fared worse than those "normalized" within units

* Stigma of mental illness a big problem, despite educational efforts (e.g. public still perceive mentally ill as dangerous. This impacts/ adds to suffering of individuals, making it hard to continue living "normal life")

* We mustn't be overly deterministic about this (S.I. tradition)

* Key questions emerge:

    (1) What causes mental disorder?
    (2) Why, in same environment, do some become mentally ill while others don't?
    (3) What should be done to treat mental illness?

* In responding, remember that sociologists don't have clinical function/ don't emphasize individual behavior

* But can't simply sidestep question of causation (implication that labeling arbitrary, and that people would be OK without labeling)

* Mental disorders reflect real problems that can't be ignored (just don't call all of them "illness")

* Some disorders more akin to physical illness/ others not/ most fall

somewhere in between

* This conception leaves open room for empirical examination of both labeling perspective/ social influences on mental disorder

(4) Social patterns of stress and patterns of mental disorder:

* Sociologists focus more on patterns of mental disorder, not individuals, including variations by:

- gender
- marital status
- class
- unemployment

* Patterns cannot necessarily = causation:

- question of causes vs. consequences
- potential of spurious relationship caused by other factor
- danger of using unrepresentative, clinical samples

* Recent community studies largely avoid such problems. Findings:

- a relatively large % of community mental health problems
- only a small minority had ever been patients
- supports labeling model re: many not officially labeled
- but labeling approach useless to explain patterns/ regularities

* Alternative approach: focus on stress as a social phenomenon.

* Two aspects of social stress that impact members of society:

(1) Socially structured inequality

(2) Socially structured ambiguity

* Socially structured inequality: differential life chances/ increased stresses for those at bottom of social structure related to:

- material deprivation
- restricted autonomy
- restricted opportunities for advancement
- stigmatization/disrepute

* Socially structured ambiguity: internalized cultural beliefs, social positions and roles that normally guide us becoming unclear due to:

- status inconsistencies
- contradictory norms/ expectations for a role
- conflicting roles
- conflicting values
- goal-means gaps
- divergent cultural values/ background

* Both factors contribute to double-bind, “crazy-making situations”

- low status = more stress; high status = less stress
- clear expectations = low stress; unclear expectations = high stress

* We must also factor in relative individual vulnerability/ ability to handle stress/ coping resources

* Social stress doesn’t necessarily = psychological distress which doesn’t necessarily = mental disorder (necessary but not sufficient conditions)

* Further research needed to clarify under what conditions:

(1) Stress does/doesn’t translate into psychological distress
(2) Psychological distress does/doesn’t translate into mental disorder

* This may partially help bridge psychological/ sociological divide, but these approaches to mental disorder ultimately remain too far apart