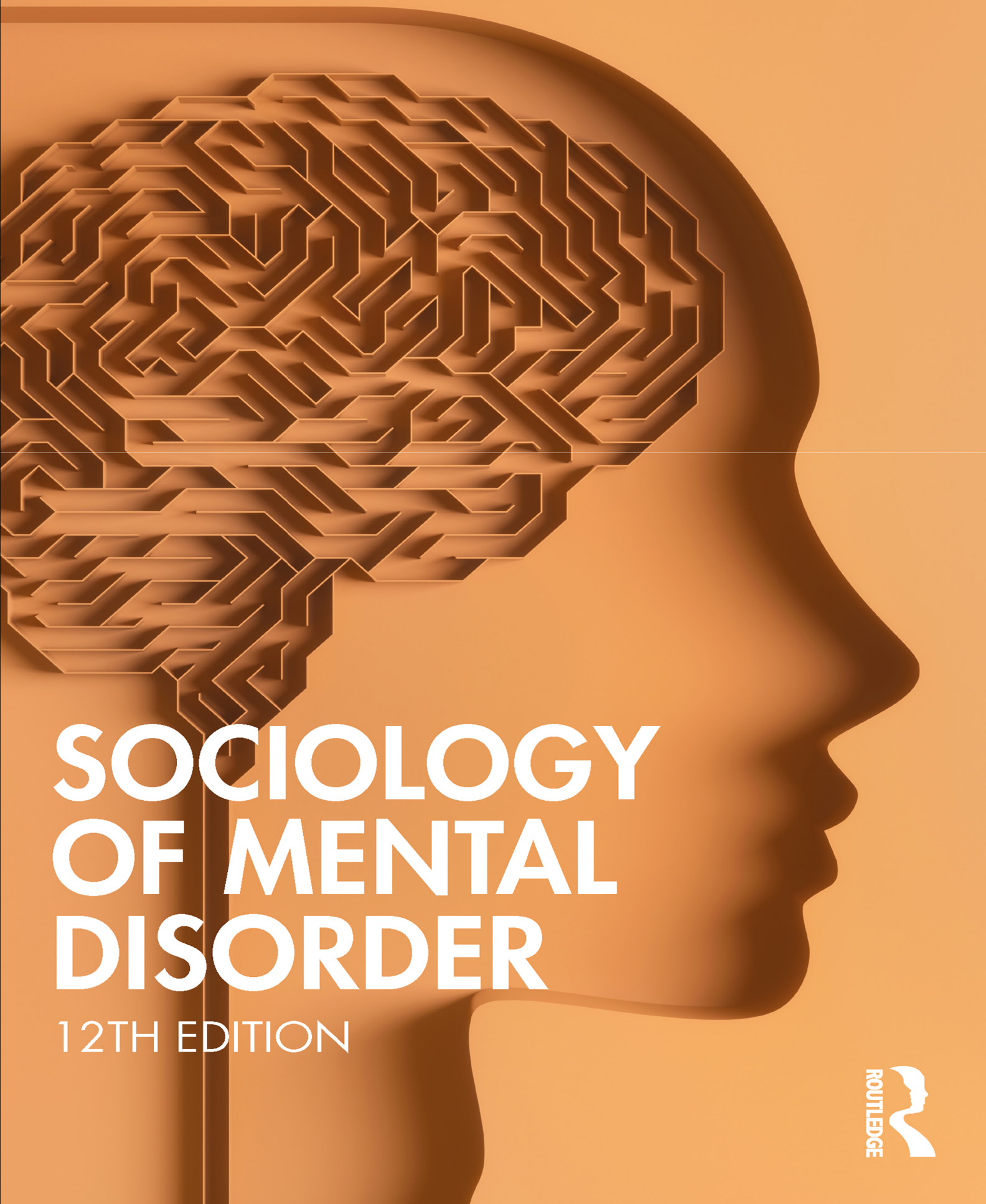
WILLIAM C. COCKERHAM



SOCIOLOGY OF MENTAL DISORDER

12TH EDITION

ROUTLEDGE

Sociology of Mental Disorder

The twelfth edition of the *Sociology of Mental Disorder* presents the major issues and research findings on the influence of race, social class, gender, and age on the incidence and prevalence of mental disorders. The text also examines the institutions that help those with mental disorders, mental health law, and public policy.

Many important updates are new to this edition:

- The mental health effects of the COVID-19 pandemic are examined.
- Aging and mental health is discussed in more detail.
- Updated review of gender differences in mental disorder.
- A revised and more in-depth discussion of mental health and race.
- Problems in the community care of the mentally ill are covered.
- Updates of research and citations throughout.

Blending foundational concepts and sociological perspectives on mental health issues with newer studies and accounts in an accessible and authoritative survey of the field, the new edition of *Sociology of Mental Disorder* remains an essential text and an invaluable resource for students and scholars.

William C. Cockerham is Distinguished Professor of Sociology and Chair Emeritus at the University of Alabama at Birmingham and Research Professor of Sociology at the University of Maryland, College Park. He previously held a joint appointment in sociology and psychiatry at the University of Illinois at Urbana-Champaign. He is past President of the Research Committee on Health Sociology of the International Sociological Association and formerly served on the editorial boards of the *American Sociological Review*, the *Journal of Health and Social Behavior*, *Society and Mental Health*, *Social Currents*, and other journals. Dr Cockerham has published numerous peer-reviewed papers in academic journals and is the author or editor of 20 books. His most recent books from Routledge include *Sociological Theories of Health and Illness* (2021), *Medical Sociology*, 15th edition (2021), and *The COVID-19 Reader: The Science and What It Says About the Social* (2021).

Sociology of Mental Disorder

12th Edition

William C. Cockerham

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To my son, Bruce Montgomery Cockerham

"Le Brave des Braves"

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PREFACE

This book presents the major issues and research findings found in the sociological literature on mental disorders. Although the study of mental health is a subfield of medical sociology, it is a significant area of sociological inquiry on its own. Numerous books and research papers have been published by sociologists on mental problems. For example, a contents analysis of the American Sociological Association's *Journal of Health and Social Behavior* up until recently disclosed that nearly as many articles are published on some aspects of mental health as are published on physical health. This led to the development of a new ASA journal focused exclusively on mental health topics, Society and Mental Health, which first appeared in 2011 and on which I served (2014–2018) as a member of the editorial board. Medical sociologists constitute one of the largest groups of scholars in sociology worldwide. The focus on mental health issues by many medical sociologists has not only resulted in a large volume of research, but it has also increased the number of courses taught on this subject in universities. The twelfth edition of this book represents a continuing effort to summarize and analyze the direction of the field.

This twelfth edition of *Sociology of Mental Disorder* has been thoroughly updated to include the most recent literature and research on mental disorder.

Here are just some of the new topics and research findings discussed in the twelfth edition:

- Discusses the mental health effects of the COVID-19 pandemic.
- Continues an updated assessment of mental health and gender examining the extensive literature on male–female differences in psychological distress, as well as the effects of gender roles and marital status, which have been identified in recent studies as increasingly important variables for mental health.
- A revised and in-depth discussion of mental health and race continues that examines why members of racial minority groups in the United States often have lower rates of mental disorder than Whites, and the reasons for this.
- Added new sections on life course theory and mental health, and cognitive behavior therapy.

The title of this book, *Sociology of Mental Disorder*, reflects its contents and orientation. I used the term "disorder" in the title rather than "illness" because illness is a medical term that involves consideration of topics focusing more or less exclusively on medicine and biology rather than the social features of mentally disordered behavior. I didn't use the phrase "mental health" because mental health can be either positive or negative, and sociologists typically study the negative features of mental health as a phenomenon causing disruptions or disorders in social relationships. Consequently, the term "mental disorder" more accurately reflects the sociological viewpoint.

Although the conclusions expressed in this book are solely the responsibility of the author, other individuals have provided extremely helpful reviews over the years. A note of appreciation is due to the following colleagues who contributed comments on the 12 editions of this book: Mehmet Balkanlioglu, Wayne State College; Stayce A. Blount, Fayetteville State University; Linda Carelli, Rutgers University; Theresa Chandler, Bradley University; John Collette, University of Utah; Gary A. Cretser, California Polytechnic University (Pomona); Meryl Damasiewicz, University of Maryland, Baltimore County; Norman K. Denzin, University of Illinois at Urbana-Champaign; Kerry M. Dobransky, James Madison University; Robert Emerick, San Diego State University; Hugh Floyd, University of New Orleans; John W. Fox, University of Northern Colorado; David D. Franks, Virginia Commonwealth University; Giriraj Gupta, Western Illinois University; Sharon Guten, Case Western Reserve University; Michael Hughes, Virginia Polytechnic and State University; John E. Johnson, SUNY–Plattsburgh; Jeffrey Kamakahi, University of Central Arkansas; Vera G. Kennedy, West Hills College; Matt Kinkley, Lima Technical College; John J. Leveille, West Chester University; Mitchell Mackinem, Clafin University; John Malek-Ahmadi, College of Western Idaho; Fred E. Markowitz, Northern Illinois University; Purna C. Mohanty, Paine College; Jean Moretto, Maryville University; and Dawne Marie Mouzon, Rutgers University.

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Medical and university libraries at the University of Illinois at Urbana-Champaign, the University of Alabama at Birmingham, College of William & Mary, and the University of Maryland, College Park provided important resources. I would also like to acknowledge the resources on mental health law provided for the various editions of this book over the years by the law libraries at the University of Oklahoma College of Law at Norman, Oklahoma; the University of Illinois College of Law at Urbana-Champaign, Illinois; the

Louisiana State University Law Center at Baton Rouge, Louisiana; the Cumberland School of Law at Samford University in Birmingham, Alabama; the Charles E. Rogers College of Law at the University of Arizona at Tucson, Arizona; the New York University School of Law in New York City; the College of William & Mary Law School in Williamsburg, Virginia; and the University of Maryland Francis King Carey School of Law, Baltimore, Maryland.

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1 MADNESS AND SOCIETY

Photo 1.1 Patients gathered for a meal at a community mental health center.

Source: BSIP/Getty.

Mental disorder affects the minds, lives, and well-being of millions of people throughout the world. The exact number of persons who suffer from it is unknown. A current estimate from the World Health Organization (2022a) is that about one out of every eight persons on the planet, some 970 million people, are living with a mental disorder. The most common conditions are anxiety and depression, which the WHO found increased substantially by 26 percent and 28 percent during the COVID-19 pandemic in 2020. In the United States, the National Institute of Mental Health (NIMH) reported that one out of five people, or 57.8 million persons, had some type of mental illness in 2021. Statistics like these make it clear that mental illnesses are not uncommon in human society. Rather, such disorders, ranging from mild to severe, affect many people. As sociologist Allan Horwitz (2020:1) describes it: "Every society, regardless of time and place, regards some of its members as mad."

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This is seen in the United States where three prominent national surveys—the Epidemiologic Catchment Area (ECA) study of the early 1980s, the National Comorbidity Survey (NCS) of the early 1990s (1990–1992), and its replication (NCS-R) a decade later (2001–2003)—had suggested that anywhere from one-third to nearly one-half of the U.S. adult population between the ages of 18 and 54 years had a diagnosable mental disorder. In a reanalysis of the NCS-R, Ronald Kessler and Philip Wang (2008; Kessler 2013) found that approximately half the U.S. population (46.4 percent) met the criteria for one or more mental disorders in their lifetimes, and about one-fourth of the population met the criteria in any given year. Most people experiencing a mental health problem were found to have their first onset in childhood or adolescence.

Although it might seem shocking that so many people could have a mental disorder of some kind in their lifetime, Kessler (2010) maintained that it is not really so remarkable. This is because classification categories are very broad and include many disorders that are either self-limiting (i.e., they disappear on their own) or mild problems of a nonserious nature. "It should be no more surprising," says Kessler (2010:59),

> to find that half the population have met criteria for one or more of these disorders in their lifetime than to find that the vast majority of the population have had the flu or measles or some other common physical malady at some time in their life.

Thus, it seems, according to all-encompassing definitions, that mental disorders are not unusual, as practically everyone becomes depressed, sad, or anxious sometime. Of course, the extent to which such moods and feelings actually constitute a clinical case of mental disorder is subject to debate. Some researchers believe these estimates are far too high (Wakefield and Schmitz 2017). One re-examination of the ECA and the first NCS studies, for example, produced a much lower but still substantial figure of 18.5 percent of all adults with a mental disorder (SAMHSA 2013). The most recent percentage available from the NIMH shows 22.8 percent of the U.S. adult population had some form of mental illness in 2021.

When it comes to *serious* mental disorders, the NIMH estimated that in 2021 some 5.5 percent of the adult population age 18 or older, had experienced such an affliction in the past year. But the fact remains that the true prevalence or actual extent of mental disorder remains a mystery. Most afflicted people do not come to the attention of reporting agencies, and community investigators face a multitude of problems in obtaining fully reliable data on the extent of mental disorders in noninstitutionalized populations. Although the number of patients receiving treatment in mental hospitals and outpatient mental health facilities can be determined, others in the community with mental health problems not undergoing care often go undetected. Nevertheless, enough evidence is available to show that mental disorder is a major health problem throughout the world (World Health Organization 2022a).

The extent of mental disorder and the high social and economic costs associated with it are considerable. But what is truly the most damaging aspect of mental illness is its shattering effect on its victims and their families. Suicide, divorce, alcoholism and drug abuse, unemployment, violence to self and others, child abuse, damaged social relationships, and wasted lives, not to mention the incalculable pain and mental anguish suffered by those involved, are among the consequences of mental illness. In these respects, mental disorder can be regarded as a terrible affliction for many people in the United States and elsewhere in the world.

With increasing numbers of studies uncovering a significant relationship between social factors and many psychiatric conditions, the study of mentally disturbed behavior is an important area of research in sociology. A substantial body of evidence has accumulated over the past several decades, supporting the conclusion that the social environment has important consequences for mental health (Aneshensel, Phelan, and Bierman 2013; Elliott 2022; Horwitz 2020, 2021; Morrall 2017, 2020; Rogers and Pilgrim 2021; Scheid 2021; Scheid and Wright 2017). Unlike psychiatrists and clinical psychologists, who usually focus on individual cases of mental disorder, sociologists approach the subject of mental abnormality from the standpoint of its collective nature; that is, they typically analyze mental disorder in terms of group and larger societal processes and conditions that affect people and their mental state. What sociologists primarily do is investigate the consequences of social structures and relationships on mental health with the goal of identifying those aspects of society and social life that cause harm. They also analyze the social interaction that takes place within groups and families or between individuals that result in someone being defined as mentally ill. What makes the sociology of mental disorder unique is that "it regards psychological distress as an expectable outcome of social arrangements, not as an individual pathology" (Horwitz 2022:1).

In a social context, mental disorder is seen as a significant deviation from standards of behavior generally regarded as normal by the majority of people in a society. The relevance of this perspective for our understanding of mental disorder is that even though a pathological mental condition is something that exists within the mind of an individual, the basis for determining whether a person is mentally ill often includes criteria that are also sociological. A psychiatric finding of generalized impairment in social functioning involves an understanding of such sociological concepts as norms, roles, and social status that establish and define appropriate behavior in particular social situations and settings. It is the disruption or disregard of the taken-for-granted understandings of how people should conduct themselves socially or recognize social reality that causes a person's state of mind to be questioned. Consequently, it is the overt expression of a person's disordered thinking and activity as social behavior that ultimately determines the need for psychiatric treatment in most cases.

This situation has attracted sociologists to the study of mental disorder and has led to its development as a specialized area of sociological research. The sociology of mental disorder is generally viewed as a subfield of medical

sociology. In fact, it was the funding and encouragement of the NIMH during the late 1940s that stimulated the development and rapid expansion of medical sociology in the United States. Therefore, from its most important beginnings, the sociology of mental disorder has been linked to medical sociology. Yet, despite its status as a subfield within medical sociology, the sociology of mental disorder has acquired an extensive literature containing significant theoretical concepts and applied knowledge of the human condition. In recognition of this development, the American Sociological Association initiated a research journal, *Society and Mental Health*, which first appeared in 2011 and publishes studies on the sociological aspects of mental disorder. The purpose of this book, accordingly, is to provide an updated overview of the field for students, sociologists, health practitioners, and others interested in and concerned with the social features of mental disorder.

DEFINING MENTAL DISORDER

Before proceeding, we should first define mental disorder. This is no easy task, as numerous definitions, many of them insufficient, have been offered over the years. In an effort to resolve this situation several years ago and formulate a precise concept for the American Psychiatric Association, Robert Spitzer and Paul Wilson (1975) began by asking (1) whether certain mental conditions should be regarded as undesirable, (2) how undesirable these mental conditions should be to warrant being classified as mental disorders, and (3) even if undesirable, whether the conditions in question should be treated within the domain of psychiatry or by some other discipline.

Some psychiatrists define mental disorder very broadly as practically any significant deviation from some ideal standard of positive mental health. This view, as pointed out long ago by Thomas Szasz (1974, 1987), a psychiatrist and long-standing critic of his profession, would regard any kind of human experience or behavior (e.g., divorce, bachelorhood, and childlessness) as mental illness if mental suffering or malfunction could be detected. Other psychiatrists, in contrast, subscribe to a narrower definition of mental disorder, which views the condition as being *only* those behaviors that are clearly highly undesirable. Behaviors that are merely unpleasant would not be considered mental illness. This narrower definition would encompass those mental abnormalities such as schizophrenia, depressive or anxiety disorders, or an antisocial personality, which Spitzer and Wilson (1975:827) describe as "manifestations which no one wants to experience—either those persons with the conditions or those without them." This latter approach appears more realistic.

The problem of defining mental disorder is further complicated by the fact that concepts of mental disorder change. For example, homosexuality was considered a mental disorder by American psychiatrists until the early 1970s, but is not considered such today after lobbying to have it removed (Horwitz 2021; Whooley 2019). Terms such as melancholia (depression), amentia (mental retardation), hysteria (conversion disorder), and moral insanity (for people who were not truly insane but were thought to be amoral and perverted) are

no longer used. Yet they were major classifications of mental disorders at one time or another during periods ranging from ancient Greece to the twentieth century. Another example is neurosis, which used to be a major behavioral disorder characterized by chronic anxiety, but now has its various subtypes classified under depressive, anxiety, somatic symptom, or dissociative disorders.

Surprisingly, neither standard textbooks in psychiatry nor the first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) defined mental disorder. Spitzer, a research psychiatrist who headed the American Psychiatric Association's Task Force on Nomenclature and Statistics charged with developing DSM-III, addressed this problem and subsequent editions have done likewise. According to Spitzer (Spitzer and Wilson 1975:829), mental disorder can be defined as follows: (1) it is a condition that is primarily psychological and alters behavior, including changes in physiological functioning if such changes can be explained by psychological concepts, such as personality, motivation, or conflict; (2) it is a condition that in its "full-blown" state is regularly and intrinsically associated with subjective stress, generalized impairment in social functioning, or behavior that one would like to stop voluntarily because it is associated with threats to physical health; and (3) it is a condition that is distinct from other conditions and that responds to treatment.

Of the three criteria, the first separates psychiatric conditions from nonpsychiatric conditions. The second specifies that the disorder may be recognizable only in a later stage of its development (full-blown) and that its identification depends upon consistent symptomatology regularly associated with the disorder. Spitzer also says that the disorder must arise from an inherent condition and that the impairment in functioning must not be limited to a single situation, but should include an inability to function in several social contexts (generalized impairment in social functioning). The second criterion also includes "behavior that one would like to stop voluntarily," for instance, compulsive eating or smoking, or hearing imaginary voices in one's head. The third criterion places the definition within a medical perspective by limiting it to distinct treatable conditions. This view continued to be followed through DSM-IV and the revised DSM-IV-TR, but is simplified in DSM-5 (American Psychiatric Association 2013) and DSM-5-TR (American Psychiatric Association 2022). The new and more generic definition stated in DSM-5 and carried forward in DSM-5-TR narrows the definition of mental disorder to that of a significant dysfunction in a person's mental processes that is distressing and/or disabling (Horwitz 2020, 2021; Wakefield and Schmitz 2017). The definition of a mental disorder in DSM-5 (2013:20) is as follows:

> A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress and or disability in social, occupational, or other important

activities. An expectable or culturally approved response to a normal stressor or loss, such as death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

MADNESS IN ANCIENT TIMES

Throughout history, societies have attempted to cope with behavior that was irrational, purposeless, and unintelligible. Ideas about mental illness have been intrinsic to ideas about the nature of human beings and their form of civilization. What people have thought about mental illness reveals what they have thought about themselves and the world they lived in. As societies have changed, concepts of madness have likewise changed. To better understand contemporary approaches to the problem of mental disorder, it is useful to review the evolution of those concepts from humankind's preliterate past up to the present. Current efforts on the part of human societies to cope with mental disorder as a social problem are grounded in these past experiences.

Primitive Concepts

Primitive attempts to explain both physical and mental disorders were based largely upon intuition. Sometimes, early humans noted a cause-and-effect relationship between taking a certain action and alleviating a certain symptom or curing a wound. Primitive people could certainly understand the effect caused by striking someone or an animal with a spear or a rock. The effect could be injury or death. Most often, an illness, however, especially if its cause could not be directly observed, was ascribed to supernatural powers. In essence, primitive medical practice was primitive psychiatry, as humans applied subjective notions about their environment to ailments whose origin and prognosis were beyond their comprehension.

In most preliterate cultures, an illness would be defined as an affliction brought on because those who were sick (1) had lost a vital substance (such as their soul) from their body, (2) had a foreign substance (such as an evil spirit) introduced into their body, (3) had violated a taboo and were being punished, or (4) were victims of evil spells. All of these explanations of disease causation are clearly bound up with ideas about magic and the supernatural. Because there was so much mystery about the world around them and the functioning of their own bodies, primitive humans attempted to explain the unexplainable by applying human motivations to the unknown.

Yet, these concepts were not random ideas, but were likely derived from linking particular symptoms to particular beliefs and customs prevalent within their society. Widely held taboos among primitive humans, for example, are murder and incest. Violations of these taboos were thought to have deleterious effects on the mind of the perpetrator, leading to madness. Insanity was often

believed to be a form of punishment by God, or whatever deities are common to that society, for misdeeds that violate collective morals.

Another example is found in Haiti, where a belief existed among some superstitious persons that a sorcerer can force the soul from a victim's head through the use of magic and replace it with the soul of an animal or an insane person who has died. This act is thought to be responsible for the victim's subsequent disordered behavior. There is also a belief that a curse can cause death. Here, one is dealing with a cultural belief that a curse is "real." The result can be a state of extreme anxiety on the part of the person cursed, who eventually dies from shock induced by prolonged, intense emotion associated with believing in the reality of the curse. This reaction is reinforced by the response of others who seek to avoid contact with the cursed person. Such an event demonstrates the possible psychological leverage that a group can have over an individual in certain circumstances and the significance of the definition assigned to that person by others. According to local customs, being cursed might result in an emotional circumstance that could hasten a person's death through sustained stress. Of course, this depends on the belief of all concerned, especially the victim, that the curse is fatal.

If evil spirits and *black* magic are believed to cause death and illness, it is perfectly permissible to employ *white* magic to counter the work of the evil person or supernatural entity causing the suffering. This belief created the need for healers, known as witch doctors or shamans, who work at producing a cure by applying magical arts grounded in folk medicine and prevailing

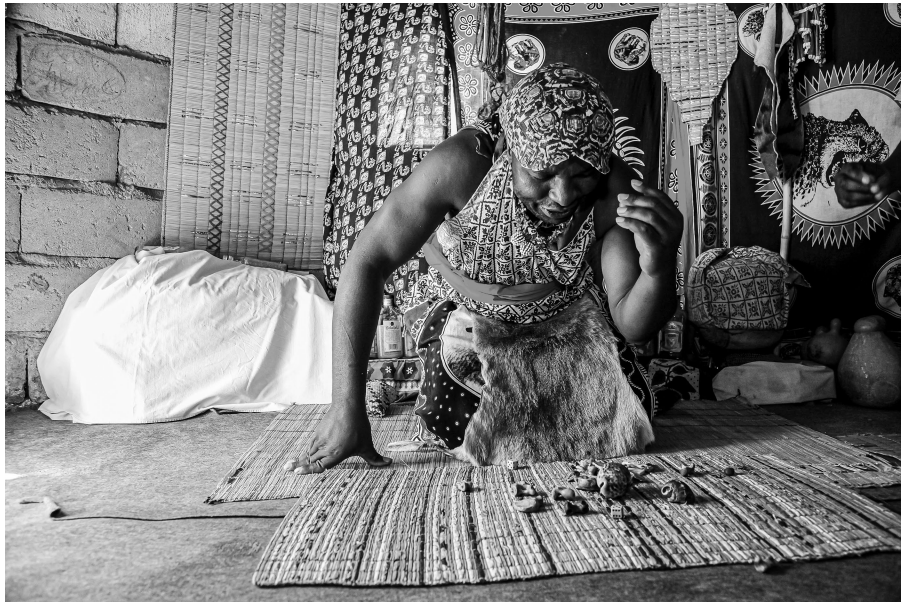

Photo 1.2 Witch doctor at work.

Source: Sunshine Seeds/Shutterstock.

religious beliefs. The most commonly held image of a shaman is that of a medicine man who is susceptible to possession by spirits and through whom the spirits are able to communicate. Shamans can be either men or women, although men are apparently more likely to be extraordinarily successful. This is probably because men can "act" more violently during rituals and thereby appear more powerful. Advanced age, high intellect, and sometimes sexual deviance, such as transvestitism and homosexuality, are characteristics of shamans. Also, being an orphan, being physically disabled, or even being mentally ill was not uncommon for a shaman.

The most important attribute for a shaman is a strong imagination, for the shaman theoretically gains his or her strength by mentally drawing upon power that he or she believes exists outside himself or herself in nature or the cosmos. Shamans try to accomplish this through deep concentration while engaging in a mindset stimulated by chants, prayers, drugs, drinking, ritual dancing, or, perhaps, sex. Shamans work themselves into a frenzy until they sense they have become the very force they seek; when this happens, they project their supposedly powerful thoughts out of their mind toward the intended target. The extent of their influence depends upon the belief that other people have in their ability to conjure up and control supernatural forces for either good or evil.

Although witch doctors have often had considerable power and prestige among the groups they serve, they by no means have always occupied a desirable role in society. They may be viewed as deviant and odd, a condition perhaps reinforced by the need to work with undesirable people and matter (e.g., snakes, insects, human organs, and body excretions). They themselves may have been recruited from the ranks of the mentally disturbed. Skill in performance is apparently the most significant criterion in shamanism, rather than heredity or special experience, although the latter can be particularly important. In this occupation, a degree of craziness can be an advantage for the performer.

Typically, the shaman's performance reflects certain principles of magic, such as similarity or "sympathetic magic" and solidarity or "contagious magic." *Sympathetic magic* is based on the idea that two things at a distance can produce an effect upon each other through a secret relationship. In other words, two things that look alike affect each other through their similarity because the shared likeness places them in "sympathy" with each other. Thus, "like" is believed to produce "like." A well-known example of this notion comes from voodoo and is the sticking of pins into a doll made in the image of a certain person to inflict pain on that individual. In healing, a shaman might act out a sick person's symptoms and recovery, supposedly to "orient" the illness toward recovery. An example of sympathetic magic comes from the Shona tribe living in southern Zimbabwe, Africa. Here, a common practice of witch doctors is to administer the shell of a tortoise in some form to a patient to promote a general feeling of strength and security; or a portion of bone removed from a python's back may be used to try to restore strength in a patient's back by having the patient eat bone fragments.

Contagious magic is based on the idea that things that have once been in contact continue to be related to each other. Hence, a shaman might use a fingernail, tooth, or hair as the object of a magical act to affect the source of that part in some way. Among the Shona, all shamans practice contagion. A member of the Shona group might, for example, obtain some article of clothing that an enemy has worn close to his or her body, take it to a shaman who can produce a spell on it, and supposedly cause the enemy to become ill.

Other measures used by witch doctors include the prescription of drugs made from parts of people, animals, or plants and prepared secretly according to a prescribed ritual. Sometimes, an evil spirit might be forced to leave a body by inducing vomiting, through bloodletting, or as bodily waste. Regardless of the technique, the witch doctor's principal contribution to therapy appears to be that of anxiety reduction, which draws upon the cultural background of the patient. The connection of treatment with the dominant values and beliefs in the community both inculcates and reinforces the patient's faith in the shaman's procedures. Many primitive people have little opportunity to develop reality-testing skills, being exposed from infancy to a system of beliefs that supports the shaman's authority and mode of treatment. Consequently, shamans are able to foster the hope and the expectation of relief by emphasizing faith in themselves, their methods, and spiritual orientation—all grounded in local community norms and customs. In some ways, the shaman or witch doctor is like a modern-day psychiatrist in that both develop a personal relationship with the patient, promote hope, help the patient understand his or her affliction within a shared cultural context, and engage in therapy.

The belief that spirits and witchcraft are responsible for mentally disturbed behavior may still be prevalent in some places. Paul Linde (2001), an American psychiatrist working in Zimbabwe in the early 2000s, found that schizophrenic patients in Zimbabwe were similar to those he formerly treated in San Francisco. One major difference, however, was the *content* of symptoms. Instead of hearing Jesus Christ speaking to them or being paranoid about the FBI, Zimbabweans hear voices of their ancestors' spirits and are paranoid about witches and sorcerers. Linde noticed that members of the Shona tribe, including medical students, avoided mental patients. The mentally ill are severely stigmatized because they are believed to be victims of witchcraft, and diseases caused by spirits are thought to be contagious. Only rarely did a Shona medical student specialize in psychiatry. Even though these students believed the Western perspective that mental illnesses are caused by biological, psychological, and social factors, they also believed the traditional view that mental disorders are caused by witchcraft or ancestor bewitchment. "Guess which perspective held sway?" asks Linde (2001:57).

These medical students had grown up in households in which spiritual models of illness were not only accepted, but regarded as the most plausible explanation. The influence of the Spirit World was part of their everyday existence, and they believed its powers could be used for evil. "Because the Shona frequently attributed their symptoms of mental illness to bewitchment," states Linde (2001:58), "a psychiatrist in that culture would have to expose himself

to the ample dangers of the Spirit World on a daily basis." Consequently, the practice of psychiatry was avoided. It was considered too close to witchcraft and regarded as an area of medicine better managed by traditional healers and the clergy.

Greeks and Romans

Like many other attributes of Western civilization and intellectual development, modern concepts of mental illness originated with the ancient Greeks and Romans. The Greeks, in particular, are noted for formulating a rational approach toward understanding the dynamics of nature and society. They replaced concepts of the supernatural with a secular orientation that viewed natural phenomena as explainable through natural cause-and-effect relationships. One of the most influential Greeks in this regard was Hippocrates, who provided many of the principles underlying modern medical practice. Whether there actually was a Hippocrates, who is thought to have lived around 400 BC, is not known. Nevertheless, the Hippocratic method, which demands a rational, systematic mode of treating patients, is credited to him. This method, based upon thorough observation of symptoms and a logical plan of treatment according to proven procedures, is central to contemporary medical practice.

As for mental illness, Hippocrates is believed to have introduced a radical change in the concept of madness by insisting that diseases of the mind were no different from other diseases. In other words, mental illness was not the result of divine, sacred, or supernatural influences. Instead, mental illness was due to *natural causes* that affected the mind and produced delusions, melancholia, and so forth. Although Hippocrates was ahead of his time, he was clearly mistaken in attributing the cause of abnormal behavior to an imbalance in the interaction of the four so-called *humors*—blood, phlegm, black bile, and yellow bile—within the body. Health, both physical and mental, was dependent upon the humors remaining in a state of equilibrium. An excess of black bile was consistently mentioned by Hippocrates as the cause of mental illness; the recommended treatment was the administration of a purgative (black hellebore) to induce elimination of the disorder through the bowels. Also, vapors, baths, and a change in diet were sometimes prescribed.

The best known of the Roman physicians was Galen, who lived from AD 130 to 200. Galen was strongly influenced by Hippocrates' notion of the four humors, and he reinforced the Hippocratic view by holding that the health of the soul was dependent upon the proper equilibrium among its rational, irrational, and lustful parts. Furthermore, he argued that sexual orgasms were necessary if mental harmony was to exist and tension was to be avoided. Galen was a strong advocate for active sexuality for the promotion of mental health.

Soranus, another leading Roman physician whose life overlapped the first and second centuries after the death of Christ, maintained that the personal relationship between the physician and the patient was of paramount

importance in curing mental illness. He argued that physicians needed to be supportive in helping mentally ill persons work out their insanity. Soranus is particularly known for his humanitarian treatment of the mentally ill. He insisted that caretakers of the mentally deranged be sympathetic; mental patients be housed in peaceful surroundings; and, whenever possible, mental patients should read, discuss what they read, and even participate in dramatic plays to offset depression. But probably very few people in ancient Rome could afford the treatment recommended by Soranus. Most treatment was limited to drugs, spells, and religious pilgrimages.

Roman law also redefined insanity as a condition that could decrease an individual's responsibility for having committed a criminal act. The defendant's state of mind, however, was determined by a judge, not a physician. Those persons presumed to be mentally ill were typically remanded to the custody of their relatives or a guardian who was charged with the responsibility for their control, safety, and well-being. Other laws were introduced that defined the ability of the mentally ill to marry, be divorced, testify in court, and make wills concerning the disposition of their property.

THE MIDDLE AGES, RENAISSANCE, AND POST-RENAISSANCE

The ideas of the Greeks and Romans were stifled with the fall of Rome in AD 476. The next 500 years were particularly chaotic, as wars, Viking raids, political and religious upheavals, plagues, and famines disrupted the existing social order. At that time, the Roman Catholic Church became *the* center for learning and preserving intellectual knowledge as Western Europe became dominated by the military power of various barbarian tribes, mostly of Germanic origin. The uncertainty of the period generated great insecurity as many people merged primitive beliefs with Christian theology to explain human suffering.

There was a return to the notion that supernatural forces, namely, the Devil and witches, were responsible for afflictions of the mind. Many psychotics had delusions and hallucinations containing religious content, which reinforced this view. Exorcism was frequently practiced by the Catholic clergy, who followed the example of Christ in the New Testament, driving evil spirits out of the bodies of those suffering from bizarre and irrational thinking. Beliefs linking the Devil with mental disorder became so entrenched in the Christian world that they persisted through the Middle Ages, the Renaissance in the fifteenth century, and even the sixteenth and seventeenth centuries. It was not until the eighteenth century that scientific thought and logic prevailed and demonology was rejected as the cause of mental illness.

True, the Renaissance marked the beginning of a European enlightenment that provided an intellectual orientation based upon empirical or practical knowledge and demonstrated scientific validity to which pagan beliefs would eventually succumb. But two other conditions helped to continue the idea that the Devil was behind abnormal behavior. First, the more often science was able to answer some questions, the more often other questions were

raised that perpetuated the uncertainty. That is, the more people learned, the more they realized how little they knew about their world and the universe beyond; intellectual discoveries stimulated the demand for more intellectual inquiry. Because so much remained unknown, the ancient beliefs that had been acceptable explanations in the past continued to support people against the anxieties of the present. Centuries of superstition were very difficult to overcome. Second, there was a tacit agreement between the Church and medical science that allowed the Church jurisdiction over the investigation of the human mind. The Church made little or no objection to medicine's interest in the human body as a weak and imperfect vessel intended to convey the soul in its earthly existence, but the study of the mind was another matter, since human reason was defined within the province of religion, not medicine. Thus, physicians largely devoted themselves to research on the physical functions of the body, leaving considerations of mental processes to theologians.

Western Witchcraft

The church defined those persons who did the Devil's work on earth as witches. Szasz (1970) notes that it was easy to blame misfortune on witchcraft. Persons identified as witches were usually relatively powerless and readily available as scapegoats. And who were these witches? Generally, they were women and included heretics, nonbelievers, eccentrics, the mentally ill, and those who in some way were regarded as different or odd by other people. Some of these women may have simply been strong-willed. Most were probably innocent victims.

Persons suspected of being witches were often arrested or were simply rounded up, tried by a court, and punished. The punishment was usually death. The so-called witch trials began in earnest in 1245 in France and reached their zenith between 1450 and 1670. A papal bull published in 1486 became the basic how-to-do-it manual for witch hunters. Written by a pair of Catholic Dominican monks named Henry Kramer and James Sprenger, the *Malleus Maleficarum*, or *The Hammer of Witches*, was the handbook of the Inquisition. Some 29 editions of this document were published up until 1669. Kramer and Sprenger insisted that there were such things as witches and that to question the existence of witches was itself a sign of being a witch. By these means, they rather adroitly overcame any criticism of their theories.

The authors of the *Malleus Maleficarum* argued that it was women who were chiefly addicted to evil superstition. The reason for this assertion was that they believed that all witchcraft was derived from carnal lust, which, they maintained, was insatiable in women. Men, on the other hand, were generally protected from witchcraft because Jesus Christ was a man, and by his being born and suffering for humankind, males were saved from becoming witches. As Szasz (1970:8) comments, "In short, the *Malleus* is, among other things, a kind of religious-scientific theory of male superiority, justifying—indeed, demanding—the persecution of women as members of an inferior, sinful, and dangerous class of individuals." The dictates of the *Malleus* matched the ideas of many males.

To aid in suppressing witchcraft, the *Malleus* required physicians (who were universally male) to verify its presence. An illness was considered to be either natural or demonic in origin; if the physician could find no proof of disease, he was expected to find evidence of witchcraft. Obviously, this gave physicians a convenient means by which to explain away illnesses they could not understand. Witchcraft was, therefore, thought to be behind those illnesses whose onset was sudden, which could not be identified, or both.

The number of people who lost their lives through persecution for witchcraft during the witchcraft mania is not known. One estimate claims that at least 200,000 people were put to death in Germany and France; considerably fewer were killed in Spain because of nationalistic and independent attitudes, and in England, where the pagan Anglo-Saxon law maintained that a person was innocent until proven guilty (Scull 2016). The persecution of witches spread to the New World, where one of the final outbursts occurred among Protestants in Salem, Massachusetts, in 1692. In Salem, a group of young girls, demonstrating manifestly silly behavior, was labeled "bewitched" after a physician, failing to find any illness, claimed that the source of the problem was beyond medicine. One of the girls attempted to change her testimony and tried to discredit that of the other girls, but the judges refused to believe her and she herself was eventually accused of witchcraft. The resulting witch trials, in a community where tension was rising between local farmers and merchants over town politics and the distribution of income, saw some 19 alleged witches executed out of the 25 brought before the court.

Those who lost their lives were mostly powerless, community outcasts, or others with little social standing. However, as more and more persons of increasingly higher social status began to be accused and as the quality of the evidence correspondingly decreased, the trials came to an end. The final blow was the withdrawal of the support of Puritan clergymen like Cotton Mather, a noted demonologist of the day, who came to express serious doubts about the whole affair, after having been very influential in initially stimulating community reaction to witches.

The processes that ended witch trials in Salem were similar to those that ended them elsewhere: Eventually, the public became appalled at the excesses committed by the witch hunters. As people of higher and higher social station were called out as witches, both the Catholic and Protestant Churches and local governments withdrew their support. Accusations had reached the point at which they were contrary to reason and unsupported by newly emerging scientific views.

Treatment of the Mentally Ill

Not all mentally deranged people were killed or persecuted as witches. Some mentally ill individuals during the Middle Ages and the Renaissance were simply regarded as "fools" and "village idiots." They were tolerated by their communities for purposes of amusement, sadism, or charity, or because they were harmless. Others were kept home by their families, sometimes in chains,

and still others were driven out of their homes and forced to wander over the countryside as vagrants, attempting to survive as best they could.

Some mentally ill people were supposedly placed in boats or ships, the so-called ships of fools, whose boatmen or sailors were bribed to put them ashore at a distant place. According to French social theorist Michel Foucault (1965), these ships of fools sparked the imagination of certain early Renaissance literary figures and artists, notably the writer Sebastian Brant and the painter Hieronymus Bosch, both of whom created highly symbolic works depicting cargoes of mad people adrift in search of their reason.

The deliberate shipment of the mentally ill out of communities signified much more than the idea of the mad being put adrift to find normality; rather, it marked the beginning of the strict separation of the insane from the company of the sane. Madness was to be controlled and the next step was confinement.

Beginning in the late Middle Ages, many mental patients were institutionalized in custodial centers to remove them from the general population. Efforts were made to cure them through prayer or physical means, such as bloodletting, emetics, and cathartics. It was generally believed that the only way to cure mental derangement was by the divine intercession of saints; therefore, religious practices were emphasized. Finally, in 1409 in Valencia, Spain, the first mental hospital was founded by a Catholic priest, Father Gilabert Jofré (1350–1417). The impetus behind Father Jofré's action was his reaction to witnessing a brutal street scene in which mentally ill persons were tormented and teased. Shortly thereafter, Spanish missionaries founded other mental hospitals in Spain and, later, in 1567, in Mexico City.

The relatively tolerant attitude in Spain toward the mentally ill was most likely influenced by its proximity and cultural ties to the Arab world. The Arab countries of North Africa and the Middle East had taken a much more humane view of mental illness. The basis of this approach was the Muslim view that the insane are loved by God and are especially chosen to tell the truth. As early as the twelfth century, travelers returning to Europe reported a high standard of humanitarian treatment for the insane at various Arab mental asylums (Porter 2003; Scull 2016). One description tells of fountains, gardens, and a relaxed atmosphere in which patients were treated with special diets, drugs, baths, and perfumes. Note is also made of concerts in which the musical instruments were tuned so as not to jar the patients' sensitivities. Rich and poor were apparently given access to the same facilities.

There were some humane trends discernible in Western Europe other than the work of the Catholic Church in supporting institutions to protect and care for the mentally ill. Johann Weyer (1515–1588), a Dutchman known as the first psychiatrist, strongly rejected the idea of witchcraft and the policies of those clergy who supported witch hunts. He insisted that patients should be treated with kindness and understanding. Therapy was to be derived only from the scientific investigation of a patient's complaints. Another significant physician was the man known as Paracelsus (1493–1541), a Swiss who argued that the insane were neither sinners nor criminals but sick people who needed

medical help. The first conceptualization of unconscious motivation promoting anxiety is found in his writings.

In Spain, Juan Luis Vives (1492–1540), who became the father of modern psychology, likewise spoke out against beliefs in demonology and claimed that mental patients should be treated peacefully if reason and sanity were to be returned. He believed, in opposition to theologians, that the mind should be studied and posited that emotions and instincts are central influences upon behavior. The work of individuals such as Weyer, Paracelsus, Vives, and Cornelius Agrippa (1486–1535), a German scholar who defended women's rights and risked his life to save a woman accused of witchcraft, eventually led to the separation of psychology and psychiatry from theology. But their ideas had little immediate impact, and in some cases, especially that of Weyer, they were viewed as radicals and deliberately ignored by their contemporaries.

THE EIGHTEENTH CENTURY: THE GREAT CONFINEMENT AND REFORM

The Great Confinement

The eighteenth century marked the age of the *Great Confinement*, for it was during this century that numerous institutions, many of them called "hospitals," spread across Europe, intended to house and control persons considered to be social problems. Actually, this process began in the middle of the seventeenth century with the founding of the *Hôpital Général* in Paris in 1656, but it reached its zenith in the eighteenth century when an entire network of such institutions was built across Western Europe. Economic recession, unemployment, higher prices, and losses of land had created a serious problem of homelessness and vagrancy throughout Europe. Begging on the streets of Europe's cities became a great public nuisance. In recognition of this problem and in accordance with a new definition of social welfare as a community rather than just a Church responsibility, municipal and national authorities began to extend public assistance to the poor by offering them food and shelter. This policy was also in line with the new notion of enlightened absolutism in which the monarchs of Europe assumed responsibility for the safety and well-being of their subjects in return for obedience to their absolute authority. Thus, for the first time, purely negative measures of exclusion (e.g., the ships of fools) were replaced by the use of confinement. The unemployed and homeless were no longer driven away or punished. Instead, they were cared for at the expense of the nation, but also at the cost of their liberty.

Consequently, an implicit system of obligation was set in motion between the poor and society at large. The poor had the right to be taken care of, but only by accepting confinement in society's "social warehouses," where they—including the sick, invalids, the aged, orphans, and the insane—were removed from mainstream society. A legacy of this outcome, existing even today in the United States, is that people with chronic health problems requiring long-term hospitalization—the insane, the incurable, and persons afflicted with highly

infectious diseases—tend to be sent to public institutions, whereas private hospitals generally accept patients needing to be hospitalized for relatively shorter periods of time. Custodial care thus remains largely within the purview of the state. For the seriously mentally ill of limited means, this meant commitment to a state or county mental hospital.

Another legacy from this period is the emergence of the Protestant Ethic, grounded in Puritanism, which had an important impact upon the thinking of many Europeans and Americans in the seventeenth and eighteenth centuries and still lingers today. The Protestant Ethic equates productive labor with goodness and morality; idleness and unemployment are viewed as sinful and immoral. The able-bodied poor, who were confined to poorhouses and hospitals, were required to work to contribute to their support, thereby becoming a source of cheap labor. The insane, however, as described by Foucault (1965), were distinguished by their inability to work and follow the patterns of community life. Hence, madness was defined as a vice as well as an unfortunate circumstance. It joined idleness as a sin. Foucault suggests that the effect of confinement upon the mentally ill was a decisive event in that insanity was now ranked among the problems of the city, similar to poverty, unemployment, and a failure to commit one's self to the collective interest. The ethical value of labor, the obligation to work, and the meaning of poverty all combined to determine the fate of the insane.

For the mentally ill, the era of the Great Confinement was a time of hardship and brutality. Foucault notes that the insane were regarded as being little more than animals and that their animalness was considered protection from hunger, heat, cold, and pain. "It was common knowledge," says Foucault (1965:74), "until the end of the 18th century that the insane could support the miseries of existence indefinitely. There was no need to protect them; they had no need to be covered or warm." The insane were crowded into rooms or cells with little or no warmth, even on the coldest days; most were chained to walls or beds. Some had no beds and slept on straw pallets in cells that were damp and perhaps rat-infested. Some went naked. Those who were violent were subjected to brutal punishment because discipline was thought to be a sound method of promoting the return of reason.

Although the insane were locked away from society, they were still the objects of bizarre curiosity. On weekends, it was not uncommon for the mad to be displayed to visitors who would pay an admission price to view the human oddities. For example, it was reported in the House of Commons in London in 1815 that the Bethlehem Hospital for the insane took in about 400 English pounds in admission fees. At a penny per visitor, this suggests that over 90,000 people visited the hospital that year during its Sunday open houses. Not only did the general public get a chance to peer at the insane, but sometimes the insane were made to perform dances and acrobatics. "The only extenuation to be found at the end of the 18th century," Foucault (1965:69) states, "was that the mad were allowed to exhibit the mad, as if it were the responsibility of madness to testify to its own nature."

Reform: Chiarugi, Tuke, and Pinel

Toward the end of the eighteenth century, public outrage grew as the abuses suffered by the mentally ill received widespread attention. Reform, however, was on the way, particularly because of three individuals—Vincenzo Chiarugi, William Tuke, and especially Philippe Pinel. Vincenzo Chiarugi (1759–1820), a physician in Florence, Italy, argued that medical personnel had a moral duty to treat the mentally ill as individuals and to treat them tactfully and humanely. Chiarugi put his ideas into operation while directing a large mental hospital, and he also wrote a three-volume work on insanity. Unfortunately, his ideas were obscured by the turmoil, revolts, and wars taking place in and between the various Italian city-states at the time.

William Tuke (1732–1819), a Quaker tea merchant living in England, was exceedingly more influential and established a mental asylum at York in 1792. Tuke's approach was strikingly radical for the day because he advocated that mental patients be treated as guests, with kindness and respect. He organized a friendly, sympathetic environment on an estate called "the Retreat," where he housed about 30 patients. The "Retreat" was intended to be a place where people who could no longer cope with the world could find relief (Scull 2016). There were no chains, physical punishment, or direct physician influence. Work in the form of moderate physical exercise was included and considered to be therapeutic. Observers from throughout Europe and the United States came to view Tuke's methods, and he achieved much with respect to humanitarian reform in England.

Slowly, small pockets of humane care for the mentally ill appeared in the Western world, but it remained for Philippe Pinel (1745–1826) to induce a widespread change in the treatment of mental patients. Pinel, a shy, retiring French physician, had impressed his superiors while still a medical student by formulating a program of "moral treatment" for the insane. Pinel believed that mental health was dependent upon emotional stability, what he called a "balance of passions." He argued that mental patients would respond to kindness and sympathy under the firm guidance of the therapist as a father figure. If possible, patients should be allowed to work and participate in recreational activities (concerts, lectures, games) rather than be confined to cells or held in restraint by mechanical devices. The main causes of mental disorder were thought to be psychological (e.g., passions, lust, and excessive masturbation) or environmental (e.g., too much freedom and economic uncertainty). As it evolved, moral treatment was essentially a program of reeducation in which mental patients were to be taught how to behave normally within the context of sympathetic living conditions.

In August 1793, in the midst of the French Revolution, Pinel received his wish and was appointed as a physician to the insane asylum of Bicêtre for male patients. Persuading the warden to allow him to unchain the inmates, Pinel walked through the asylums, going from cell to cell freeing the patients. The first man unchained had not walked in 40 years but somehow managed to hobble out of his cell to view the sky in a state of amazement. The next to be

released was a former solider and a drunkard who had been in chains for ten years because of his violent temper compounded by mental illness. He was considered incurable, according to one historical account (Bromberg 1975), but in time was released because of his good conduct.

Pinel ordered that beatings and other forms of physical abuse be halted; food was improved, and the patients were treated with a new drug: kindness. And apparently in many individual cases, there was great improvement. "Dazed lunatics, rubbing their eyes at their good fortune, talked for the first time in years, and became almost human again" (Bromberg 1975:97). Pinel's program thus called attention to the need for and possible benefits of reform in the care of the mentally ill. It was also an act of great personal courage on his part because it came when the French Revolution had turned on a course of terror. Citizens suspected of royalist rather than republican sympathies, or whose actions could be judged as supporting the old regime, were sent to be beheaded on the guillotine. Pinel's ideas, however, turned out to be extremely successful. His book, *Treatise on Insanity*, published in 1801, was likewise very popular, and his concept of moral treatment became the basis for French laws pertaining to mental health. He was appointed to a top medical school faculty position and honored by election to the membership of the Institute of France. For about 20 years, he enjoyed success and fame, but eventually he was affected by politics. Suspected of being a royalist for allegedly allowing certain priests and refugees wanted by the government to stay at the Bicêtre asylum, Pinel lost his teaching post and spent the remainder of his life living in poverty.

THE NINETEENTH CENTURY: EMERGENCE OF THE MEDICAL MODEL AND THE DECLINE OF MORAL TREATMENT

The nineteenth century began with the influence of Pinel's moral treatment in full bloom. Also influential, especially in England and in the United States because of their close cultural ties, were Tuke's methods as practiced at the York Retreat. Another authority was Benjamin Rush (1746–1813), the father of American psychiatry. Even though Rush maintained that abnormal behavior was caused by brain disease that had its locus in the brain's blood vessels, he nonetheless argued that the human spirit had influence over the organic functioning of the body and advocated spirit healing. In response, several mental asylums were founded in the United States between the turn of the century and the American Civil War. The most noted of these, initially, was the Worcester State Hospital in Worcester, Massachusetts. Here, the philosophy of moral treatment was held as an example for the rest of the country, but the reader should not get the impression that all or even most mental patients received moral treatment. Generally, moral treatment was provided by private hospitals or by only the most progressive public asylums. In the United States, moral treatment was most prevalent in New England, and the patients were usually from upper- and middle-class families. Mentally ill persons who were violent, poor, or nonwhite often found themselves in jails or workhouses.

The goal of moral treatment for all the insane was not to be realized, for within a few decades, its influence declined significantly. Five factors were largely responsible for this outcome. First, there was no truly cohesive program detailing a systematic approach to moral treatment. Thus, it was difficult to train others in its methods and implement any type of standardization or coordination. This also impeded public recognition of its value. Second, some critics viewed moral treatment as simply a method for enforcing patient conformity—which essentially it was, because of its system of rewards for good behavior and punishment (separation) for bad behavior (Scull 2016). Third, mental asylums were overcrowded with people who not only were insane but also had related problems of criminality, alcoholism, vagrancy, and poverty. Most mental patients were not misguided souls from affluent families. Instead, most were from the lower class and thus were held in low social esteem. In the United States, inmates of mental institutions came to be considered unworthy tax burdens by many citizens. Resentment was bred by the notions of moral treatment, with its emphasis upon pleasant surroundings and recreation for socially objectionable people who had outraged the morals of the community.

A fourth factor was the increasing popularity of the theory that madness was incurable, a theory that was due principally to ideas about heredity. This influence, largely European in origin but later embraced in the United States, encouraged a pessimistic outlook that little or nothing could be done to return mental patients to society in any normal capacity. Social Darwinism, with its advocacy of the survival of the fittest, further contributed to doubts about helping the insane. With a view primarily toward reducing costs, there was a great expansion of large, essentially custodial, mental hospitals.

Ironically, this process was helped by Dorothea Dix (1802–1887), a New England school teacher who devoted her life to reforming conditions for the mentally ill. During a visit to a Massachusetts jail in 1841, she was outraged by the sight of the mentally ill being housed with criminals, and so she visited every jail and poorhouse in Massachusetts over the following two years. Her next step was to send a report to the Massachusetts legislature describing the plight of the insane. This report caused a sensation, not only in Massachusetts, but nationwide. She subsequently devoted her life to traveling throughout the country inspecting mental institutions and demanding increased financial support from state governments. In 1883, Oregon opened the first state-funded mental hospital, and by 1890, every state had at least one public hospital for mental patients. Dix personally founded or enlarged some 32 mental hospitals and saw to it that physicians were added to the staffs of many of those institutions. In addition, she got the mentally ill out of jails and poorhouses and into asylums.

One of the hospitals helped by Dix was the Worcester State Hospital, formerly a model of moral treatment. What had happened at Worcester was typical of many other places. The low status and bizarre behavior of the inmates promoted contemptuous attitudes toward them by the staff and the community. The overwhelming number of patients, the limited amount of funds available to run the hospital, and the low social value of the inmates influenced the administration in not maintaining an environment for moral treatment.

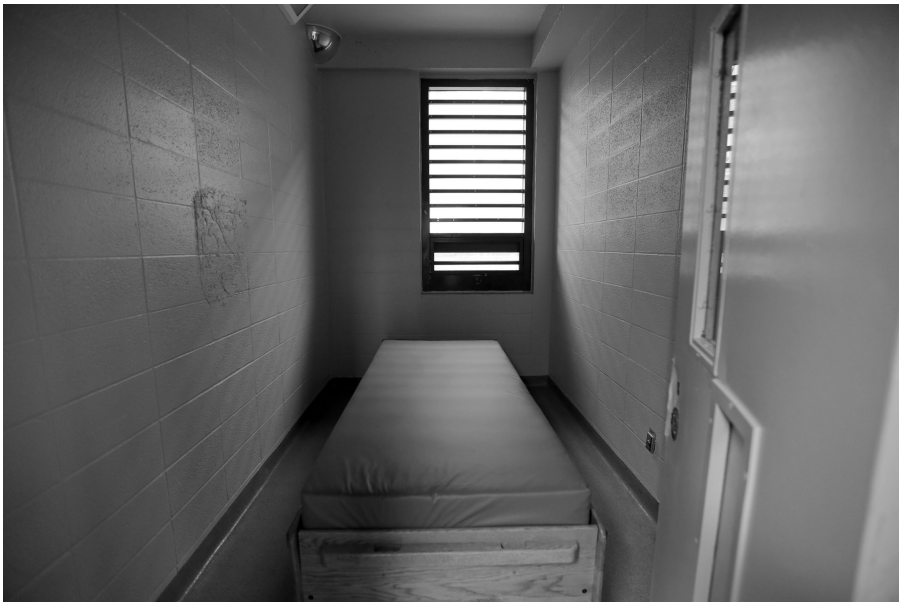

Photo 1.3 Patient's room at a state mental hospital.

Source: Jeff Roberson, Flle/AP Photo.

Instead, they adopted custodial procedures that were more cost-effective, as did other institutions. The use of mental hospitals to house the aged poor in particular remained common in state and county mental hospitals until well into the twentieth century.

Finally, there was a fifth factor, the powerful influence of psychiatrists who viewed mental disorder as a disease brought on by organic causes that needed to be treated medically. At the Worcester State Hospital, staff psychiatrists began emphasizing this approach as part of their claim to professional legitimacy in medicine. They saw themselves as "scientists" working in the same manner as other medical doctors. Although moral treatment recognized both organic and psychological causes of mental disorder, psychiatric ideology tended to negate measures such as moral treatment because they featured the therapeutic value of the environment. Instead, purely medical techniques were to be used in treating mental patients.

The overall result was the demise of moral treatment, which may not have been the most effective approach for some patients, but had brought improvement to others; more importantly, its philosophy had meant humane care for all.

The Medical Model

Nineteenth-century physicians were not the first to argue that abnormal mental behavior was the result of mental disease, not the manifestation of witchcraft and sin. Such arguments had been growing since the sixteenth century,

but the 1800s saw the emergence of a scientific framework supporting the concept as it never had before. This was a period of tremendous advancement for medicine, as research discoveries led to highly significant improvements in medical knowledge, procedures, and technology. Louis Pasteur, Robert Koch, and others engaged in bacteriological research leading to the conceptualization of the germ theory of disease, establishing the premise that every disease had a specific pathogenic cause whose treatment could best be accomplished within a biomedical mode. This approach, as is well known, was highly successful in producing cures for infectious diseases. In view of this success, it was perhaps inevitable that physicians as psychiatrists would come to view mental disorder in a similar fashion, as an extension of the germ theory. Rush the first of American psychiatrist, maintained, for example, that abnormal behavior was derived from brain disease that had its locus in the brain's blood vessels. Consequently, organic dysfunctions of the brain were credited as the primary cause or etiology of mental disorder. The most influential textbook of this period, for instance, was written by a leading German psychiatrist, Wilhelm Griesinger (1817–1868), and was titled *Pathology and Theory of Mental Diseases*. The title clearly indicates the approach of its author, for Griesinger claimed that mental illness was brought on by biochemical changes in the nervous system caused by disease. By the mid-1850s, almost all American psychiatrists had come to believe that psychological problems had physiological causes (Harrington 2019; Horwitz 2020; Porter 2003). This viewpoint also became accepted by the American public.

Postmortem examinations were now the primary methods of attempting to discover the origins of mental disorder. Research moved away from living patients to morgues and clinical laboratories as the emphasis turned to brain dissection. Neurology became an important ally of psychiatry as diseases of the nervous system gained acceptance as causes of insanity. Psychiatry, however, struggled with organic definitions of mental disorders, as it was unable to produce scientific verification of the disease approach. Syphilis was one disease under investigation that produced a psychosis that could be verified as having an organic pathology, and that was treatable by biomedical means. Except for a few other mental disorders related to such conditions as cerebral atherosclerosis, chronic intoxication, vitamin deficiency, and outright physical injury to the brain, there was a lack of direct evidence to sustain the medical model. Nevertheless, bolstered by success in treating *physical* diseases of the body, the medical model remained the most widely accepted explanation of mental disorder.

THE TWENTIETH CENTURY: THE AGE OF THERAPIES

The twentieth century was unlike any other century preceding it in the variety of concepts of mental illness. Some ideas of the past remained, such as beliefs based upon superstition or notions of the role of the Devil. Other ideas, however, competed for attention and money. Those ideas ranged from sophisticated biochemical research to psychoanalysis, behavior modification, and community psychiatry, to self-help procedures embodied in techniques such

as biofeedback and transcendental meditation. All in all, there are at least 200 therapies and numerous pseudotherapies available in contemporary Western society, all intended to counteract psychological stress and behavioral abnormality. Professionals, paraprofessionals, and laypeople are involved in treating mental problems. The most influential developments in mental health during the twentieth century were the work of Sigmund Freud, the extensive use of psychoactive drugs, and the community mental health movement.

Sigmund Freud

Freud (1856–1939), an Austrian physician who began practice as a neurologist, established a theoretical basis for much of mid-twentieth century psychiatry. He emphasized psychological concepts of learning, motivation, and personality over purely organic approaches. Most important, he directed attention to the role of instincts and the unconscious in shaping behavior. Freud was a controversial figure, and even some of his supporters and students disagreed with him and broke away to form their own approaches. Yet he was extremely influential—particularly in the United States, where many psychiatrists were receptive to new ideas. At that time, psychiatry had become a relatively static branch of clinical medicine mired in the search for organic causes of mental disorders.

Freud breathed new life back into psychiatry with the formulation of the psychoanalytic approach, which was highly popular with White middle- and upper-class Americans in the 1940s and 1950s. In psychoanalysis, patients reconstructed their childhood experiences and life events over a period of time. This process was directed toward resolving present conflicts by uncovering the source of mental discomfort in the formative years of the patient's life. Behind this technique was Freud's belief that human behavior was determined by unconscious influences shaping conscious thoughts and actions. Freud, accordingly, developed an elaborate theory of instincts, personality structure, stages of psychosexual development, and ego defense mechanisms, as well as delving into dreams, group psychology, religion, and other matters.

Psychoactive Drugs: The New Medical Model

By the 1960s, however, the optimism that had been generated by Freud had begun to run its course and his influence declined. Psychoanalysis was time-consuming, expensive, and not particularly effective with seriously deranged patients such as schizophrenics and others lacking ego strength and an adequate sense of reality. Its greatest gains had been with patients suffering from anxiety. But as psychiatry was again becoming stalled, it was rescued by the second twentieth century revolution in mental health, the discovery and use of psychoactive drugs to treat the mentally ill. Although the attempt to justify the medical model through theories of organic brain disease had failed, success came through biochemical approaches.

Research in France in 1952 showed that chlorpromazine was effective in treating psychotic patients. Chlorpromazine was first used in the United

States in 1954, and by 1977 other phenothiazines had been developed for treating schizophrenia and manic states; drugs such as iproniazid and, later, imipramine were used for depression. The results were astounding, and the number of resident patients in mental hospitals decreased significantly from 1956 onward.

To recognize what has happened, we need to briefly review the situation in most mental hospitals since the mid-1800s. Following the reforms of Dorothea Dix, mental hospitals in the United States had grown progressively larger and were generally constructed away from large population centers in order to remove the insane from society. Overcrowding continued to foster trends toward custodial care as hospital staff became increasingly limited in their capabilities to contend with large numbers of patients. Beginning in 1860, there was a decline in discharges for mental hospitals as patients began to remain hospitalized for longer periods. Discharge rates and lengths of hospitalization stabilized somewhat in the 1920s, but from 1945 to 1955, there was an average annual increase of some 13,000 patients. The situation in the 1950s before the introduction of drug therapies has been described as one in which many patients lived in overcrowded and poorly furnished facilities and there was little success, great pessimism, and few discharges for patients with severe mental illness (Harrington 2019; Horwitz 2020; Scull 2016). The causes of their disorders were often unknown and neither neurological diagnosis nor psychoanalytic psychotherapy had any substantial effect in the treatment of schizophrenia, mania, or other severe afflictions. Psychiatrists, regardless of their training and approach to therapy, served mainly as administrators and custodians.

In 1950, there were 512,000 patients housed in state and county mental hospitals, a figure that had risen to nearly 559,000 by 1955. In 1956, the first year of the widespread use of psychopharmaceuticals in state and local mental hospitals, the number of resident patients dropped to 551,000. This drop has continued, and today the number of resident mental patients at any one time is about 30,000. Moreover, there has been a decline in the average length of hospitalization from six months in 1955 to less than two weeks today. It is clear that the inpatient population of mental hospitals is considerably smaller than ever before. Instead, most mentally ill persons are either treated or untreated in community settings.

Although not all the credit for the reduction in the number of mental hospital resident patients is due to psychopharmaceuticals, certainly the use of psychoactive drugs has played a central role. Additionally, the use of drugs helped to promote feelings of optimism and innovation among hospital staff members and encouraged other new forms of therapy, such as family therapy, crisis intervention, and brief psychotherapy. Yet the use of psychoactive drugs is not a miracle remedy for mental disorder. These drugs do not cure; they relieve symptoms and make social life possible when it was not before. Unpleasant side effects—such as interference with thinking and concentration, drowsiness, nausea, and addiction—accompany the use of certain drugs. Hence, the utilization of psychoactive chemical compounds in the mind has both positive and negative results.

Box 1.1 Medicalization and Pharmaceuticalization

As sociologists Peter Conrad (2007, 2013; Conrad and Bergey 2014; Conrad and Slodden 2013), Adele Clarke and her colleagues (Clarke et al. 2010), and Allan Horwitz (2010, 2020; Horwitz and Wakefield 2007, 2012) point out, the medicalization or biomedicalization of society has increased in recent years. To medicalize means "to make medical"; thus, medicalization is the process that occurs when nonmedical problems are defined as problems that need to be treated medically, usually as an illness or disorder of some type (Conrad 2007). Medicine is depicted to be more willing to take increasing responsibility for treating problems clinically that once were viewed as normal, including, in Conrad's view, natural outcomes such as short stature and male baldness, among others. This situation is seen in psychiatry when normal sadness and grief are defined as a depressive disorder and hyperactivity in children as an attention-deficit/hyperactivity disorder (ADHD) (Horwitz 2011, 2021, 2022; Horwitz and Wakefield 2007).

What this means for the pharmaceutical industry is increased sales as psychoactive drugs are prescribed in growing quantities for depressed adults and hyperactive children. As Horwitz (2010, 2021) points out, the most dramatic change in medicalization has occurred with ADHD. People with ADHD have difficulty paying attention, act impulsively, and are overly active. The average age of diagnosis is seven years. Horwitz notes that in the 1990s, less than 1 percent of all youth (about 600,000) 4–17 years of age were diagnosed with ADHD. The most recent figures available as this book goes to press are for 2016–2019 and show that 9.8 percent of all youth—some 6 million—were diagnosed with ADHD and 62 percent of them were taking medication for the condition. The danger in all of this is one of overprescribing drugs for some children who may not need them and labeling them with a mental disorder when this may not be the case. Some estimates suggest that perhaps only 10 percent of children with ADHD actually benefit from the drugs (Horwitz 2010). It may be the case that some teachers, parents, and psychiatrists prefer to think that a child's hyperactive behavior is due more to a biochemical imbalance in the brain than to social pressures, unavailable parents, and overworked teachers (Whitaker 2010, 2011).

Drug prescriptions for ADHD have risen nearly 50 percent in the last decade, and by 2022 had grown into a business worth more than $9 billion in sales annually. While psychoactive drugs (typically stimulants) help many individuals with ADHD, others may not need these drugs; additionally, the possible side effects include upset stomach, decreased appetite, nausea or vomiting, dizziness, tiredness, depression, agitation, and mood swings. The long-term effects are unknown.

The ultimate question is whether the great increase in medicated ADHD patients is due to a modern epidemic of ADHD or to medicalization. The answer seems to be medicalization, as seen in a greater willingness to create it through diagnosis. Once, ADHD was a disorder that mostly affected overactive schoolboys, but it has been expanded into a lifetime condition that can persist into adulthood, affecting children as young as two years of age, girls, adolescents, and adults (Conrad and Slodden 2013). Formerly confined to the United States, this non-infectious disorder is also being diagnosed more often in Europe and elsewhere. This trend is driven by the availability and marketing of ADHD drugs by large transnational pharmaceutical corporations ("big pharma"), the influence of American psychiatry, the Internet making information about ADHD readily available, and advocacy groups, some partially funded by drug companies, providing education and lobbying to affect policy (Conrad and Bergey 2014).

Community Mental Health

The third mental health revolution in the twentieth century in the United States was the community mental health movement. With the release of large numbers of mental hospital patients back into the community, many of whom were not cured but merely sustained by drugs, some new measure was needed to assist these patients in maintaining themselves outside the hospital. In 1955, Congress authorized and funded the Joint Commission on Mental Illness and Mental Health. The commission's final report, *Action for Mental Health*, published in 1961, described institutional mental health care as hopelessly custodial and recommended the establishment of local community mental health centers. In the United States, the 1960s were a time of social protest and demand for reform. Particular issues were civil rights and, later, American involvement in the Vietnam War; yet reform in the area of mental health was also included in those issues that attracted community support. Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1963 to support the establishment of easily accessible and locally controlled mental health centers. This law reflected the philosophy that the objective of modern treatment should be to support mental patients in their own communities as much as possible, so that such persons could lead relatively normal lives.

Community mental health programs have four basic goals. First is the idea that the mental patient's entire social environment be viewed as a "therapeutic community" with treatment resources for mental health professionals. The second goal, clearly related to the first, is that some means must be found to use the patient's relationships with family and friends to improve therapy and prevent recurrence of the mental disorder. The third goal is to develop and organize local community control over these centers so that center policies are community-based and oriented. Fourth is the goal of reducing patient populations at state and local mental hospitals by providing prompt responses and 24-hour service.

The establishment of community mental health centers has also meant the emergence of a new kind of mental health worker—a layperson, living in the community, intended to fill the gap between the mental health center client and the professional worker. The community mental health worker is supposed to be someone who can understand and work with people living in lower-class environments more effectively than middle-class professionals can. This broadening of community participation in mental health recognized that many client problems are social rather than medical. These problems include unemployment, poverty, poor housing, lack of food and clothing, racial discrimination, law violations, child support, and other characteristics of low-income living.

The movement to extend mental health services into community settings was not just the result of new psychoactive drugs and the negative effects of housing people in mental institutions for extensive periods. A host of other influences were important as well. These included growing public support for a more enlightened, humane approach to treating mental patients; the

extension of civil rights as a means to solve social problems of mental patients, thereby making it difficult to administer psychiatric care to people without their consent; and strong lobby efforts on the part of community psychiatry interest groups aimed at obtaining greater government funding and resources for community care. Criticism also emerged in psychiatry, particularly the work of R. D. Laing (1969) and Thomas Szasz (1970, 1974, 1987), who depicted mental illness as either a different type of reality or a myth, and mental hospitalization as a form of oppression. Underlying these influences was the strong support of many state legislatures to transfer the costs of care for the mentally ill from state budgets to the federal government.

By 2020, there were over 1,553 community mental health centers in the United States treating noninstitutionalized patients. Although these clinics have had some success in working with patients who could be helped best in the community and in providing prompt crisis intervention services, they have historically been handicapped by low levels of funding and overburdened by large numbers of patients. Moreover, many of the planned community mental health centers were never constructed, and the program itself has been largely disbanded (Dobransky 2014). Furthermore, a comprehensive and coordinated system of facilities and services to support the work of the mental health clinics, to include halfway houses and support networks for patients, never fully materialized in many communities. Basically what happened was that community care helped separate patients away from mental hospitals, but the system that emerged in communities was fragmented without an "all-encompassing oversight body" (Dobransky 2014:8). Instead, needed services, such as the treatment of mental illness, housing, vocational services, income support, and health care, were all administered by a maze of different government agencies with different eligibility criteria, financing, and regulations. This has made it difficult for patients to obtain comprehensive care, and it was not unusual for some to disappear or drop out of community programs.

Consequently, the community mental health movement has not shown widespread success and, in fact, has contributed to a new problem—the presence of mental patients living in the community who are ill-equipped to deal with life outside an institution. Many of these patients do not live with their families for various reasons and tend to congregate in ghettos of the mentally ill, where some live lonely, disorganized, frustrated lives in slum environments. Some are homeless and living on the streets, while others are in jails and prisons. Mental disorder remains a major social problem in the United States.

THE TWENTY-FIRST CENTURY: THE NEW GENETICS?

The twenty-first century is still too recent to forecast its approaches to coping with mental disorder. Research on new and improved psychoactive drugs will undoubtedly continue along with advances in understanding brain chemistry. However, a recent and potentially promising development is in the field of genetics. The mapping of the human genome system was completed in 2003 and ranks as a major scientific breakthrough for mental health researchers. It is an established fact that mental disorders can be genetically transmitted from one generation to

the next—causing them to be more prevalent in some families than others. Gene therapy involving alterations or changes in a person's genetic code may be able to prevent an inherited mental disorder. Furthermore, genetic information may be able to help produce "designer" drugs tailored to match an individual's DNA and be more effective in treating the mental problems of people who need this type of treatment. These promising therapeutic procedures await development but may revolutionize the treatment of mental disorder later this century.

In line with this new strategy, the NIMH made the study of genetic and biochemical processes in the brain the priority for research funding beginning in 2013. As we move further into the twenty-first century, the medical model of mental illness has been rejuvenated with an emphasis upon finding the genetic pathways to disturbed behavior. A current focus is on investigating the interaction between genes and the environment in order to determine what causes mental illness. While genes provide the information to create the behavioral traits inherited by individuals, the environment determines which traits are activated and which ones remain dormant. Whether this approach will prove to be more successful than similar efforts to turn psychiatry into a precise medical science remains to be seen. "To date," however, as Horwitz (2020:320) points out, "the extremely sophisticated technologies that view brains and genomes have not produced fundamental breakthroughs in understandings of mental disorders." Pinpointing precise causes and effects in the brain indicative of mental abnormality represents a significant challenge.

SUMMARY

This chapter has defined mental disorder and traced the changing concepts of madness through the ages. We have seen how ideas about the causes of mental illness have changed from those of evil spirits in preliterate times to contemporary views based largely upon medical perspectives. In the twentieth century, there were three revolutions in the United States that initiated highly influential patterns of treatment for the mentally ill: (1) psychoanalysis and the theories of Sigmund Freud; (2) the widespread use of psychoactive drugs to treat mental patients; and (3) the establishment of community care. To date, the twenty-first century has yet to make its definitive contribution to the treatment of mental disorders, simply because it is too early. But new measures may be forthcoming, especially in the area of brain chemistry and genetics now that the human genetic code has been mapped.

Critical Thinking Questions

1. How do sociologists approach the study of mental disorder?
2. Define mental disorders.
3. Describe the evolution of ideas about what causes mental disorders, from primitive times until the present.
4. Explain how the medical model became dominant in the definition and treatment of mental disorders. What is the basis of this dominance?