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Theorising Mental Disorder: A Sociological Approach

Santrauka

Straipsnyje yra pristatoma ir kritiškai aptariama keletas sociologinių psichikos sutrikimo perspektyvų: Parsons'o ligos kaip deviacijos bei kaip negalėjimo atlikti įprastus socialinius vaidmenis modelis, etikečių teorija ir ligos, kaip socialiai priskirtos etiketės samprata, konflikto teorija bei ligos kaip socialinės nelygybės pasekmės modelis, Foucault beprotystės ir racionalaus proto priešpriešos diskursas, socialinio konstruktyvizmo ir ligos kaip socialinio konstrukto teorija. Kadangi sociologinė analizė ilgą laiką ignoravo biologinį psichikos sutrikimo aspektą, straipsnyje supažindinama ir su nauja teorine kryptimi, bandančia spręsti sąsajos tarp socialinio ir biologinio psichikos sutrikimo pagrindų problemą, pasitelkiant emocijas kaip analitinį įrankį.

Sociologai vyraujančias psichikos sutrikimo sampratas bei psichiatrines praktikas sieja su platesniu socialiniu kontekstu bei socialinių santykių analize. Šitaip yra praplečiamas psichiatrinis psichikos sutrikimo suvokimas, sociologinė analizė padeda geriau suprasti psichikos sveikatos priežiūros organizaciją, psichiatrines praktikas, specialisto - paciento santykius bei vaidmenis, tapimo psichiatrinio pacientu procesus.

Introduction

Mental health and disorder have been already for a long time a topic of sociological interest. Initiated by Durkheim's concepts of normal and pathological and Parsons' theory of the sick role, the discussion on mental disorder has circulated around the categories and boundaries of mental disorders, explanations of the causal factors in their aetiology, treatment procedures, changes in and characteristics of mental health services, as well as relationships between various groups of health care professionals in the mental health field.

Sociology of mental disorder is a recognised discipline in many Western countries. However, in Lithuania as in most of the post-communist societies, the phenomenon of mental disorder or health lack research attention from sociologists. Understanding of mental disorder is considered to be an issue for psychiatry, psychology and other allied professions. However, the way mental health and disorder are defined, categorised and explained by the professional discourses, tells us much about the prevailing power relations, gives a deeper compre-

hension of how mental health care services are organised, disorders diagnosed and treatments administered. Sociological perspective, therefore, explores dominant concepts of mental disorder and offers other ways of thinking about mental phenomena, while locating them within a broader social context and an analysis of social relations (Busfield 1996; 51).

This article presents major sociological ideas and conceptualisations of mental disorder, which serve as a theoretical framework for sociological analysis of mental phenomena and psychiatric practice. The limited length of it doesn't allow to provide the reader with a comprehensive review of sociological work on mental disorder. The concept of mental health is also left outside the scope. Moreover, the reader shouldn't expect to find a smooth chronological presentation of sociological perspectives: some of the theories overlap in time, as well as there are no clear boundaries between some of them (e.g., social constructivist work is based on various theoretical perspectives within sociology; Foucault is also difficult to loca-

te in only one of the major theoretical approaches). The main aim of this article is to introduce major ideas developed within sociology of mental disorder as well as their critique, and to show how sociology could contribute to better understanding of the phenomenon of mental distress.

Conceptual model of psychiatry

First I will start with the theoretical model by means of which psychiatry organises its knowledge around the object. This model serves as a background for most sociological insights about psychiatric knowledge and practice.

There is a considerable diversity in the ideas and practices of different specialities within modern medicine, however it is possible to summarise them under a shared framework of beliefs and assumptions, which guide the medical practice. This framework in sociological literature or elsewhere is usually referred to as medical or disease model, which conceptualises modern medicine as institutionalised, scientific and technologically directed (Turner 1987). The medical model presents illness and disease as organic malfunctions located primarily within the body; disease is regarded as being a discrete entity, having specific causal origins, which can be objectively identified and treated accordingly.

Also, this medical model with some variations applies to psychiatry, which is a specific branch of medicine. The conceptual model of psychiatry has its roots in the values of scientific rationality and reason that were enhanced by the Enlightenment thought and became standards of natural sciences in general and medicine in particular. As natural sciences have become the basis for the intellectual foundations of psychiatry, biological thinking has been dominating in the field since the nineteenth century. Therefore, the conceptual model of psychiatry maintains that there are distinct boundaries between the 'normal' and the 'abnormal' that can be objectively recognised (diagnosed) and classified as discrete disease entities, applying value neutral scientific reasoning. The emphasis is pla-

ced on the idea that the causes of mental disorders are to be found in the disturbances of a biological kind, presenting themselves as specific symptoms for each particular disorder, that should be targeted by somatic treatments (Haslam 2000). Consequently, this standpoint implies that mental disorders are not considered to be deeply cultural or time bound.*

There are some differences in determining the nature of a disorder between psychiatry and other branches of medicine. In medicine diagnosis implies the causal identification of disorder, however in psychiatry diagnosis in most cases involves "assigning a diagnostic label on the basis of the observed and/or reported behaviours and symptoms" (Allen 1998; 29). Consequently, assigning a psychiatric diagnosis does not necessarily suggest that "the aetiology (cause) of the symptoms is known, but only that an individual's symptoms meet the criteria for the particular mental disorder" (ibid.). Both main classifications of mental disorders used internationally - the American version or the Diagnostic Statistical Manual (DSM) in its fourth edition now and the WHO's International Classification of Disease (ICD) now in its 10th edition - are based on this kind of reasoning which is called descriptive categorical approach.

Yet, these intellectual constructions guiding psychiatric practice are far from stable. What constitutes psychiatric knowledge is always under negotiation and subject to revision and transformation (Busfield 1996). This instability of psychiatric knowledge is reflected in the frequent revisions of diagnostic manuals. For example, the first edition of DSM appeared in 1952. It was revised in 1968, 1979, and in 1987. The DSM-IV, which is used now, was issued in 1994 (Allen 1998). Each of the new versions was supposed to provide a more elaborated and refined description of mental disorders since research evidence showed that there are difficulties and inconsistencies among clinicians in deciding on diagnoses (see Manning 2000). Moreover, some of the previous mental disorders during these revisions disappeared from the list (e.g., homosexuality), at the same new ones were included (e.g., hyperactivity in children).

Since the precise boundaries and meanings of mental disorder vary over time (and place) and are highly contested, mental disorder seems in fact to be a culturally and socially relative category. Moreover, the frequent revisions of diagnostic manuals, which reflect the changing boundaries of mental disorders, imply that the concept of disorder in psychiatric field is not free from value judgements, despite the declared scientific basis of psychiatric knowledge. Here is where sociological approach might contribute.

Sociological explanations of mental disorder

The concept of mental disorder and the diagnostic categories with which psychiatrists and other mental health professionals operate have drawn particular interest of sociologists. A lot of their insights can be traced to the work of Emil Durkheim. Durkheim argued that the rules and standards that define what is normal and what is pathological are necessary for the societal cohesion. The normality is sustained and strengthened by the definitions of the pathological (Durkheim 1964). The rules that define the normal and the pathological vary according to the values of the social group; moreover, since there is always an element of social control in the application of rules, the same counts also for the rules defining the normal and the pathological. Durkheim was talking about rules of behaviour and about crime and wrongdoing but his analysis is also pertinent to understanding concepts of mental disorder: these concepts help to define the acceptable behaviour in the society (Busfield 2000). Therefore, the understanding of mental disorder in terms of deviance became one of the primary ways to think about the phenomenon sociologically.

Parsons and the functionalist model of mental disorder

Parsons (1951) was one of the first in the field of medical sociology to conceptualise illness as deviance. Since Parsons was interes-

ted in how various components of society function so as to keep the whole social system in balance, for him illness constitutes a threat to social cohesion, because it inhibits an efficient role playing which is crucial for maintaining social order. Therefore, Parsons equates health with person's capability to function as an efficient role partner, and illness becomes conceptualised as deviance since it involves motivational withdrawal (albeit not necessarily consciously wilful) from expected roles and responsibilities.

In his analysis of the motivational structures in illness Parsons heavily relies on psychoanalysis. Parsons argues that motivation to fall into a deviant state of illness refers to the residues of the pre-oedipal mother-child relationship. As the child approaches adulthood, he/she has to emancipate from this dependency relationship. This process is particularly psychologically stressful in a culture, which emphasises an early independent achievement. Moreover, the modern life is a complex one, making big demands on the individuals, for whom this might become too strenuous. As a consequence, the motivation to retreat into ill health through mental or psychosomatic channels, becomes accentuated (*ibid.*; 74). Motivation to ill health therefore constitutes a kind of defence mechanism directed against the strains of modern everyday life, the more so as illness presents certain privileges and exemptions from social roles provided by a legitimated sick role.

Gerhardt (1989) argues that the secondary literature on Parsonian theory to an overwhelming degree, has omitted the two-model structure of his thought. Often, the first model of illness as deviance presented above has been conflated with his conceptualisation of illness as incapacity, though they are, of course, interrelated. For Gerhardt, however, the deviancy model is concerned particularly with the motivational forces in the aetiology of illness, whereas the capacity model focuses on illness as incapacity - a gradual erosion of a person's capacity to perform a role. Moreover, while the deviancy model involves a more voluntary action of falling ill, the capacity model regards

the individual as being not responsible for his or her mental or physical incapacity. Illness in this model is characterised by passivity (in a predominantly active society), helplessness (while society values the personal independence) and emotional confusion (where the modern world is characterised by the means-ends rationality). Here is also where the concept of sick role is largely developed.

The sick role is defined as “the set of patterned expectations that define the norms and values appropriate to being sick, both for the individual and others who interact with the person” (Cockerham and Ritchey 1997; 117). Since it is in role capacity that the person fails, the recovery is achieved also through a role (namely the sick role): “the sick role is perceived as some kind of niche in the social system where the incapacitated may withdraw while attempting to mend their fences, with the help of medical profession” (Gerhardt 1989; 15).

The sick role includes several key expectations: that sick individuals be exempted from their normal social responsibilities; that it be accepted that they cannot help being ill; that they should want to get well; and that they should seek, where appropriate, medically competent help in so doing. Through these expectations, the sick role provides a mechanism by means of which sickness is regulated, thereby contributing to the smooth functioning of the social system:

The individual who is incapacitated from performing his role-functions would be a disturbing element in the system if he still attempted to perform them. Hence we may say that it is important to have some way of preventing him from attempting to do so, both in his own interest and in that of the system itself (Parsons 1981; 58)

The institutionalisation of the sick role with all the rights and responsibilities it involves, serves the reaffirmation of the valuation of health and provides the countervailing influence against the temptation for illness (ibid.). The therapeutic process then aims at motivating a sick person to work (or actively co-operate with therapeutic agency) to achieve his or her reco-

very. The emphasis on *active work* by the patient in trying to recover is particularly strong in Parsons. However, as he notices, particularly within the field of mental disorder a patient within the therapeutic process is “conceived of as anything but a passive object of the manipulations of the therapeutic personnel” (ibid.; 76). Yet, he is also arguing that with some mentally disordered patients there might be a problem not only how to involve them into co-operation with a medical personnel but even how to make him or her to recognise the need for the exemption permitted by virtue of illness. That is why some of the types of mental disorder might be most disruptive for society: they might involve not only emotional disturbance but the reality distortion as well. This prevents people from correctly perceiving and therefore adequately responding to role expectations.

Capacity model, therefore, defines illness as incapacity that prevents satisfactory role performance and the deviance model conceptualises it as motivational withdrawal from expected social roles. Parsons makes clear that the boundaries between health and illness vary between societies and in society over time. His theoretical model allows accounting for variations in the categories of illness across time and place, as the requirements of role performance vary (Busfield 1996).

Parsonian concept of sick role has been criticised as unable to incorporate chronic illness (somatic or mental). However, as chronic illness is concerned, Parsons, responding to this kind of critique has argued that:

There are many conditions, which are, in any given state of the art of medicine, incurable. However, recovery is the obverse of the process of deterioration of health, that is, a level of capacities, and in many of these chronic situations tendencies to such deterioration can be held in check by the proper medically prescribed measures based on sound diagnostic knowledge (Parsons in Gerhardt 1989; 33)

Therefore, for example, medications might help a person to maintain his or her capacity to perform expected roles even if his or her “normal” health will never be restored. The pro-

blem in this case might arise with, as it has been mentioned above, certain types of mental disorders, where it might be difficult for an individual even to enter the sick role, since he or she might not recognise a need for that.

Indeed if we apply Parsons' theory to mental disorder several problems occur. On one hand, defining mental disorder as deviance might seem to be a relevant way of thinking about it since it corresponds to the Freudian notion of the role of psychological motivations in generating mental disorder. Moreover, since deviance here implies the ambivalent motivational structures that underlie role performance, the focus is on motivations and not on conformity in the content of thoughts, ideas and beliefs (the latter aspect is more relevant to Durkheim's conceptualisation of deviance). This is an important aspect since it allows distinguishing between the "appropriateness of the content of thought" and the "appropriateness of processes of mental functioning" (Busfield 1996; 62). Namely the latter aspect is the focus in psychiatry.

On the other hand, there are some problems with the Parsonian illness as deviance formulation. According to Busfield, neither of the two basic requirements of deviance is met – that is, that the behaviour breaks some socially accepted rule (the rule breaking requirement), and that there is agency (the agency requirement):

First, since the withdrawal from social obligations associated with illness is socially sanctioned, it cannot itself be properly described as rule-breaking. Second, to recognise that there can be some motivational elements in illness is not sufficient to establish that the illness itself is willed and that there is agency... (Busfield 1996; 64)

Gerhardt (1989; 47) adds to this critique some other observations. She notices that Parsons emphasises only the positive aspects of the withdrawal from the social roles: "the unpleasant or threatening aspects of suffering pain, being humiliated by not being able to walk, talk or use the toilet are not taken into account". Yet, these aspects of illness are what make it an unwanted and unpleasant experience. Moreover, how to explain a motivational

recourse to mental disorder in a society where it is highly stigmatised?

Another thing that is problematic with Parson's model of illness as deviance is that he does not account for the threats of hardships that might arise for impoverished groups of society, which because of illness might be unable to retain their income (*ibid.*). This is an important insight since various studies (I will refer to them later) indicate that mental disorder has a social gradient and that there are inequalities between social groups in the rates of mental disorders, those in the lower classes being mostly vulnerable to it.

As far as the capacity model is concerned, the major strength of it is that by linking illness and social obligations it accounts for the controversy surrounding the issue of wilful and false attempts to occupy the sick role (see Szasz 1961), since it emphasises the capacity not the will to conform to certain role expectations. Also, Parsons analysis illuminates the linkages between illness and social control, indicating how and why control is exerted (Busfield 1996; see also Armstrong 1993). Since effective role performance is necessary to the smooth functioning of social system, illness as incapacity to perform those roles presents a threat. Therefore, doctors or psychiatrists while providing a treatment act also as agents of regulation in the interests of the wider society (of course, this does not mean that they may not be genuinely concerned to help such individuals).

Parson's analysis of illness has potential value in analysing psychiatric practice. However, at the same it is problematic because of the functionalist approach, which ignores the nature of conflicts imminent to society.

The labelling theory: symbolic interactionist model of mental disorder

Before starting to talk about labelling theory, it would be useful to present some of the main ideas of the so-called anti-psychiatric movement. These ideas illustrate the context within which the labelling theory of mental disorder was developed.

Psychiatry has been criticised a lot throughout its history. However, one of the most challenging critiques came from within the psychiatry itself. Anti-psychiatry, a movement, which emerged in Britain and elsewhere during the 1960s and 1970s, included a diverse group of theorists, yet its main proponents (e.g., Laing, Szasz) belonged to the psychiatrists (Crossley 1998). In contrast to previous as well as to many subsequent critiques, anti-psychiatrists “questioned the very basis of psychiatry itself: its purpose, its foundational conception of mental illness and the very distinction between madness and sanity itself”. (ibid.; 878.) The anti-psychiatrists ideas were rooted in a wider critique of society, which was regarded as oppressive and required repression of human potentialities for its own effective functioning. For them the very notion of mental disorder referred to oppressive control for those deemed mentally disturbed.

According to British anti-psychiatrist Laing, the use of labels of sanity and madness involves evaluation and judgement not of physical functioning but of human action. For him what counts as sanity and insanity is largely a question of conformity to social norms. There is no such mental ‘disease’ as schizophrenia: for Laing, the experiences and behaviour of diagnosed schizophrenics are to be seen as strategies to cope with the inconsistencies of the social world (Gerhardt 1989). Labelling someone as schizophrenic, therefore, constitutes an act of social control, which imposes particular consequences (e.g. hospitalisation, stigmatisation) on the labelled person.

The American proponent of anti-psychiatry Szasz (1961) has also argued that mental disorder is just a label used by psychiatry to mystify social control. Like Laing, he maintained that conceptualisation of mental disorder involves moral judgement. Since it is the human thought and action and not physical functioning that are being judged, the standards applied should be ethical, social and political but not medical. The phenomena labelled as mental illness should, more properly, be termed ‘problems in living’. To call these ‘problems in

living’ diseases and place them into the province of psychiatry (unless they are clear biological failures but in this case they are organic diseases), is to mystify the social control that is involved (Szasz does not object to social control as long as it is explicit).

Many of these ideas were taken and developed further by the labelling theory. The labelling theory has its origins in symbolic interactionism. It analyses the ways in which certain behaviour comes to be defined as deviant. The theory is also referred to as societal reaction theory since in general it is preoccupied with societal reactions to deviant behaviour and its impact on the person whose behaviour is thought to be deviant.**

Lemert, in his book *Social Pathology* (1951) explained the focus of labelling theory when applied to mental disorder as follows:

One of the more important sociological questions here is not what causes human beings to develop such symptoms as hallucinations and delusions but, instead, what is it about their behaviour which leads the community to reject them, segregate them, and otherwise treat them as irresponsible, i.e. as insane (Lemert 1951; 387-8, cited in Busfield 1986; 91)

Thomas Scheff sociologically developed the labelling theory with the application to mental disorder. Scheff explicitly theorises mental disorder in terms of deviance (Scheff 1999). He is interested in how mental disorder differs from other types of deviance, and therefore, what are the rules that a person has to break in order to be identified as mentally disturbed (deviant). Scheff suggests, that persons labelled mentally disturbed are breaking “residual” rules:

The culture of the group provides a vocabulary of terms for categorising many norm violations: crime, perversion, drunkenness, and bad manners...After exhausting these categories, however, there is always a residue of the most diverse kinds of violations for which the culture provides no explicit label...For the convenience of the society in construing those instances of unnameable rule-breaking that are called to its attention, these violations may be lumped together into a residual category: witchcraft, spirit possession, or, in our own society, mental illness (Scheff 1999; 55)

The definition of behaviour as deviant will also depend on the visibility of infraction, the power of rule-breaker, the frequency of rule breaking, the particular rule broken, the amount of tolerance available in the society, any alternative explanations that might clarify or rationalise the rule breaking behaviour, and the social context in which the behaviour takes place (Busfield 1996, Cockerham and Ritchey 1997). The societal reaction to rule breaking behaviour is crucial: only if it receives some social response, the rule-breaker will begin to be pressured into entering the role of mentally disturbed person. The first reaction usually occurs in lay area – from family or “significant others”. They are important in impelling the individual to move towards the role of a psychiatric patient. The implication of symbolic interactionist perspective here is that “people become deviant or sick, or mentally ill when they cease to perceive positive definitions of themselves from their primary social groups” (Turner 1987; 73). Furthermore, if the person will be labelled as mentally ill by the psychiatric agency, he or she “will be launched on a career of chronic mental illness and thus irreparably stigmatised as a mental patient” (Cockerham and Ritchey 1997; 76). Particularly damaging in this way is the large long-stay psychiatric hospital. Whereas Scheff focused more on the validation of the mentally ill label by a physician, Goffman (1961) focused on the hospital as an institution putting on the individual this irreversible label of mental patient. In any case, the label applied to the patient by the institutionalised processes of social control (medical agencies) ensures that he or she will internalise the respective role expectations into themselves and thus make the role incumbency permanent (Gerhardt 1989). Therefore, as Turner points out “the paradox is that social intervention by agents of social control produces deviance and amplifies it” (Turner 1987; 73). In this respect, contrary to Parsons, labelling theory suggests that sickness is produced by role, not vice versa.

Labelling theory was an important critique of the psychiatric model of illness, since it drew

attention to the fact that health and illness are negotiated social concepts and as such they cannot be understood simply in terms of cause and effect relationships. Moreover, they necessary imply value judgements. Labelling theory provided a theoretical framework to analyse the process of becoming mentally disordered. However, its importance as one of the dominant paradigms in health sociology declined eventually because of some serious criticisms. First of all, the main focus on the secondary deviance (or the process through which a person is relegated to the deviant role) led to the neglect of the issue of what has caused the deviance in first place. As Cockerham and Ritchey point out (1997; 77) “societal reaction alone does not explain why certain people commit deviant acts and why others in virtually the same circumstances do not”, or why certain people become mentally disordered yet other in virtually the same situations do not. In other words, a label in itself does not cause mental disorder. On the other hand, persons who are labelled mentally disordered might indeed experience mental distress, quite apart from how they are labelled. There is also a question whether being labelled mentally ill indeed results in lasting stigma for former mental patients. Moreover, labelling theory of mental disorder is too general and as such it is insensitive towards different categories of disorder. Again, the concept of deviance as applied to mental disorder becomes problematic: it implies a wilful or purposeful action on the part of a rational agent, however the concept of insanity normally rules out the idea of responsibility (Turner 1987). Nonetheless, the conceptual framework of labelling theory can claim at least some of the credit for the major shift in social and health policy, called deinstitutionalisation of mental health care.

M.Foucault: reason vs. madness

It is difficult to locate Foucault in just one of the main sociological traditions. His work can be best understood as a sort of anti-history of psychiatry. However Foucault's ideas pro-

vided many useful insights for a sociological approach, especially in terms of social control aspects of psychiatric knowledge and practice.

The common focus within secondary literature on Foucault is usually devoted to his work *Madness and Civilisation* (1967). Yet, the earliest work *Mental Illness and Psychology* (1954, edition in French) is also of interest here since it prefigures some of the arguments that were developed in *Madness and Civilisation*. In *Mental Illness and Psychology* Foucault argued that modern psychiatric practice by imposing artificially unifying analytical categories on what are different forms of mental disorder, effaces the specificity of each individual case of mentally disturbed condition (McNay 1994). The concern here is with the modern notion of mental disorder as linking mental and organic illness around the idea of the psychological and physiological totality of the individual. Foucault argues that to be properly understood, mental pathology requires methods of analysis that are fundamentally different from those of organic pathology (ibid). Furthermore, Foucault criticises the alienating effects of psychiatric practice in its negative understanding of mental disorder. Modern psychiatry views mental disorder as a failure or suppression of normal psychological functions. However, for Foucault mental disorder involves not only negative but as well as positive behaviours and these should be analysed in order to better understand the mentally disturbed individual and meanings he or she develops towards his or her condition. Moreover, this individual experience should be contextualised in respect of broader cultural conception of madness (he uses the term interchangeably with mental disorder, yet, madness is a narrower category of mental disorder) focusing particularly on the historical transformations of the concept. Such a focus would highlight the cultural and historical relativity of the concept of madness and allow to see that there is nothing natural or inevitable about the modern strategies of confinement and social exclusion of the mentally disordered (ibid.). The notion that madness is a historical concept forms then the basis of *Madness*

and *Civilisation*.

In *Madness and Civilisation* (1967) Foucault offers a study of the changing ideas of madness during the period from the mid-seventeenth century to the end of the eighteenth century. Foucault tries to show that the best way to understand psychiatry is to look at its practice rather than at its claims, which are often inconsistent with practical applications (Turner 2000). Moreover, whereas official histories view the development of psychiatry as leading to the adoption of an increasingly liberal and humane approach to the insane, Foucault argues that not all improvements in the management of mental disorder should be apprehended as progress (Petersen and Bunton 1997). Rather the new therapeutic regimes presented as such shall be understood as enhancing new forms of social control and regulation of madness.

Foucault theorises madness as an opposition to reason. He argues that whereas in the Middle Ages reason was engaged in a dialogue with madness - a dialogue shaped by religious ideas and imagery - in the consequent period (that of the Enlightenment) a new value was placed on reason. Unreason in all its forms, whether those of madness, poverty, crime or disease, was separated from the 'reasonable' world. This demarcation resulted from the Enlightenment's preoccupations with reason, and madness became a regulatory discourse for the management of large populations of poor, needy and incompetent. For Foucault, the notion of rationality with which Enlightenment was underpinned, served to exclude and derogate those forms of experience (like madness) that couldn't be readily assimilated into the notion of a pure, self-sustaining rationality (like, e.g., that which placed a value on economic activity) (McNay 1994).

The meanings of madness began to change once again in the eighteenth century, when madness, as indefinite concept began to give way to modern notions of mental disorder. Mental illness became a technical discourse, which attempted to distance itself from the more traditional notions of mad behaviour. This discourse

argued that the mad, as a specific group, needed special places of confinement, both to protect others from their dangers and to give them the special help they needed. The result was the birth of the modern asylum (or psychiatric hospital), the place, which permitted the medical profession eventually to acquire new powers and status vis-à-vis the mad and to silence madness in the name of reason (Turner 2000).

Actually Foucault provides no definition of madness as a term because he rejects an assumption that madness is a unitary, constant phenomenon with continuous history. According to him, the apparent unity of the concept is created by the medical discourses of insanity. These discourses constitute reality of mental disorder and define what counts as knowledge of it. Therefore, Foucault sees madness not as a self-evident behavioural or biological fact but as a product of various socio-cultural practices. Moreover, since for Foucault knowledge is inextricably linked with power (though in *Madness and Civilisation* he did not provide broader theoretical accounts on this linkage), these discourses are the form in which the power of psychiatry exists and operates. In other words, scientific concepts of insanity operating in psychiatric discourses are not neutral descriptions of mental disorder and it is impossible to separate out value judgements from scientific accounts of the concept. Psychiatry should be understood then as an institution of regulation and control, which disciplines persons identified as mentally disturbed (Turner 1987; 61). In other words, psychiatry's power exists in its ideas.

Conceptualisation of madness as an opposition to reason offered a new theoretical framework for analysing the concept of mental disorder. By defining mental disorder in terms of mind and conceptualising it as unreason and irrationality, Foucault has shifted the sociological emphasis from behaviour or body to mind and mental processes. This allowed to go beyond *the content* of beliefs, thoughts and actions (what is unavoidable in the conceptualisations of mental disorder as deviance) and to look at the judgements of rationality as primarily concerned with *the grounding* of beliefs and

behaviour (what is the focus of psychiatric attention). Also, this conceptualisation offered new ways to account for lay judgements of mental disorder, which often comprehend it namely in terms of disturbance in mental processes.

Moreover, reason, rationality and what is reasonable are complex notions that vary across time and place and so do the boundaries of mental disorder. If, for example, modern societies are characterised by legal rationality as Weber saw it, in such societies we might expect a stronger and more extensive regulation of rationality and hence of its antithesis, madness. According to Busfield (1996), theorisation of mental disorder in terms of rationality complements Parson's formulation of illness in terms of incapacities of role: where role performance is inadequate, then there is a greater possibility that assessments about individual's rationality will be made.

Therefore Foucault's conceptualisation of mental disorder in terms of rationality allows examining the social processes that underpin their regulation through the setting of the boundaries of mental disorder. His approach directs attention to the function of concepts of mental disorder as components of a larger system of social regulation.

However, Foucault has been criticised for his pessimistic view of psychiatry as an apparatus of social control, allowing for no possibility of resistance against its regulative practices, denying individual freedom and agency, as well as for ignoring the more positive aspects of psychiatric developments in general (Busfield 1996, McNay 1994). Besides, he was primarily concerned to portray differences in meaning over time and to relate them to cultural changes, whereas economic and structural changes within society and their implications to the shifting boundaries of madness were left aside.

Conflict perspective and social origins of mental disorder

From the 1970's a number of writers influenced by Marxist ideas offered perhaps the most detailed attempts to account for the so-

cio-economic conditions involved in setting the boundaries both of illness in general, and of mental disorder in particular. The particular emphasis was on the inequalities in health and attempts were made to explain these by focusing on the capitalist society, with its specific class structure and mode of production (and consumption) that underlie conflicts, tensions, struggles and power relations between different social groups. In addition, the Weberian line of thinking was used in accounting on the role and power that medicine came to play in the contemporary society. For example, Freidson (1970, 1994) by directing his attention to the medical profession, argued that doctors tend to act in their own interests rather than those of the patient and that the profession has acquired an enormous authority and power in defining who is ill and who is not, as well as what is biologically normal and what is abnormal. For Freidson illness may or may not have biological reality but it always has a social one and in that sense it is possible to perceive illness as wholly a social construct. Navarro, one of the proponents of Marxist thinking saw ill health, whether mental or physical as a way in which the tensions and problems of the capitalist order are channelled (Busfield 1996). He was arguing that medicine plays an important ideological role in strengthening this order: in its emphasis on the physical causes of illness and ignorance of the social ones, it individualises and depoliticises illness.

Since conflict perspective offers very diverse ways for looking at mental health and disorder it is not possible to discuss all of them within this article. I will concentrate on texts within conflict perspective that focus on the links between social conditions and illness. These studies are important for understanding social aetiology of mental disorder. The main idea underpinning them is the belief that structural inequality is one of the major sources of suffering in modern society, and that inequality is an expression of covert or overt social conflict (Gerhardt 1989)

Research done within this perspective resembles that of psychiatric epidemiology, ho-

wever it applies sociological analysis on the gathered data. An early, influential sociological study within this approach was *Mental Disorders in Urban Areas* ([1939] 1965) conducted by the US sociologists of the Chicago school, Faris and Dunham. They examined the cases of mental disorder across the range of treatment facilities in different residential zones of Chicago. The authors noticed the differing prevalence of manic-depressive psychosis and schizophrenia: whereas the former appeared to be randomly distributed across the city, suggesting the role of genetic factors in its aetiology, the latter was concentrated in the poorer areas. This differing distribution, namely in case of schizophrenia, could not be explained by processes of geographical drift, which would imply that individuals diagnosed with schizophrenia end in the poorest zones of the city because of their disorder: those people used to live in the area before the onset of their illness. Therefore, the authors suggested that the high level of schizophrenia in the poor localities of the city could be due to the lack of community networks and the high levels of social isolation. The study provided clear evidence that the observed distribution of schizophrenia cannot be accounted only by the genetic factors (the dominant explanation of the aetiology of schizophrenia at that time). It suggested the importance of the social factors in the aetiological accounts of this disorder.

Another study (1958), by Hollingshead, a sociologist, and Redlich, a psychiatrist, suggested further links between class and prevalence of mental disorder. The study found that class was significantly related to the type of mental disorder, the pathway to treatment, and the type of treatment received. The lowest social class experienced more mental disorder, particularly psychosis, being more likely to enter treatment via courts and official agencies, and being more likely to receive organic rather than psychological therapies compared to other social classes.

Many subsequent studies that explored the relationship between class and mental disorder focused on social stress. For example, the

well-known British study *Social Origins of Depression* (1978) by Brown and Harris examined class differences in levels of depression, and suggested that the high rates of depression in lower social groups are related to the stressful events and ongoing difficulties that interact with socially generated vulnerability factors in generating disorder.

This type of explanatory research grounded in social epidemiology showed that social factors must be brought into the understanding of the aetiology of mental disorder. The model became useful in explaining the risk factors of falling mentally ill depending on different social groups (gender, ethnicity, etc.). The differences in prevalence of mental disorder among various social groups were explained in terms of the differing levels of adversity, the presence of stressful events, social vulnerability and individual management of stress (Turner 1987). The main assumptions presented by this kind of studies are formulated as following (Pilgrim and Rogers 1998):

- The probability of mental health problems increases with decreasing socio-economic status (however here is a considerable debate whether it is poverty that increases the vulnerability of mental disorder or disordered people simply drift into poverty because their illness makes them socially incompetent).

- Women are diagnosed as suffering from mental disorder more often than men, though most of this difference is accounted for by diagnosis of depression. Here the explanations come primarily from the feminist perspective, which conceptualises the phenomenon in terms of differing expectations governing male and female behaviour, gender based beliefs, power relations, etc.

- Mental health is racially patterned. Generally, this reflects continuing disadvantages that were rooted in slavery, enforced migration, colonialism, and racial discrimination.

However, the epidemiological model as applied by sociologists is often criticised for taking the concepts of mental disorder for granted (Busfield 2000). Diagnoses such as “schizophrenia” or “depression” are accepted as

being valid without questioning them. The position here – in contrast to labelling theorists – is that there is a stable reality of mental disorder that exists independently of the investigator. The main aim is not to look for particular causes of disorder but explain why certain groups in the population are more susceptible to mental disorder in general.

The strength of this model is that it focuses on inequalities in health among various social groups and as a consequence raises the questions of preventive (in a wider or narrower sense) issues. At the same time, attention is drawn to the broader issues of poor working conditions, low educational or housing standards and from this to the analysis of prevailing power relations in a modern capitalist society.

Social constructivism: is there reality beyond mental disorder?

Social constructivism is one of the most influential theoretical positions evident in sociology of health and illness over the past 20 years. In general, social constructivism can be looked upon as a reaction against positivism and naive realism. It constitutes a separate sociological approach, however, at the same time it is used by different sociological perspectives in explaining the phenomenon of mental disorder***. Since it is difficult to provide a comprehensive review of all the work done within this approach, I will limit myself with summarising the core assumptions guiding constructionist research on mental disorder and psychiatric practice.

The central idea is that “reality is not self-evident, stable and waiting to be discovered, but instead it is a product of human activity” (Pilgrim and Rogers 1999; 18). There are certain core approaches that can be distinguished within the constructivist framework. First, even if reality is not rejected (as in most strict version of constructivism) it is nonetheless questioned to some degree. Second, reality is a product of human activity (in whole or in part). Third, power relationships are inextricably bound up with definitions of reality. Therefo-

re, constructivist approach to mental health and disorder can be used, for example, in questioning the factual status of mental disorder (see, e.g., Szasz 1961), analysing links between mental health work, production of psychiatric knowledge and concepts of mental disorders (see, e.g., Prior 1996), or looking upon the ways in which mental health professions have shaped our understanding of ourselves (see, e.g., Rose 1999).

Concerning the constructed nature of mental disorder, following examples within social constructionist theorising can be presented (Pilgrim and Rogers 1998; 548-549):

- Even if schizophrenia has the status of an illness that is widely diagnosed, its diagnosis lacks both conceptual validity and reliability. Despite vast amounts of research that have tested a variety of environmental and biological hypotheses the aetiology of this disorder remains unknown. One possible explanation for the continuation of a weak construct is the role it plays in supporting the mandate of psychiatry in society and the comfort it gives to the relatives of the mentally disordered people.

- Agoraphobia emerged at a time when the social emancipation of women became a possibility. For this reason, the meaning of the condition can be understood as part of a context that questioned the use of the public space, not just as a set of symptoms within its individual sufferers.

- Like schizophrenia, the concept of psychopathy is incoherent because it covers so many people who have different symptoms but can share the same label and has no biological marker. The definition is inevitably circular: people are deemed to be psychopathic because of their antisocial acts and their antisocial acts are explained by the actor's psychopathy. As a consequence there is no independent way of validating the diagnosis. It has the same explanatory value as the notion of evil.

- Depression seems to be a straightforward description of depressed mood. However, ascription of helplessness, powerlessness, and worthlessness can only be made in relation to interpersonal processes. Thus depression can-

not be understood simply as a set of affective and cognitive characteristics of suffering individuals: it is defined and constituted by social processes.

Therefore constructivist critique of the psychiatric categorisations of mental disorders makes an emphasis on the fragile, incoherent or even invalid nature of the concepts. Their use despite the lack of validity or reliability is explained as serving particular interests of social groups associated with discourses utilising the constructs (e.g., mental health professionals, drug companies, patients' relatives or even patients themselves).

However, there might arise some problems with the presentations of mental disorder as a social construct. The phrase that mental disorder is "socially constructed" can mean that it is a social category, or in other words, that what is so categorised and the meanings attached to the categories, vary across time and place. Or, as Pilgrim and Rogers (1999) notice, this may mean that it is not a reality of mental disorder as such that is constructed but theories of that reality. Yet, also it can be understood as a claim that mental disorder is *only* a category and does not refer to any objective reality (like in a strict version of constructivism). This reading of the phrase social construct has been particularly strongly exposed by post-structuralist and postmodern theorists who focus on the cultural analysis of texts and narratives and suggest that we cannot get beyond such texts and narratives to any material reality. As Busfield warns, namely this latter notion of "mental disorder as a social construct" is most often assumed by non-sociologists when they hear or use the phrase and that might have some negative consequences:

The concept because of its epistemological and ontological connotations, can generate hostility towards sociological ideas about mental disorder from doctors, patients and families who feel it rejects the reality of the pain, difficulty and suffering in mental disorder (Busfield 2000; 547)

Busfield suggests some alternatives to the concept "social construct" like, e.g. 'social fra-

ming' of disorder or 'social structuring'. According to her, these conceptualisations have advantages as they indicate that the way we understand illness varies across time and place, but do not suggest any denial of material reality of the mental states. Thus, the use of terminology of 'framing' or 'structuring' would help to secure sociological insights and understandings of mental disorder rather more effectively than the language of social constructs.

Mental disorder and emotions: new ideas in sociology of mental disorder

The sociological perspectives on mental disorder I have presented so far, have conceptualised it either in terms of behaviour or thought. Sociology has paid remarkably little attention, however, to the issue of body in the conceptualisations of the phenomenon of mental disorder.

However, it is not possible to neglect the recent progress in genetics, the neurosciences and pharmacology that point to the importance of natural sciences in explaining mental phenomena. The increasing evidence about the impact of biological processes on at least some of the mental states calls for a need to think about new ways (or to rethink the older ones) in which sociology could still contribute to explanations of mental disorders. In other words, there is a necessity to develop imaginative models of the interaction between the biological and the social (Lyon 1996, Busfield 2000, Williams 2000).

One of the most recently suggested new approaches in that direction refers to the combination of sociological theories of emotions with those of health and illness. James and Gabe (1996) argue that mind, body and society are combined through somatic, cultural and social relational connections. Here is where the concept of emotions becomes crucial as providing a link between all these realms, which are woven into the complex nature of the individual's being in the world. According to Williams and Bendelow (in James and Gabe 1996; 36):

Emotions...are most fruitfully seen as embodied exist-

tential modes of being, ones which involve an active engagement with the world and an intimate connection with both culture and self. Not only do emotions underpin the phenomenological experience of our bodies in health and illness, they also provide the basis for social reciprocity and exchange, and the "link" between personal problems and broader public issues of social structure.

Lyon (in James and Gabe 1996) says that since emotions are phenomena of both body and social reactions (it is through bodies that people feel and act), they provide means to overcome the profound division between two modes of explanation (biological and social) without denying the fundamental differences between the two. As a consequence there is no necessity to deny the ontological reality of mental disorder (*ibid.*; 57).

Mental disorder in this approach can be addressed sociologically through its phenomenological experience, which allows to relate bodily symptoms with their emotional expressions (or vice versa) and to look how both of them, in their turn, relate to the wider social context. The reconceptualisation of mental disorder from this standpoint provides insights about the psychosocial causes of disorder and the role of life events, difficulties, and social support in the onset of both physical and mental problems. Williams and Bendelow (in James and Gabe 1996) suggest that individuals' social position and status will determine the resources they have at their disposal in order to define and protect the boundaries of the self and counter the potential for "invalidation" by powerful and significant others. The lower the individual is situated in the social hierarchy, the less resources (power) he or she has to manage unpleasant emotionality or emotional modes of being. Williams explains this as follows:

Differing modes of emotional being – physical and psychic states which can be either 'pleasant' or 'unpleasant' – are in effect, different felt ways of feeling empowered or disempowered: feelings which are very much linked to people's material and psychosocial conditions of existence throughout their embodied biographies...Less powerful people, therefore, face a 'structurally in-built handicap' in managing social and emotional information; one which, in turn, may

contribute to existential fear, anxiety and neurophysiological perturbation of many different sorts (Williams 2000; 568-569)

In short, a powerless social status increases the likelihood of experiencing “unpleasant” emotional modes of being and consequently may contribute to the onset of mental disorder.

Williams, in defending the importance of emotions for sociological approach to mental disorder, criticises the psychiatric debates on the (un)reasonableness of mental disorders as well as the sociological conceptualisations of mental disorder in terms of reason and rationality (see, e.g., Busfield 1996). The latter sociological approach to mental disorder, according to him perpetuates the same dualism introduced by Enlightenment’s thinking, namely that reason is incompatible with emotion and that emotions therefore are “unreasonable” from the viewpoint of instrumental rationality. By referring to Barbalet (1998), he points to the possible links between emotion and reason: first, emotions are central to the effective deployment of reason, since they allow to make priorities between multiple goals and options; second, the reason itself is founded on emotion (i.e. as it is in a passionately held belief or a cherished ideal).

Indeed emotionality is still considered to be somehow irrational and inappropriate to be expressed in many areas of the modern rational world. As Lupton argues, in the self-reflexive late modernity “emotional management and regulation, paying constant attention to how best to deport oneself emotionally, is an integral aspect of reflexive work upon oneself” (Lupton 1998; 92). Emotional self-expression has to be controlled since not all emotions can be showed to the public. In order to deal with this project of the self, Lupton says, a new ‘expertise of subjectivity’ has developed, in which numerous professions like psychologists, psychiatrists, social workers, counsellors etc., have established themselves as experts in measuring the psyche and providing the necessary ‘corrections’ (ibid.; 93, see also Rose 1999). The clear example of this expansion is depression,

the boundaries and categories of which are constantly broadening making it one of the major mental sufferings of the modern individual. Thus, conceptualising mental disorder solely as unreason and irrationality doesn’t allow apprehending the diverse nature of mental phenomena.

Therefore, the concept of emotion provides an analytical tool in thinking sociologically about mental disorder (as well as health). It allows to account for the way mind and body are linked in a disordered condition without ignoring the ontological reality of it (think, e.g., about anxiety in which the anxious state is expressed in heart racing, trembling hands or even pain). Moreover, it provides the link to the broader public issues of social structure (e.g., through the anxious emotional expression of one’s social conditions of being in the world). Shifting the focus to the links between emotions and mental health this theoretical approach also opens new ways to account for the blurring boundaries of ‘normal’ and ‘pathological’.

Conclusion

Sociological theories of mental disorder have conceptualised the phenomenon in different terms: as deviance (and therefore focused on behaviour), as reason (putting main emphasis to the mental processes), and recently as an emotional expression of distress (combining body and mind). They have stressed the importance of social factors in the aetiology of mental disorder and criticised the narrowness of biological explanations within psychiatric theories. The socially constructed and negotiated nature of the conceptual boundaries of mental disorder was emphasised drawing attention to the power relations that impinge upon the conceptualisations of ‘normal’ and ‘abnormal’, and showing that psychiatric concepts might be not value free. All these theoretical approaches provide valuable insights and ways to contest sometimes for granted taken views about the phenomenon of mental disorder.

Yet, there is a need to realise that mental disorder is not a single unifying category of what

is understood as mental problem. There is a diversity and complexity of mental health conditions with their particular aetiology and symptomatology. These require reassessing the relevance of sociological explanations, especially those that are insensitive to the complex nature of mental disorders. At the same there is also a need to accept the ontological nature of mental disorder. Sociology has often ignored the reality of mental suffering, while trying to construct or deconstruct the boundaries of mental disorders. As a consequence, it criticised psychiatric ways of biologizing mental phenomena without realising that it itself perpetuates the mind and body dualism. Moreover, there is a necessity to realise that psychiatric thinking about mental disorder is not exclusively biological and that there are various bio-social or bio-psycho-social models applied in its practice and in its accounts on mental phenomena (even if the major role of biological thinking can't be doubted). Sociology itself has often taken this medical model for granted.

Also, we should be aware that with the move to the community mental health care the understanding of mental disorders is changing since the role of other mental health care specialists that have diverse explanations of mental phenomena is increasing. This changing organisational context of psychiatric work therefore requires reassessing the relevance of some of the sociological explanations.

Nevertheless, sociology has a potential to offer ways of thinking about mental disorders, ways of going beyond the medical conceptualisations and locating what is often understood as mainly bodily phenomena within the broader social context and analysis of social relations. In this sense sociology makes the understanding of mental disorder a political issue. It shows that focusing on individual vul-

nerability to disorder often prevents us of recognising the role that structural and institutional arrangements of society play in generating mental distress. It points, therefore, to a need to be more aware of how personal misfortunes relate to the social and material circumstances in which an individual comes to live, how gender, class, ethnicity come to shape the boundaries of mental disorder and how these boundaries and categories in their turn contribute to social order. It also shows that the concepts of mental disorder are necessarily a part of the social regulation mechanism, because they present the ways in which behaviour comes to be accounted for, classified and ordered. Control and regulation are inherent in psychiatric practice, however, not necessarily always in a negative sense. The task of sociology, however, is to question to what purpose this regulation is applied: is it to the interest of the individual or does it justify some other aims?

Therefore, we need to examine how appropriate the judgements of disorder are, what consequences they have to the individual and what values are at stake here. We need to be aware of the professional interests and struggles that also shape the boundaries of mental disorders and consequently affect the psychiatric practice.

Medicine does not attempt, nor is it necessarily reasonable to expect it to attempt, given its professional concerns to ask broader questions about why we have the category of mental disorder, or the place of mental disorder in the wider society, or even about how the boundaries of mental disorder come to be set in particular ways in particular times and places (Busfield 1996; 60)

These are the issues that belong to the realm of sociological thinking about mental disorder.

Notes

*The 4th version of the American Psychiatric Association's Diagnostic Statistical Manual (DSM) defines mental disorder "as a pattern of behaviour, or psychological features, occurring in an individual that are currently associated with any of the following: a subjective sen-

se of distress; impairment in important areas of functioning, such as work, school, relationships; or a significantly increased risk of posing a danger to oneself or others, or of losing an important freedom" (Allen 1998; 29). The definition implies that a mental disorder invol-

ves both behaviour and psychological discomfort, and, that mental disorder is conceptualised mainly as a problem or dysfunction within an individual. However, as DSM-IV (1994; xxi) observes, no definition of mental disorder adequately specifies its precise boundaries; therefore no operational definition exists that covers all situations.

**Labelling theory contains three central propositions (Turner 1987; 72-73):

- Deviant behaviour has no consistent unitary content or essence; it is merely behaviour, which is labelled as deviant (because of some social rule that the 'deviant' breaks) by powerful, influential or significant social groups, which are important in shaping public opinion.
- People who are labelled as deviant suffer stigmatisation, which excludes them from normal interactions and thus converts their behaviour into a distinctive career of deviance.
- Behaviour that is stigmatised by social labelling becomes amplified because alternative lifestyles and careers are no longer available for the deviant.

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***Pilgrim and Rogers describe main currents within this approach as follows (1999; 18-19):

- The first current is not concerned with demonstrating or rejecting the reality of a phenomenon but with the social forces that define it. In this way it refers to the theoretical frameworks of symbolic interactionism.
- The second current refers to the post-structuralist (following Foucault) and postmodern tradition 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'). The emphasis here is placed on ideas about mental disorder.
- The third current is concerned with understanding the production of scientific knowledge and the pursuit of individual and collective professional interests. Therefore, it would examine the ways in which mental health professionals and other interested parties would develop, debate and use facts of knowledge about mental disorder. It is thus interested in networks of people involved in these activities. The emphasis here is placed not on ideas but upon action and negotiation.

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Summary

The article introduces and critically discusses major sociological ideas on the concept of mental disorder. Starting with Parsonian 'sick role' and illness as deviance, the article proceeds with labelling theory and further on with Foucault's conceptualisation of madness as an opposition to reason. Conflict approach on mental disorder is presented as based on belief that structural inequality is one of the major sources of suffering in modern society. Constructivist critique makes an emphasis on the fragile, incoherent nature of the categories of mental disorder. Finally, the introduction of the con-

cept of emotion into sociology of mental disorder is presented as providing new analytical tool to account for the ways mind and body are linked in a disordered condition.

Sociological perspective explores dominant concepts of mental disorder and offers different ways of thinking about mental phenomena, while locating them within a broader social context and an analysis of social relations. This helps to understand better the social organisation of mental health care, patterns of psychiatric practice and the process of becoming mentally disordered.

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