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# A Sociology of Mental Health and Illness

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## Health, illness and societal norms

In the light of arguments in previous sections, if it is the case that public mental health and public health more generally are difficult to clearly distinguish, what does this say about causes and meanings? This question can be answered partially in social science by some sort of philosophical inquiry about ontology (what is deemed to exist) and epistemology (what form of knowledge it is legitimate to generate). Broadly three positions are evident in the sociology of health and illness in relation to ontology and epistemology (see Chapter 1). Naïve realists take the current naming of causes and outcomes for granted (confusing reality with what we currently opt to call reality). Radical constructivists consider that reality is always socially constructed and so we cannot get beyond representations to understand reality in, and of, itself. Critical realists argue that reality exists and is forceful in its impact on health but that social interests shape and constrain how we can come to know it, so we must approach knowledge claims sceptically. Our arguments, because they adopt this third position, emphasize the following.

- First, distress, madness and dysfunction have occurred in all societies and are determined by many factors, some known and some still mysterious, but what they are called and how they are valued varies over time and place.
- Second, distress (fear and sadness) is easier to understand than madness because it has many stable elements across contexts and even species. Fear in particular has predictable and measurable physical signs in all mammals. And most of us know what it is to feel sad in the face of loss and can even spot it with some confidence in other animals. This regularity of observation is not the case with madness or 'personality disorder', which arise from context specific norms about rationality, mutual recognition and obligations and intelligibility. These forms of deviance are peculiarly human and so must be understood in the normative contexts of our forms of social organization.
- Third, any notion of positive mental health necessarily subsumes hedonic and eudemonic aspects (about positive feelings and social competence respectively).
- Fourth, judgements about illness or health thus are inherently social. Ultimately they are value judgments about what it is to act, or be capable of acting, in a good way (connoting implicitly or explicitly some version of Aristotle's 'eudaimonia' or 'good life'). Put differently, terms like 'mental disorder' or 'mental abnormality' always imply other forms of action and emotion, which are mentally 'ordered' or 'normal'; the way that people *ought* to think, feel and act as part of an ideal moral order.

These arguments about how we understand illness be it physical or mental have not been discussed in sociology alone. They have also taxed physicians and epidemiologists. For example Smith (2002: 884), then the editor of the *British Medical Journal*, makes the following point about medical diagnosis:

> It may allow the authorities to lock you up or invade your body. You may be denied insurance, a mortgage, and employment. You are forever

> labelled. You are a victim. You are not just a person but an asthmatic, a schizophrenic, a leper, an epileptic. Some diseases carry an inescapable stigma, which may create many more problems than the condition itself. Worst of all, the diagnosis of a disease may lead you to regard yourself as forever flawed and incapable of 'rising above' your problem. Consider the case of alcoholism, a hotly disputed diagnosis. Better perhaps to be 'an alcoholic' than a morally reprehensible drunk. But is it helpful to think of yourself as 'powerless over alcohol,' with your problem explained by faults in your genes or body chemistry? It may lead you to a learned and licensed helplessness.

In this paper Smith also reports a number of studies in which doctors and lay people were given long lists of phenomena and then asked to decide whether each item was or was not a disease. This 'non-disease' approach to understanding lay and professional discourses about pathology is very revealing. Not surprisingly, medical practitioners ascribe pathology more often than lay people. However, they do not pathologize *all* deviations from norms. They also disagree with one another about what is a disease and how important diagnosis is in principle (compared for example to negotiating a desired outcome with and for the patient). In Box 12.1 Smith shows how the 'top 20' non-diseases identified by the readership of the *British Medical Journal* were ranked in order.

It is worth noting how many of these items are psycho-social phenomena of interest to mental health researchers and practitioners (e.g. work, road rage, boredom, unhappiness and loneliness). Indeed even the ones which are

***Box 12.1* Top 20 non-diseases (voted on bmj.com by readers), in descending order of 'non-diseaseness'**

1 Ageing
2 Work
3 Boredom
4 Bags under eyes
5 Ignorance
6 Baldness
7 Freckles
8 Big ears
9 Grey or white hair
10 Ugliness
11 Childbirth
12 Allergy to the 21st century
13 Jet lag
14 Unhappiness
15 Cellulite
16 Hangover
17 Anxiety about penis size/penis envy
18 Pregnancy
19 Road rage
20 Loneliness

somatic indicators (e.g. freckles, baldness and big ears) imply that it is merely the way that people *think* about bodily variations that is at issue not the variations themselves. This may suggest that from a general medical perspective at least, somatically based judgements of true diseases persevere and there is a bias towards the exclusion of the new public mental health agenda of happiness, as we discussed earlier.

This was a self-selected general medical sample. A targeted survey of physicians involved in treating or researching say pregnancy or childbirth would probably yield a different result. Their medical management (obstetrics) constitutes a high status specialism, which claims a superior medical authority over what others might deem to be 'non-diseases'. Thus, current general medical scepticism about non-diseases is not neatly aligned with the enthusiasm of specialist clinical gazes, such as obstetrics and psychiatry. The latter might diagnose bodily dysmorphoric disorder to account for a patient's obsession with their big ears or baldness.

Also experiences, such as jet lag or a hangover, may not be called 'diseases' but they still may be ameliorated by remedies. Something that is not called a disease may still be an uncomfortable state; a form of experienced dis-ease. Moreover, some forms of disease may have no functional expression – they are 'clinically silent', as when a person is HIV+ but feels very healthy. Ageing was at the top of the list of non-diseases. However, given a range of 'normal changes' in functioning in old age from loss of sensory acuity and memory to benign enlargement of the prostate and weaker bones, when do any of these phenomena become diseases inviting medical expertise and intervention? This complexity permits plenty of scope for argument about what any of us mean by pathology and normality.

The point here is not to arbitrate about which group in society is more correct in those arguments. Rather it is to highlight that ultimately it is a matter of judgement. Disease and health are socially contested not self-evident in their appearance. For example, the 'happiness' agenda is essentially a socio-political one, which appeals to economists and politicians (because it implicates such matters as productivity, fiscal burden and even voting behaviour). Psychiatrists, clinical psychologists and psychotherapists have been keen to support and reinforce this discourse because it raises their status and expands their jurisdiction. However, orthopaedic surgeons may be more opposed to the pathologization, rather than the normalization, of misery and so too might Buddhists. The latter consider that suffering is part of the human condition and dealing with it is a recurring human challenge, not an abnormal state inviting professional expertise or understanding.

At this point we encounter a contestable assumption in the professional literature, particularly about mental health: the drive to improve 'mental health literacy'. This has emerged as one attempt, mainly by social psychiatrists, to reduce stigma in community settings of workplaces and neighbourhoods by increasing lay people's understanding of 'knowledge and beliefs about mental disorders, which aid their recognition, management and prevention' (Goldney *et al.* 2001: 278). The argument advanced is that the more that the general public understand abut the nature of mental illness, the less that stigma and discrimination will occur.

The problem with the cogency of this type of campaigning, as an aspect of a public mental health policy, is that it assumes that the nature of mental illness