Chapter 1

Perspectives on mental health and illness

Chapter overview

This chapter will explore some of the different perspectives and arguments about conceptualizing mental health and illness. We make some necessary conceptual clarifications about the question of terminology. Our assumption at the outset is that terminology remains a controversial issue for the sociology of mental health and illness because there are markedly differing ways of speaking about mental normality and abnormality in contemporary society. Rather than assuming that there are competing claims about the same issue, or set of issues, we need to take a step back and check on different frameworks of understanding. In other words, what perspectives or discourses do we need to understand at the outset about normal and abnormal mental life?

The chapter will cover the following four perspectives outwith sociology:

• psychiatry;
• psychoanalysis;
• psychology;
• the legal framework.

The lay view is dealt with in the next chapter because of its importance to understanding public responses to mental health problems. Labelling theory (societal reaction theory) will also be dealt with in the next chapter.

This chapter will then cover the following four perspectives within sociology:

• social causation;
• critical theory;
• social constructivism;
• social realism.
The perspectives outwith sociology

Psychiatry

We start with psychiatry because it has been the dominant discourse. Accordingly, it has shaped the views of others or has provoked alternative or opposing perspectives. While psychiatric patients (Rogers et al. 1993) and those in multi-disciplinary mental health teams (Colombo et al. 2003) evince a complex range of views about the nature of mental disorder, each of these models competes for recognition and authority alongside the traditional and dominant medical approach deployed by psychiatry.

Psychiatry is a specialty within medicine. Its practitioners, as in other specialties, are trained to see their role as identifying sick individuals (diagnosis), predicting the future course of their illness (prognosis), speculating about its cause (aetiology) and prescribing a response to the condition, to cure it or ameliorate its symptoms (treatment). Consequently, it would be surprising if psychiatrists did not think in terms of illness when they encounter variations in conduct which are troublesome to people (be they the identified patient or those upset by them). Those psychiatrists who have rejected this illness framework, in whole or in part, tend to have been exposed to, and have accepted, an alternative view derived from another discourse (psychology, philosophy or sociology).

As with other branches of medicine, psychiatrists vary in their assumptions about diagnosis, prognosis, aetiology and treatment. This does not imply, though, that views are evenly spread throughout the profession, and as we will see later in the book, modern Western psychiatry is an eclectic enterprise. It does, however, have dominant features. In particular, diagnosis is considered to be a worthy ritual for the bulk of the profession and biological causes are favoured along with biological treatments.

This biological emphasis has a particular social history, which is summarized in Chapter 8. However, this should not deflect our attention from the capacity of an illness framework to accommodate multiple aetiological factors. For instance, a psychiatrist treating a patient with antidepressant drugs may recognize fully that living in a high-rise flat and being unemployed have been the main causes of the depressive illness, and may assume that the stress this induces has triggered biochemical changes in the brain, which can be corrected by using medication.

The illness framework is the dominant framework in mental health services because psychiatry is the dominant profession within those services (see Chapter 8). However, its dominance should not be confused with its conceptual superiority. The illness framework has its strengths in terms of its logical and empirical status, but it also has weaknesses. Its strengths lie in the neurological evidence about madness: bacteria and viruses have been demonstrably associated with madness (syphilis and encephalitis). Such a neurological theory might be supported further by the experience and behaviour of people with temporal lobe epilepsy, who may present with anxiety and sometimes florid psychotic states. The induction of abnormal mental states by brain lesions, drugs, toxins, low blood sugar and fever might all point to the sense in regarding mental illness as a predominantly biological condition.
The question begged is: what has medicine to do with that wide range of mental problems that elude a biological explanation? Indeed, the great bulk of what psychiatrists call ‘mental illness’ has no proven bodily cause, despite substantial research efforts to solve the riddle of a purported or assumed biological aetiology. These illnesses include anxiety neuroses, reactive depression and functional psychoses (the schizophrenias and the affective conditions of mania and severe or endogenous depression). While there is some evidence that we may inherit a vague predisposition to nervousness or madness, there are no clear-cut laws evident to biological researchers as yet. Both broad dispositions run in families, but not in such a way as to satisfy us that they are biologically caused. Upbringing in such families might equally point to learned behaviour and the genetic evidence from twin studies remains contested (Marshall 1990).

It may be argued that biological treatments that bring about symptom relief themselves point to biological aetiology (such as the lifting of depression by ECT or the diminution of auditory hallucination by major tranquillizers). However, this may not follow: thieving can be prevented quite effectively by chopping off the hands of perpetrators, but hands do not cause theft. Likewise, a person shocked following a car crash may feel better by taking a minor tranquilizer, but their state is clearly environmentally induced. The thief’s hands and the car crash victim’s brain are merely biological mediators in a wider set of personal, economic and social relationships. Thus, effective biological treatments cannot be invoked as necessary proof of biological causation.

A fundamental problem with the illness framework in psychiatry is that it deals, in the main, with symptoms, not signs. That is, the judgements made about whether or not a person is mentally ill or healthy focus mainly (and often singularly) on the person’s communications. This is certainly the case in the diagnosis of neurosis and the functional psychoses. Even in organic conditions, such as dementia, brain damage is not always detectable post-mortem (see Chapter 6). In the diagnosis of physical illness the diagnosis can often be confirmed using physical signs of changes in the body (e.g. the visible inflammation of tissue as well as the patient reporting pain).

However, it is possible to overdraw the distinctions between physical and mental illness. For example, an internal critic of psychiatry, Thomas Szasz (1961), has argued that mental illness is a myth. He says that only bodies can be ill in a literal sense and that minds can only be sick metaphorically (like economies). And yet, as we noted earlier, physical disturbances can sometimes produce profound psychological disturbances. Given that emotional distress has a well-established causative role in a variety of psychosomatic illnesses, like gastric ulcers and cardiovascular disease, the mutual inter-play of mind and body seems to be indicated on reasonable grounds.

It is true (following Szasz 1961) that the validity of mental diagnosis is undermined more by its over-reliance on symptoms and by the absence of detectable bodily signs, but this can apply at times even in physical medicine. For instance, a person may feel very ill with a headache but it may be impossible to appeal to signs to check whether or not this is because of a toxic reaction, for instance a ‘hangover’, or a brain tumour. Also, people with chronic physical problems have much in common, in terms of their social role, with psychiatric patients – both are disabled and usually not valued by their non-disabled fellows.
The absence of a firm biological aetiology is true of a number of physical illnesses, such as multiple sclerosis. Moreover, mental illnesses often lack treatment specificity (i.e. the diagnosis does not always imply a particular treatment and the same treatment is used across different diagnostic categories) but this is also true of some physical conditions, such as rheumatoid arthritis (which attract analgesics, anti-inflammatories and even anti-cancer drugs). Thus, the conceptual and empirical uncertainties that Szasz draws our attention to, legitimately, about mental illnesses, can apply also to what he considers to be ‘true illnesses’.

A final point to note about the biological emphasis in psychiatry is that it has been repeatedly challenged by a minority of psychiatrists, including but not only Szasz. For example, some retain diagnosis but reject narrow biological explanations. They prefer to offer a biopsychosocial model which takes into account social circumstances and biographical nuances (Engel 1980; Pilgrim 2002a; Pilgrim et al. 2008). Others have argued that madness is intelligible provided that the patient’s social context is fully understood (Laing and Esterson 1964). More recently some psychiatrists have embraced social constructivism and argued that their profession has no privileged understanding of mental disorder. This emerging ‘post-psychiatry’ ‘emphasizes social and cultural contexts, places ethics before technology and works to minimize medical control of coercive interventions’ (Bracken and Thomas 2001: 725).

Thus although a biomedical approach in clinical psychiatry is common (focusing on the twin fetish of diagnosis and medication), not all psychiatrists conform to its logic (Pilgrim and Rogers 2009). Many are committed to alternative perspectives, such as social causationism and social constructivism (see later) or the next approach to be discussed.

**Psychoanalysis**

Psychoanalysis was the invention of Sigmund Freud. It has modern adherents who are loyal to his original theories but there are other trained analysts who adopt the views of Melanie Klein; others take a mixed position, borrowing from each theory. Thus, psychoanalysis is an eclectic or fragmented discipline. Its emphasis on personal history places it in the domain of biographical psychology. Indeed, Freud’s work is sometimes called depth or psychodynamic psychology, along with the legacies of his dissenting early group such as Jung, Adler and Reich. Depth psychology proposes that the mind is divided between conscious and unconscious parts and that the dynamic relationship between these gives rise to psychopathology.

Like other forms of psychology, psychoanalysis works on a continuum principle – abnormality and normality are connected, not disconnected and separate. To the psychoanalyst we are all ill to some degree. However, the medical roots of psychoanalysis and the continued dominance of medical analysts within its culture have, arguably, left it within a psychiatric, not psychological, discourse. It still uses the terminology of pathology (‘psychopathology’ and its ‘symptoms’); assessments are ‘diagnostic’ and its clients ‘patients’; people do not merely have ways of avoiding human contact, they have ‘schizoid defences’ and they do not simply get into the habit of angrily
blaming others all of the time, instead they are ‘fixated in the paranoid position’. The language of psychoanalysis is saturated with psychiatric terms. Thus, the discipline of psychoanalysis stands somewhere between psychiatry and psychology.

Psychoanalysis, arguably, has two strengths. First, it offers a comprehensive conceptual framework about mental abnormality. Once a devotee accepts its strictures, it offers the comfort of explaining, or potentially explaining, every aspect of human conduct. Second, there is a symmetry between its causal theory and its corrective programme. That which has been rendered unconscious by past relationships can be rendered conscious by a current relationship with a therapist.

Its first weakness is the obverse of biological psychiatry. The latter tends to reduce psychological phenomena to biology, whereas psychoanalysis tends to psychologize everything (i.e. the biological and the social as well as the personal). A person with temporal lobe epilepsy or a brain tumour would be helped little by a psychoanalyst. The brain-damaged patient would certainly give the analyst plenty to interpret, but the analyst would be wrong to attribute a psychological, rather than a neurological, cause. Likewise, socially determined deviance (like prostitution emerging in poor or drug-using cultures) may be explained away psychoanalytically purely in terms of individual history (Pilgrim 1992; 1998). A second weakness of psychoanalysis as a frame of reference is that it can do no more than be wise after the event. It has never reached the status of a predictive science.

Psychology

Psychoanalysis has competed with other psychological accounts of mental abnormality. Moreover, because psychology, as a broad and eclectic discipline, focuses, in the main, on ‘normal’ conduct and experience it has offered concepts of normality as well as abnormality. Buss (1966) suggests that psychologists have put forward four conceptions of normality/abnormality:

1 the statistical notion;
2 the ideal notion;
3 the presence of specific behaviours;
4 distorted cognitions.

The statistical notion

The statistical notion simply says that frequently occurring behaviours in a population are normal – so infrequent behaviours are not normal. This is akin to the notion of norms in sociology. Take as an example the tempo at which people speak. Up to a certain speed, speech would be called normal. If someone speaks above a certain speed they might be considered to be ‘high’ in ordinary parlance or ‘hypomanic’ or suffering from ‘pressure of thought’ in psychiatric language. If someone speaks below a certain speed they might be described as depressed. Most people would speak at a pace between these upper and lower points of frequency.
A question begged, of course, is who decides on the cut offs at each end of the frequency distribution of speech speed and how are those decisions made? In other words, the notion of frequency in itself tells us nothing about when a behaviour is to be adjudged normal or abnormal. Value judgements are required on the part of lay people or professionals when punctuating the difference between normality and abnormality. Also, a statistical notion may not hold good across cultures, even within the same country: for example, slow speech might be the norm in one culture, say in rural areas, but not in another, such as the inner city. The statistical notion of normality tells us nothing in itself about why some deviations are noted when they are unidirectional rather than bidirectional. The example of speech speed referred to bidirectional judgements. Take, in contrast, the notion of intelligence. Brightness is valued at one end of the distribution but not at the other. Being bright will not lead, in itself, to a person entering the patient role, but being dim may well do so.

In spite of these conceptual weaknesses, the statistical approach within abnormal psychology remains strong. Clinical psychologists are trained to accept that characteristics in any population follow a normal distribution and so the statistical notion has a strong legitimacy for them. This acceptance of the normal distribution of a characteristic in a population means that in psychological models there is usually assumed to be an unbroken relationship between the normal and abnormal. However, this notion of continuity of, say, everybody being more or less neurotic, may also assume a discontinuity from other variables. For instance, in Eysenck’s (1955) personality theory neurosis and psychosis are considered to be personality characteristics that are both normally distributed but separate from one another.

The ideal notion

There are two versions of this notion: one from psychoanalysis and the other from humanistic psychology. In the former case, normality is defined by a predominance of conscious over unconscious characteristics in the person (Kubie 1954). In the latter case, the ideal person is one who fulfils their human potential (or ‘self-actualizes’). Jahoda (1958) drew together six criteria for positive mental health to elaborate and aggregate these two psychological traditions:

1 balance of psychic forces;
2 self-actualization;
3 resistance to stress;
4 autonomy;
5 competence;
6 perception of reality.

The problem is that each of these notions is problematic as a definition of normality (and, by implication, abnormality). The first and second are only meaningful to those in a culture who subscribe to their theoretical premises (such as psychoanalytical or humanistic psychotherapists).
The resistance-to-stress notion is superficially appealing but what of people who fail to be affected by stress at all? We can all think of situations in which anxiety is quite normal and we would wonder in such circumstances why a person fails to react in an anxious manner. Indeed, the absence of anxiety under high-stress conditions has been one defining characteristic of ‘primary psychopathy’ by psychiatrists. Likewise, those who are excessively autonomous (i.e. avoid human contact) might be deemed to be ‘schizoid’ or be suffering from ‘simple schizophrenia’.

As for competence, this cannot be judged as an invariant quality. As we will see when discussing young adults and mental health in Chapter 6, norms of competence vary over time and place, likewise with perceptions of reality. In some cultures, seeing visions or hearing voices is highly valued, and yet it would be out of sync with the reality perceived by most in that culture. In other cultures the hallucinators may be deemed to be suffering from alcoholic psychosis or schizophrenia.

The presence of specific behaviours

The emergence of psychology as a scientific academic discipline was closely linked to its attention to specifiable aspects of conduct. It emerged and separated from speculative philosophy on the basis of these objectivist credentials. Behaviourism, the theory that tried to limit the purview of psychology to behaviour and eliminate subjective experience as data, no longer dominates psychology but it has left a lasting impression. Within clinical psychology, behaviour therapy and its modified versions are still common practices. Consequently, many psychologists are concerned to operationalize in behavioural terms what they mean by abnormality.

The term ‘maladaptive behaviour’ is part of this psychological discourse, as is ‘unwanted’ or ‘unacceptable’ behaviour. The strength of this position is that it makes explicit its criteria for what constitutes abnormality. The weakness is that it leaves values and norms implicit. The terminology of specific behaviours still begs questions about what constitutes ‘maladaptive’. Who decides what is ‘unwanted’ or ‘unacceptable’? One party may want a behaviour to occur or find it acceptable but another may not. In these circumstances, those who have more power will tend to be the definers of reality. Thus, what constitutes unwanted behaviour is not self-evident but socially negotiated. Consequently, it reflects both the power relationships and the value system operating in a culture at a point in time.

Distorted cognitions

The final approach suggested by Buss emerged at a time when behaviourism was becoming the dominant force within the academic discipline. However, during the 1970s this behavioural emphasis declined and was eventually displaced by cognitivism. As a result, psychologists began to treat inner events as if they were behaviours (forming the apparently incongruous hybrid of a ‘cognitive-behavioural’ approach to mental health problems) or they increasingly incorporated constructivist, systemic and even psychoanalytical views...
It is not clear even now whether the ascendancy of ‘cognitive therapy’ within clinical psychology during the 1980s was driven by cognitivism or was merely legitimized by it. So much of the seminal writing on cognitive therapy came not from academic psychology but from clinicians, some of whom were psychiatrists, not psychologists, offering a pragmatic and a-theoretical approach to symptom reduction (e.g. Beck 1970; Ellis 1970).

The legal framework

Mental disorder represents the main point of contact between psychiatry and the law. The early days of psychiatry in the nineteenth century were heavily influenced by eugenic considerations – it was assumed that a variety of deviant conduct could be explained by a tainted gene pool in the lower social classes. This degeneracy theory, which characterized early biological psychiatry, linked together the mad, the bad and the dim. However, during the First World War and its aftermath such an underlying assumption began to falter. In the forensic field, there emerged a resistance to the old eugenic ideas of degeneracy, which accounted for criminality in terms of an inherited disposition to bad conduct (Forsythe 1990). This was replaced by an increasing interest in environmental or psychological explanations for lawbreaking. Since that time, psychiatric experts have played a major role in identifying and explaining criminal conduct.

Currently, in British law the notion of ‘mental disorder’ includes four separate conditions: ‘mental illness’, ‘mental impairment’, ‘severe mental impairment’, and ‘psychopathic disorder’. The first of these is not defined; the second and third are references to people with learning difficulties, who are additionally deemed to be dangerous; the fourth refers to antisocial individuals who are ‘abnormally aggressive’ or who manifest ‘seriously irresponsible conduct’. In Britain at present mental disorder is defined legally in the following way (Department of Health 2004):

‘Mental disorder’ means an impairment of or a disturbance in the functioning of the mind or brain resulting from any disability or disorder of the mind or brain . . .

Superficially this reads like a coherent English sentence. However, it poses a number of problems for the reader:

- the inter-dependent constituent parts of ‘impairment’, ‘disturbance’, ‘disability’ and ‘disorder’ are not explained or defined;
- the word ‘disorder’ is used to mean both the whole and a part, with no clear logical distinction between the two roles in the definition;
- the inclusion of the word ‘brain’ suggests that any patient suffering from a neurological disease affecting the central nervous system could potentially be framed as being mentally disordered;
- the word ‘functioning’ is used to connote functional criteria, apparently dealing with the difficulty that most mental health problems are of unknown or contested origins. Confusingly though, the words ‘resulting from’ are
inserted, implying causal reasoning to the reader. This offer is then immediately retracted. The antecedents suggested are simply a restatement of dysfunction in the mind or brain (the use of the words ‘disability’ and ‘disorder’).

The legal framework thus tends to deploy tautological definitions or accepts that mental disorder is what mental health experts say it is. In particular cases tried in court, psychiatric opinion is offered as an expert view on the presence or absence of mental disorder. Because mental illness is not legally defined, judges have sometimes resorted to the lay discourse. In 1974, Judge Lawton said that the words ‘mental illness’ are ‘ordinary words of the English language. They have no particular medical significance. They have no particular legal significance’. Lawton refers to the dictum of Lord Reid in a case where the defendant’s mental state was being considered:

I ask myself what would the ordinary sensible person have said about the patient’s condition in this case if he had been informed of his behaviour? In my judgment such a person would have said ‘Well the fellow is obviously mentally ill’.

(cited in Jones 1991: 15)

This lay conception of legal insanity has been called ‘the-man-must-be mad’ test (Hoggett 1990).

In one sense, therefore, the legal framework accepts a psychiatric framework, but when the latter is found lacking then ordinary language definitions are invoked. It also raises the question about whether mental disorder is simply, for legal and lay purposes, incomprehensible conduct. ‘Normal’ criminal acts are clearly goal directed. ‘Mentally disordered’ criminal acts are not directed towards obvious personal gain. The boundary between these is not easy to maintain though, especially when making judgments about sex offenders. The latter seek personal gratification even if this is not financial. Under different circumstance, they may or may not be diagnosed as mentally disordered. Sex offenders may end up either in prison or in secure psychiatric units, showing that sexual gratification as a criminal motive confuses those prescribing a judicial response.

Also, some murderers are adjudged in commonsensical terms to be sane, despite the contrary view of expert witnesses. If the legal framework looks to lay people through a jury system to clarify the presence or absence of mental abnormality, then this ambivalence is likely to be reflected in their judgments. Lay people may argue that, on the one hand, a person must be ‘sick’ to perpetrate heinous acts but, on the other, that the acts warrant severe punishment or even death.

Whatever the logical strengths and weaknesses of the legal framework and the varied outcomes generated by the interaction of legal, psychiatric and lay opinion, it is practically and politically very important for two key reasons. First it defines the conditions under which mental health professionals can and cannot detain patients and compulsorily treat them, even when they have not broken the criminal law. These conditions will be dealt with in more detail in Chapter 10. Second it makes decisions about those who have broken the criminal law and who provisionally are deemed to be mentally disordered. In criminal law, for a person to be judged guilty, the court must be satisfied
that there was malicious intent. Unintended but reckless or negligent acts are lesser crimes than those where ‘malice aforethought’ or ‘mens rea’ is evident. For this reason, they tend to lead to less severe sentencing. In the case of British mentally disordered offenders, these judgments about culpability may be modified further in a legal setting, when the defendant’s mental state is considered:

- The perpetrator may not be deemed fit to stand trial – they lack a ‘fitness to plead’. In these circumstances, they may be sent to a secure hospital without trial, provided that their role in the offence is clear to the court. If their mental disorder is treatable or recovery emerges naturally with time, then they may be recalled at a later date to face trial;
- Whether or not the patient is deemed fit to plead, they may be judged to be ‘not guilty by reason of insanity’. When this is the case, then the court, having taken psychiatric advice, decides that the person was sufficiently mentally disordered at the time of the offence that they were unaware that their actions were wrong. The insanity defence is more common in some countries than others. It is rare in Britain, where the next contingency is more likely to operate;
- The defence of ‘diminished responsibility’ can be invoked, when mentally disordered offenders commit murder, but not in the case of other crimes in current English law. The legal term used in this context is suffering from ‘abnormality of mind’, which does not map neatly on to diagnostic categories preferred by psychiatrists;
- The most contentious decision is in relation to temporary loss of reason and intention. This might apply to automatism (crimes committed while sleepwalking) and more commonly but also, more controversially, crimes committed while under the influence of drugs or alcohol. Substance abuse is particularly contentious. On the one hand it is deemed to be a mental disorder. On the other hand in some crimes, such as dangerous driving, the intoxicated driver is typically treated much more harshly, by the courts, than the sober one. When this happens, the presence of a mental disorder, where the offender can demonstrate their long-term substance dependence, does not mitigate the action but the reverse occurs.

**Conclusion about the perspectives outwith sociology**

The expert perspectives on mental health and illness all have some persuasiveness. Equally, we have noted some credibility problems that each encounters. The illness and legal frameworks emphasize discontinuity (people are ill/disordered or they are not) whereas the other perspectives tend to emphasize continuity. It is a matter of opinion whether a continuous or discontinuous model of normality and abnormality fits our knowledge of people’s conduct and whether one or the other is morally preferable. Traditional psychiatrists might argue that, unlike psychoanalysts, they do not see abnormality everywhere. Psychoanalysts might argue that the pervasive condition of mental pain connects us all in a common humanity.
Our concern here is not to resolve these questions but to record them in order to demonstrate that the topic of mental health and illness is highly contested. There are no benchmarks that experts from different camps can agree on and discuss. Thus ‘mental disorder’ or ‘mental illness’ or ‘maladaptive behaviour’ or simply being ‘loony’ do not necessarily have a single referent. It is not only a matter of terminology, although it is in part. It is not simply like the difference between speaking of motor cars and automobiles. In our discussion, each perspective may be warranting certain types of reality but not others. What we have is a fragmented set of perspectives, divided internally and from one another, which occasionally overlap and enter the same world of discourse.

A final comment on the four perspectives is that all of them have difficulty in sustaining notions of mental health and illness which are stable, certain or invariant. In each case, the caveat of social relativism has to be registered. Judgements about health and illness (physical as well as mental) are value laden and reflect specific norms in time and place.

The perspectives within sociology

Having discussed perspectives about mental health and illness from outside of sociology, we now turn to contributions within the latter academic discipline. Four major sociological perspectives will be outlined: social causation, critical societal reaction or labelling theory) will be considered separately in Chapter 2. These five perspectives bear the respective imprints of major contributions from Durkheim, Weber, Freud, Foucault and Marx. These influences are not linear but cross-cut and are mediated by the work of later contributors such as Sartre and Mead. Different theoretical perspectives have been popular and influential at different times. However, it is important to acknowledge that there is no set of boundaries to neatly periodize disciplinary trends. Rather, there are sedimented layers of knowledge which overlap unevenly in time and across disciplinary boundaries and professional preoccupations. The social causation thesis arguably peaked in the 1950s when a number of large-scale community surveys of the social causes of mental health problems and of the large psychiatric institutions were undertaken.

However, one of its most quoted exemplars appeared in the late 1970s and early 1980s (Brown and Harris 1978) and studies in the social causation tradition were set to proliferate in the late 1990s with an explicit government policy agenda designed to tackle the social, economic and environmental causes of mental health problems (Department of Health 1998). Similarly, there is no absolute distinction between sociological knowledge and other forms of knowledge. In relation to lay knowledge/perspective some sociological perspectives (such as symbolic interactionism) in large part draw on the meaning and understandings of lay people. More recently, and in line with a refound enthusiasm for psychoanalytical approaches applied to sociology, the sociological perspective of ‘social constructionism’ within sociology has been treated ‘as if it were a client presenting itself for psychoanalysis’ (Craib 1997). According to Craib social constructionism (discussed in more detail later):
A sociology of mental health and illness

...can be seen as a manic psychosis – a defense against entering the depressive position ... Sociologists find it difficult to recognize the limitations of their discipline – the depressive position – one reason being that we do not actually exercise power over anybody; social constructionism enables us to convince ourselves that the opposite is true, that we know everything about how people become what they are, that we do not have to take account of other disciplines or sciences, but we can explain everything ... a non-psychotic theory is one which knows its own limitations.

(p. 1)

The four sociological perspectives will now be considered.

Social causation

This response from sociologists essentially accepts constructs, such as 'schizophrenia' or 'depression' as legitimate diagnoses. They are given the status of facts in themselves. Once these diagnoses are accepted, questions are then asked about the role of socially derived stress in their aetiology.

The emphasis within a social causation approach is upon tracing the relationship between social disadvantage and mental illness. Given that many sociologists have considered the main indicator of disadvantage to be low social class and/or poverty, it is not surprising that studies investigating this relationship have been a strong current within social studies of psychiatric populations (see Chapter 3). Social class has not been the only variable investigated within this social causation perspective. Disadvantages of other sorts, related to race, gender and age have also been of interest. These studies will be picked up in Chapters 3, 4, 5 and 6.

The advantage of this psychiatric epidemiological perspective is that it provides the sort of scientific confidence associated with objectivism and empiricism (methodological assurances of representativeness and pointers towards causal relationships). However, four main disadvantage of the approach can be identified:

• First, pre-empirical conceptual problems associated with psychiatric knowledge are either not acknowledged or are evaded (see for example Brown and Harris 1978).
• Second, psychiatric epidemiology investigates correlations between mental illness and antecedent variables. However, correlations are not necessarily indicative of causal relationships.
• Third, the investigation of large subpopulations cannot illuminate the lived experience of mental health problems or the variety of meanings attributed to them by patients and significant others.
• Fourth, medical epidemiology attempts to map the distributions of causes of diseases, not merely the cases of disease. Because most of psychiatric illness is described as 'functional' (i.e. it has no known biological marker and its cause or causes are either not known or contested), then psychiatric epidemiology cannot fulfil the general expectation of mapping causes.
Critical theory

During the twentieth century, a number of writers attempted to account for the relationship between socio-economic structures and the inner lives of individuals. One example was the work of Sartre (1963) when he developed his ‘progressive-regressive method’. This method was an attempt to understand biography in relation to its social context and understand social context via the accounts of people’s lives. This existential development of humanistic Marxism competed with another and more elaborate set of discussions about the relationship between unconscious mental life and societal determinants and constraints.

Within Freud’s early circle, a number of analysts took an interest in using their psychological insights in order to illuminate societal processes. This set a trend for later analysts, some of whom tended to reduce social phenomena to the aggregate impact of psychopathology (e.g. Bion 1959). The dangers of psychological reductionism were inevitable in a tradition (psychoanalysis) which had a starting focus of methodological individualism. Moreover, the individuals studied by psychoanalysis were from a peculiar social group (white, middle-class, European neurotics).

Out of this tradition emerged a group of Freudo-Marxists who came to be known as ‘critical theorists’, most of whom were associated with the Frankfurt Institute of Social Research which was founded in 1923 and led after 1930 by Horkheimer (Slater 1977). This group accordingly came to be known as the ‘Frankfurt School’. The difference between the work of the Frankfurt School and most of clinical psychoanalysis was the focus on the inter-relationship between psyche and society. In an early address to the Institute, Horkheimer (1931: 14) set out its mission as follows:

What connections can be established, in a specific social group, in a specific period in time, in specific countries, between the group, the changes in the psychic structures of its individual members and the thoughts and institutions that are a product of that society, and that have, as a whole, a formative effect upon the group under consideration?

These inter-relationships between the material environment of individuals and their cultural life and inner lives were subsequently explored by a number of writers in the Institute, including Marcuse, Adorno and Fromm. In addition, there were contributions from Benjamin (who was a marginal and ambivalent Institute member) and Reich, a Marxist psychoanalyst and outsider. These explorations had an explicit emancipatory intent and were characterized by anti-Stalinist as well as anti-fascist themes. Within the Frankfurt School, Freudianism was accepted as the only legitimate form of psychology which was, potentially at least, philosophically compatible with Marxism. (Both Freud and Marx were atheists and materialists, although Freud’s materialism was barely historical.) The compatibility was explored and affirmed, though, by one member in particular who was a psychoanalyst – Fromm. The integration of Freudianism was selective and critical, filtering out or querying elements such as the death instinct (a revision of classical psychoanalytical theory by Freud himself (Freud 1920)) and questioning the mechanistic aspect of instinctual drive-theory.
The role of this group of critical theorists in social science has been important and seemingly paradoxical. For a theory which drew heavily, if selectively, upon clinical psychoanalysis, the raft of work associated with the Frankfurt School (which was largely relocated in the USA with the rise of Nazism) focused not on mental illness but instead upon what Fromm called the ‘pathology of normalcy’. It was only seemingly paradoxical because psychoanalysis was (and still is) concerned with the notion that we are all ill – psychopathology for Freud and his followers was ubiquitous, varying between individuals only in degree and type. Accordingly, the concerns of this group of Freudo-Marxists were about life-negating cultural norms associated with authoritarianism and the capitalist economy and the ambiguous role of the super-ego as a source of conformity and mutuality. These norms were said to be mediated by the intra-psychic mechanism (especially the repression) highlighted in Freud’s theory of a dynamic unconscious.

Critical theory is exemplified in studies of the authoritarian personality (Adorno et al. 1950), the mass psychology of fascism (Reich 1933/1975; Fromm 1942) and the psychological blocks attending the transitions from capitalist to socialist democracy (Fromm 1955). When Habermas (1989) came to review the project of the early Frankfurt School, he suggested a six-part programme of topic focus: forms of integration in post-liberal societies; family socialization and ego development; mass media and culture; the social psychology behind the cessation of protest; the theory of art; and the critique of positivism and science.

The work of the Frankfurt School eventually fragmented, with Horkheimer recanting his younger Marxism, and Fromm and Marcuse in post-war USA taking divergent and mutually critical paths about the programme summarized in Horkheimer’s mission statement cited above (Marcuse 1964; Fromm 1970). The continuation of a project to examine a ‘critical theory of society’ was maintained by Habermas and Offe in the 1970s and 1980s (Habermas 1972; 1975; 1987; Offe 1984). Moreover, resonances of critical theory can be found in a variety of leftist Freudian projects which continued to explore the relationship between economics, culture and the psychopathology of the individual (Sennett and Cobb 1973; Jacoby 1975; Holland 1978; Lasch 1978; Richards 1984; Kovel 1988), as well as ‘anti-psychiatry’ (Cooper 1968; Laing 1967).

There is a continuing body of work which examines the way in which contemporary Western society is developing in a pathological direction – through the culture of narcissism or the fragmented self represented in the metaphor of schizophrenia (Harvey 1989). Thus, critical theory is included here as an important sociological current of relevance to this book because it has been an influential framework for connecting the psyche and society.

The problems of critical theory have been twofold. First, as was indicated earlier, the theoretical centre of gravity of this project (the Frankfurt School) fragmented. Second, the meaningfulness of any hybrid of dialectical materialism and psychoanalysis requires social scientists to accept the legitimacy of both of its component parts and their conceptual and practical integration. This requires a triple act of faith or theoretical commitment which leaves many unconvinced, dubious or even hostile to the expectation.

The German version of Freudo-Marxism (the Frankfurt School) emerged in the first half of the twentieth century and its traces in social science, with the
exception of Habermas and Offe, tend recently to be faint and influenced by
other theoretical positions. For example, the long list of post-war American
and British writers cited above have been part of a theoretical tradition which
is still psychoanalytically orientated but reflects changes such as the impact of
Klein and later object-relations theorists. Another Freudo-Marxian hybrid can
be found, more recently, in French intellectual life, especially following the
work of Althusser and Lacan (Elliot 1992). This current moved in a different
direction from the Frankfurt School and contributed to the emergence in the
1970s of post-structuralism; a variant of the next perspective we summarize.

Social constructivism

One of the most influential theoretical positions evident in the sociology of
health and illness over the past 30 years has been social constructivism – as
mentioned earlier, it sometimes appears as ‘social constructionism’, especially,
though not only, in psychological literature. A central assumption within this
broad approach is that reality is not self-evident, stable and waiting to be
discovered, but instead it is a product of human activity. In this broad sense all
versions of social constructivism can be identified as a reaction against positiv-
ism and naïve realism. Brown (1995) suggests three main currents within
social constructivism:

1 The first approach is not concerned with demonstrating the reality or
otherwise of a social phenomenon but with the social forces which define it.
The approach is mainly traceable to sociological work on social problems
(Spector and Kitsuse 1977). To investigate a social problem, such as drug
misuse or mental illness, is to select a particular aspect of reality and thus,
implicitly, concede the factual status of reality in general (Woolgar and
Pawluch 1985). In particular, the lived experience of social actors, those
inside deviant communities or those working with and labelling them, are
the focus of sociological investigation. The social problems emphasis, which
gave rise to this version of social constructivism, has been associated, like
societal reaction theory, with methodologies linked to symbolic interaction-
ism and ethnomethodology;

2 The second approach is tied more closely to the post-structuralism of
Foucault and is concerned with deconstruction – the critical examination of
language and symbols in order to illuminate the creation of knowledge, its
relationship to power and the unstable varieties of reality which attend
human activity (‘discursive practices’). Foucault’s early work on madness,
however, was not about such discursive concerns (Foucault 1965). The latter
have been the focus of interest of later post-structuralists (see below);

3 The third approach is associated neither with the micro-sociology of social
problem definition nor with deconstruction but with understanding the
production of scientific knowledge and the pursuit of individual and collect-
ive professional interests (Latour 1987). This science-in-action version of
sociology is concerned with the illumination of interest work. This version
of social constructivism examines the ways in which scientists and other
interested parties develop, debate and use facts. It is thus interested in the
networks of people involved in these activities. Unlike the post-structuralist
version of social constructivism noted earlier, it places less emphasis upon ideas and more upon action and negotiation (e.g. Bartley et al. 1997). This approach is thus compatible with both symbolic interactionism and social realism (see next section).

These three versions of constructivism are not neatly divided within many studies within medical sociology. Bury (1986) notes that the notion of social constructivism subsumes many elements, some of which are contradictory. However, certain core themes can be detected across the three main types described by Brown. The first is that if reality is not rejected as an epiphenomenon of human activity (as in very strict constructivism) it is nonetheless problematized to some degree – hence the break with positivism. The second relates to the importance of reality being viewed, in whole or part, as a product of human activity. What constructivists vary in is whether this activity is narrowly about the cognitive aspects of human life (thought and talk), or it is conceived in a broader sense in relation to the actions of individuals and collectivities. The third is that power relationships are inextricably bound up with reality definition. Whether it is the power to define or the power to influence or the power to advance some interests at the expense of others, this political dimension to constructivism is consistent.

When we come to examine sociological work on mental health and illness these three core elements are evident. Constructivists problematize the factual status of mental illness (e.g. Szasz 1961). They analyse the ways in which mental health work has been linked to the production of psychiatric knowledge and the production of mental health problems (e.g. Parker et al. 1995). Also, they establish the links which exist in modern society with the coercive control of social deviance by psychiatry on the one hand and the production of selfhood by mental health expertise on the other (e.g. Miller and Rose 1988).

The final point to be made about social constructivism is that it does not necessarily have to be set in opposition to social realism (the view that there is an independent existing reality) or social causationism (the view that social forces cause measurable phenomena to really exist). It is certainly true that strong social constructivism challenges both of these positions (see e.g. Gergen 1985). However, a number of writers who accept some constructivist arguments point out that, strictly, it is not reality which is socially constructed but our theories of reality (Greenwood 1994; Brown 1995; Pilgrim 2000). So much of the apparent opposition between constructivist and realist or causationist arguments in social science results from a failure to make this distinction. This brings us to our next perspective.

Social realism

The final perspective to be discussed in this chapter is that of social realism – a perspective held by the authors (Pilgrim and Rogers 1994) as well as others working in the field of mental health and the social psychology of emotions (Greenwood 1994). Bhaskar (1978; 1989) outlines the philosophical basis of realism and we will draw out, briefly, the implications of his work for a sociology of mental health and illness. His version is called ‘critical realism’.

As the name implies, critical realism accepts that reality really does exist
(contra strict constructivism). However, the ‘critical’ prefix suggests that it diverges from social causationism. The latter follows the Durkheimian view that external social reality impinges on human action and shapes human consciousness. The Weberian view emphasizes the opposite process – that human action inter-subjectively constructs reality. Critical theory, following Freud, emphasizes the role of unconscious processes, especially repression, and is rooted in methodological individualism (clinical psychoanalysis). By contrast to all of these, critical realism attends to conscious action or agency and is critical of methodological individualism.

Bhaskar argues, following Marx, that human action is neither mechanically determined by social reality nor does intentionality (voluntary human action) simply construct social reality. Instead, society exists prior to the lives of agents but they become agents who reproduce or transform that society. Material reality (the biological substrate of actors and the material conditions of their social context) constrains action but does not simply determine it. Social science and natural science warrant different methodologies and social phenomena cannot be reduced to natural phenomena, even though the latter may exert an influence on the former and are a precondition of their existence.

Bhaskar (1989: 79) highlights the difference between natural and social science in the light of this basic starting point. Here we quote three major differences between natural and social structures and then draw out the implications for the topic of this book:

1. social structures, unlike natural structures, do not exist independently of the activity they govern;
2. social structures, unlike natural structures, do not exist independently of the agents’ conceptions of what they are doing in their activity;
3. social structures, unlike natural structures, may be only relatively enduring so that the tendencies they ground may not be universal in the sense of a space-time invariant.

The implication of point 1 is that mental health work is part of a social structural set up so that objective or disinterested descriptions and action within that work are untenable. Point 2 follows closely in its implication – the professional knowledge perspectives we rehearsed earlier in the chapter contribute to the constitution of mental health work and the health and welfare structures they inhabit. Point 3 implies that mental health work must be understood within its specific context of time and place – it is historically and geographically situated. As a consequence of points 2 and 3 social psychiatric investigations should be accepted tentatively. They may supply useful information about the relationship between social variables such as gender or class (see later chapters) but they cannot be credited with the same scientific status as, for example, knowledge claims from biochemistry or physiology.

Because critical realism is a materialist, rather than idealist, basis for social science (cf. the Kantian idealism underlying the work of Weber and Foucault and their followers) it can accommodate material causation (e.g. temporal lobe epilepsy) alongside a critical analysis of the interests being served by the way mental health problems are described and conceptualized in a society at a point in time (e.g. a critique of the interests served by psychiatric knowledge). Such a critical reading comes near to the deconstruction emphasis of
post-structuralism and the critiques of interest work found in critical studies of
the production of scientific knowledge, but differs in its position during the
exercise about the factual status of reality.

Critical realism can be contrasted with naïve realism, which separates and
discards values and interests from knowledge and assumes that methodological
rigour in and of itself ensures bona fide knowledge. Naïve realism (for example
to be found in the biomedical model of psychiatry and the traditional empirici-
sm of much of clinical psychology) assumes simplistically and erroneously
that we can observe and measure aspects of reality in a non-problematic way;
without reference to the interests and values implied by the pre-empirical and
non-empirical constructs that constitute our systems of knowledge. As a con-
sequence, critical realism draws attention to two types of error, the ontic
and the epistemic fallacies, that occur with that conflation. In the epistemic
fallacy, statements about being are to be interpreted as statements about
knowledge. In the ontic fallacy, knowledge is analyzed as a direct, unmediated
relation between a subject and being. The ontic fallacy ignores the cognitive
and social mechanisms by which knowledge is produced from antecedent
knowledge, leaving an ontology of empirical knowledge events (raw percep-
tions) and a de-socialized epistemology. Bhaskar sees a close relation between
these two fallacies, especially in relation to classical empiricism. The epistemic
fallacy first projects the external world onto a subjective phenomenal map,
then the ontic fallacy projects the phenomenal entities of that subjective map
back out on the world as objective sense data, of which we have direct per-
cptual knowledge. So reality independent of thought is first subjectified, then
the subjectified elements are objectified to explain and justify our knowledge
(Irwin 1987). Put simply the ontic fallacy is about naively trusting our perceptions
too readily. The epistemic fallacy is about naïvely assuming that reality is
what we call it (in the case of the diagnostic psychiatry ‘schizophrenia’,
‘depression’ etc.). Thus (contra a radical constructivist account) according to
critical realism misery or madness are not socially constructed but our ways of
describing and understanding them. In all societies, people act in ways which
signal their distress and which others cannot readily understand and so we can
talk with some certainty about the ‘reality’ of madness and misery. What is
contested across time and place though is how those states are described,
understood and valued or dis-valued.

As will become clear, we consider that evidence of social structural influ-
ences on mental health can be furnished by methodologies rooted in
Durkheimian sociology. Equally, the concerns of social constructivists can
furnish critical readings which give insights into the interests being served by
discourses (what Bhaskar calls the ‘agents’ conceptions’). In other words, all
sorts of methodologies used by sociologists to study mental health and illness
can furnish illuminative information and, potentially, can be subjected to a
critical reading (Pilgrim and Rogers 1999).

The relevance and applicability of sociological theory are themselves influ-
enced by the particular time and social context in which they are used. More
and more sociologists are employed in applied research contexts which lie
outside their core disciplines. Sociology has also influenced generations of
health workers including medical practitioners, nurses, psychologists and
social workers. In comparison, ‘pure’ sociologists are a small minority of those
who have had access to sociological knowledge through their socialization and
education as health and social welfare professionals. Additionally, working in the field of mental health and health services research is a largely interdisciplinary endeavour. Thus, social realism allows coexisting explanations about mental health, provided that those explanations are subjected to critical scrutiny in relation not just to their empirical plausibility but also their conceptual coherence and their ideological underpinnings. For example, what does it mean when drug companies fund (even more) research into the biological basis of madness? What does it mean when clinical psychologists provide evidence for the effectiveness of cognitive approaches to the treatment of misery? Why have incoherent diagnoses such as ‘schizophrenia’ continued to have a reified scientific status in professional and government circles? These sorts of question highlight that critical realism accepts reality but also interrogates the ways in which values and interests in society seek to depict reality.

**Border disputes**

With the exception of social causationism, sociological perspectives problematize the notion of mental disorder. The force of these arguments can be seen in the continuing debates both within sociology and increasingly from across other disciplines particularly those who encounter mental distress in their everyday work. Various forms of ambivalence are evident on all sides. Social realists can still ‘do business’ with psychiatry, particularly if a biopsychosocial model is deployed and investigated in a spirit of genuine inter-disciplinary collaboration. The inter-disciplinary project of ‘social psychiatry’ describes this convergence of disciplinary interests. We also mentioned the tendency for some critical psychiatrists and other professional group to embrace social constructivism.

Some sociologists have gone some way to legitimize the core business of psychiatry by accepting that the psychoses are ‘true’ illnesses, while designating ‘common mental disorders’ as being forms of social deviance (not illnesses). Horwitz argues that ‘a valid definition of mental disorder should be narrow and should not encompass many of the presumed mental disorders of diagnostic psychiatry, especially appropriate reactions to stressful social condition and many culturally patterned forms of deviant behaviour’ (2002:15). A problem with this partial validation of psychiatric diagnosis is that it relies too readily on immediate social intelligibility. That is, stress reactions and cultural context warrant attributions of non-pathology, whereas psychosis does not. We return to this point in Chapter 5.

Some medical practitioners have rejected the concept of mental illness but not in the way that was evident in the Szaszian critique noted earlier. Baker and Menken (2001) suggest that the term ‘mental illness’ must be abandoned because it is an erroneous label for true brain disorder. They are dismissive of the countless critiques and ambiguities previously identified by dissenting psychiatrists and sociological critics. Instead they argue for a clear philosophical assertion that all mental illnesses are brain disorders as ‘an essential step to promote the improvement of human health’ from within clinical medicine:
We suggest that it is unscientific, misleading and harmful to millions of people worldwide to declare that some brain disorders are not physical ailments. Neurology and psychiatry must end the twentieth century schism that has divided their fields.

(2001: 937)

This resort to dogmatic assertion, about biodeterminism, in one fell swoop discards all of the sociological theorizing about mental disorder in favour of medical jurisdiction and paternalism, purportedly in service of the common good. However, this medical confidence simply evades an obvious point: the bulk of what are called ‘mental disorders’ still have no definitive proven biological cause. The only aspects of the social this medical dogmatism leaves intact are the environmental factors, which might putatively contribute to the aetiology of illness. However, this stance is one reflection of a deeper problem for both medicine and sociology; the problem of mind/body dualism.

Baker and Menken create a unity between mind and body by asserting the single centrality of the skin-encapsulated body out of which each and every form of human ill emerges. Radical social constructivism generates another unitary position by arguing instead that ‘everything is socially constructed’. In this view, reality, truth claims and causes are all dismissed just as readily as Baker and Menken dismiss the conceptual objections facing the concept of mental illness. This goes further than labelling theory, which left the ontological status of primary deviance intact. It ascribed to it a basic reality and permitted a variety of causes. Radical social constructivism does not make this concession, and primary not just secondary deviance is examined critically. The constructivist position is not consistent though. For example, Szasz deconstructed the representations of mental illness in order to render it a ‘myth’. At the same time he accepted uncritically the reality of physical illness. Carpenter (2000) notes the proliferation of diagnostic categories after the appearance of the third edition of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSMIII).

Various sociological commentators have pointed to how interests, agencies and technology have promoted the medicalization and institutionalization of certain diagnostic categories, such as post-traumatic stress disorder, depression and eating disorders. Lyons (1996) points to activities of the drug companies in promoting Prozac as an acceptable drug to make life better for all – almost a recreational drug. Such a trend is reinforced in primary care, where depression has come to be accepted as a legitimate condition amenable to a technical fix. Identifying technologies (e.g. antidepressant medication and counselling) as a means of management located within primary care is likely to have contributed to increasing medicalization and acceptability of depression as a valid presenting problem in GP consultations (May et al. 2004).

In response to this proliferation of diagnostic categories and the medicalization of everyday suffering Horwitz argues that only symptoms that reflect psychological dysfunctions, considered to be universally inappropriate, should warrant being labelled as true mental diseases. The advantage of this approach is that it is an attempt to overcome the void left by the relativistic nihilism characteristic of some post-modernist approaches to the conceptualization of mental health problems.

On the face of things, this line of reasoning is follows those sociologists of
mental health and illness who have aligned themselves with a critical realist position (i.e. presenting a weak social constructivist argument without abandoning the notion of mental illness and undermining the notion that mental distress exists). However, this argument may precariously be introducing another essentialist view of psychiatric disorder. Implying some self-evident and natural distinction between true mental illness and varieties of socially generated mental distress is akin to some older psychiatric classifications which distinguished mental illness from distressing environmental reactions (Fish 1968).

From a critical realist perspective it is clearly the case that pressure groups and drug companies also do much to promote and maintain all diagnostic categories (Pilgrim 2007a). Profit makes none of the distinctions considered or asserted by Horwitz. Moreover the criteria of ‘universal inappropriateness’ is difficult to sustain for any diagnostic category. For example ‘hearing voices’ has been associated with the diagnostic category of ‘schizophrenia’ but it would fail to fit the categorization of ‘universally inappropriate’. Not only is voice hearing evident in the general population (including in those without a diagnosis of psychosis) in some cultures it provides evidence of spiritual superiority. Hallucinations have no universal meaning – they might occur universally but what they mean varies from place to place.

Another difficulty for sociology trying to define the unique and troublesome features of mental illness is the tendency to leave physical illness non-problematized (the Szaszian error). The focus on mental disorder means that sociologists have at times claimed for mental health what applies more generically. For example, Horwitz’s key argument about the proliferation of psychological categories clearly includes examples which are considered to be essentially physical (even though they may also be identified with certain psychological tendencies). In accepting mind/body dualism sociologists, like those in other disciplines, may disregard or dismiss physical health problems as unproblematic and fail to consider the common social processes shaping the definition and causes of all illness behaviour and experience.

The ontological status of musculoskeletal disease, as an essentially physical entity, provides an interesting point of comparison of the way in which the mind/body dualism has overridden the experience and conceptualizations of peoples’ pain and distress provided in a recent study in which:

respondents’ conceptualizations of the physical body emphasized fragility and paralysis. This view of the body resonates with an understanding of incapacity, or of not being able to act as desired, which emerges from a sense of ineptness, weakness and pain. . . . Descriptions of an amorphous sense of pain which accompanied this sense of precariousness seemed to suggest a lack of demarcation between pain located in specific parts of the body and concerns in broader social and personal worlds and in this respect pain and suffering transcended the commonly understood notion of the physical body and extended to include other personal disappointments.

(Rogers and Allison 2004: 81)

Ironically, in failing to construct alternative models of illness in general both sociologists and medical practitioners may remain trapped in forms of mind/
body dualism or offer implausible assertions to impose a unity, such as medical naturalism or radical social constructivism.

Finally, it may seem, at first reading, that sociology is somehow a separate and recent commentator on mental health and illness. This is only partially true. Over the past 50 years newly trained sociologists have contributed to knowledge about psychiatry and the mental patient, but this may give the false impression that sociology is merely responding to the dominant discourse on health and illness, coming from health professionals.

However, social science existed at the beginnings of medicine. Before the latter settled down to become preoccupied with individual bodies and their parts, social medicine emerged in the eighteenth century as a programme of political intervention to prevent ill health (Rosen 1979). Indeed, Foucault (1980) argues that medical surveys of society in the early nineteenth century were the true roots of modern sociology, not its reputed fathers like Comte, Marx, Durkheim and Weber. (For a wider discussion of this topic see Kleinman (1986) and Turner (1990).)

In the particular case of mental health, so much research of the epidemiological variety was intertwined with medical research. The discipline of social psychiatry demonstrates this overlap (Goldberg and Morrison 1963; Warner 1985). Also, some of the ground-breaking epidemiological work of the 1950s and 1960s involved the collaboration of sociologists (e.g. Hollingshead and Brown) with psychiatrists (e.g. Redlich and Wing).

However, it is also true that the more recent response of sociologists has been seen as oppositional by those inside clinical psychiatry. During the late 1960s, sociologists became part of ‘anti-psychiatry’ or ‘critics of psychiatry’, according to leaders of the offended profession, such as Roth (1973). Thus, sociologists are in an ambivalent relationship to psychiatry. On the one hand, they have contributed to an expanded theory of aetiology, in tracing the social causes of mental illness; on the other, they have set up competing ways of conceptualizing mental abnormality.

The bulk of the work we have reviewed in this chapter reflects a dominant sociological interest in mental abnormality and in psychiatry. By comparison, over the past 100 years, there has been much less sociological (and for that matter general social scientific) interest in ordinary emotional life, non-deviant conduct and professional knowledge outside of the governance of psychiatric experts. However, this is changing as we discuss in depth in the final chapter of this book. One major shift about this became evident in the work of post-structuralists (e.g. Rose 1986; 1990). Although this had mental health experts as a central focus (the ‘psy complex’), it did demonstrate, under the prompt of Foucault, the diffused and widespread influence of ‘the confessional’ and other personalizing discourses in everyday life.

Outside of post-structuralist frameworks we find a more pluralistic sociological interest in ordinary emotions (Elias 1978; Hochschild 1983; Freund 1988; James 1989; Giddens 1992; Beck and Beck-Gersheim 1995; Bendalow and Williams 1998). This range itself may reflect an aspect of post-modernity – diverse commentaries on personal life are becoming increasingly legitimate and demanded with resonances of psychoanalytical ideas about ordinary emotional life and those which bridge psychoanalysis and social constructionism (Craib 1998; Lupton 1998).

Within this shift in social science, there has developed an interest in
the ways in which society has followed the trend of the fast food chain McDonald’s in a whole range of cultural process (including sexual activity, health care ‘delivery’, and dying). This ‘McDonaldization thesis’ (Ritzer 1995; 1997) reflects a shift in society towards consumerism, which suggests that the emotions, like food, have become subject to both commercial prepackaging and increasing everyday interest to ordinary people.

The emphasis in this chapter has been on sociological ideas about the definition and shifting knowledge claims about what constitutes mental health and illness. Sociological analyses can also influence other disciplines at time in their revisions about the nature of mental health and illness. The weak validity of ‘depression’ as a biological notion has not only been challenged by sociological studies (e.g. Brown and Harris 1978) but by re-formulations based on observations in routine clinical practice. The need to transcend current classifications has become a mainstream controversy for clinicians, with the observation that categories, such as ‘depression’ and ‘anxiety’ in population groups do not have distinct features (Das-Munshi et al. 2008). These observations in clinical practice confirm conceptual critiques offered by critical realists (e.g. Pilgrim and Bentall 1999). It is clear now that there is little evidence to support ‘depression’ as a discrete biological entity. Clinical research about the ‘management of depression’ suggests that there is a major overlap in practice with a wide range of ‘unexplained symptoms’ and there is a recurring conflation of social difficulties and the individual experience of distress experienced by patients (Chew-Graham et al. 2008).

The practical challenges for clinicians are not the analytical and empirical challenges for sociologists. The former have to personally engage and ‘manage’ people with mental health problems. Nonetheless in working how best to do this, sociological concepts both inform these formulations and the formulations that are suggested in turn feed into sociological ideas. This is evident in the analyses put forward by Dowrick (2004) and Gask et al. (2000) when examining the personal and social circumstances of miserable patients. In response to this extensive conceptual doubt, the lack identified by medical researchers is not better medical diagnostic categories and but rather a lack of an adequate theory of self. Dowrick (2009) suggests that what is required in practice is the generation of a new set of metaphors to guide practice ‘which are dynamic and temporal offering possibilities of hope, action and purpose’. What is clearly evident is that in response to the philosophical debates about the conceptual underpinnings of what constitutes mental health and illness a number of theoretical frameworks underpin approaches to psychiatry and mental health work more generally. We return to these in the chapter on professions.

This chapter has rehearsed and summarized a set of perspectives about mental health and illness both inside and outside of sociology. The existence of such a wide range of viewpoints highlights that the field of mental health and illness is highly contested. As a result, any discussion of the topic cannot take anything for granted – one’s own assumptions, and those of others, need to be checked at the outset and at each stage of a dialogue or analysis thereafter.
Questions

1. What are the strengths and weaknesses of the legal perspective on mental illness?
2. Compare and contrast two approaches to mental health and illness within sociology.
3. Discuss the relevance of the Frankfurt School to contemporary discussions about mental health.
4. Compare and contrast social constructivism with social realism when conducting sociological studies of mental health and illness.
5. Discuss recent developments in the sociology of the emotions.
6. How have sociology and psychiatry dealt with the mind/body dualism?

For discussion

Consider your own views about mental health and illness. How do they relate to the range of perspectives offered in this chapter?

Further reading