rather than mental illness. Finally, families might recognize that their relative is experiencing mental problems but define those problems as temporary or unimportant.

Two factors explain how and why families can long ignore behavior that others would label mental illness. First, those who share cultural values, close personal relationships, and similar behavior patterns have a context for interpreting unusual behavior and therefore can interpret behavior as meaningful more easily than outsiders could. Second, families often hesitate to label one of their own for fear others will reject or devalue both the individual and the family. As a result, families have a strong motive to develop alternative and less stigmatizing explanations for problematic behavior.

Moreover, even when relatives and other intimates define an individual as mentally ill, they don't necessarily bring the individual to treatment. Instead, they can continue to protect the individual against social sanctions through a process Lynch (1983) refers to as **accommodation**. Accommodation refers to "interactional techniques that people use to manage persons they view as persistent sources of trouble" and to avoid conflict, such as humoring problematic individuals or minimizing contact with them (Lynch, 1983:152).

Nevertheless, despite these attempts to normalize and accommodate mental illness, families and friends may eventually conclude that an individual needs treatment. At that point, they must either get the individual to agree or coerce the individual into getting treatment despite his or her active resistance. One study of persons seeking care for a serious mental illness for the first time found that 42% had actively sought care and 23% had been coerced (Pescosolido, Gardner, and Lubell, 1998). Coercion was most common among those with bipolar disorder, who often enjoyed the "highs" of mania even though others regarded them as seriously disturbed, and among those with large, tight social networks. In another 31% of cases, families "muddled through": Either the individuals went along with treatment decisions made by others without accepting or rejecting those decisions, or no one in the family seemed to have been in charge of the decision-making process.

Labeling by the Psychiatric Establishment Once individuals enter treatment, a different set of rules applies. Whereas the public tends to normalize behavior, mental health professionals tend to assume illness. First, because the medical model of mental illness stresses that treatment usually helps and rarely harms, it encourages mental health workers to define mental illness broadly. Second, because mental health workers see prospective patients outside of any social context, behavior that might seem reasonable in context often seems incomprehensible. This is especially likely when mental health workers and prospective patients come from different social worlds, whether because they differ in gender, ethnicity, social class, or some other factor. Third, mental health workers assume that individuals would not have been brought to their attention if they did not need care. Finally, because normalization and accommodation are so common, mental health workers often don't see individuals until the situation has reached a crisis, making it relatively easy to conclude that the individuals are mentally ill.

Mental Illness and Identity

Similarly, at some point, most who conclude their troubles are serious also conclude they need treatment but that being mentally ill is an important part of their identity (Karp and Birk, 2013). As one person explained to sociologists David Karp and Lara Birk:

> I am a mental patient. I am a depressive. *I am a depressive* (said slowly and with intensity). This is my identity. I can't separate myself from that. When people know me they'll have to know about my psychiatric history, because that's who I am. (2013:34)

This change in identity, even if it helps individuals find appropriate treatment, can raise difficult questions about the self. First, those considered mentally ill are often feared and rejected by others, even if their symptoms disappear over time (Link et al., 1999; Moses, 2009; Pescosolido, 2013; Schnittker, 2013). Those who identify as mentally ill typically hold the same views and thus experience increased depression, increased social isolation, and lower self-esteem (Link et al., 1999; Moses, 2009). This does not mean, however, that treatment is not worth it, but it does mean that stigma can partially cancel out its positive effects (Karp and Birk, 2013; Link et al., 1999).

Second, the goal of psychiatric treatment is to change essential components of the self: feelings, emotions, and ways of thinking. Especially when the treatment relies on external forces such as surgeries or drugs, it raises the question of whether one's thoughts and feelings are really one's own (Aneshensel, 2013; Karp and Birk, 2013). Am I a happy person, or am I just happy because of the drug? Am I in love with my girlfriend, or is the drug making me feel that way? And so on. Such questions can lead individuals to experiment with drugs and drug dosages to try to find a way to feel not only healthy but also truly themselves.

IMPLICATIONS

In this chapter, we have compared the sociological and medical models of mental illness. As with the medical models of physical illness and disability discussed in Chapters 5 and 6, the medical model of mental illness asserts that mental illness is a scientifically measurable and objective reality that requires prompt treatment by scientifically trained personnel. As such, this model downplays the role of social and moral values in the definition and treatment of mental illness and the effect of mortification and stigma on those who receive treatment.

We now find ourselves facing a situation uncomfortably similar to that of past centuries. As in the years before the Great Confinement, thousands of mentally ill persons now live on the streets and support themselves at least partly by begging. Many more are confined in nursing homes, jails, or prisons in the same way that earlier societies confined persons with mental illness in almshouses. Although drugs largely have replaced shackles, society still allocates far too few resources to provide humanely for those with mental illnesses. Similarly, the Affordable Care

Act expanded access to care for mental illness—but only for those who have insurance coverage. Thus, we can only hope that in the future, with a greater understanding of the nature of mental illness and of the social response to it, we can develop more compassionate and effective means of coping with mental illness.

SUMMARY

1. All societies from simple to complex contain some individuals who behave in ways considered unacceptable and incomprehensible and who might be labeled mentally ill in our society.
2. During the course of a year, approximately one-third of working-age adults experience a diagnosable mental illness, with one-fifth experiencing a moderate or severe disorder.
3. Ethnicity has little effect on rates of *major* mental illnesses. However, African Americans are *less* likely than whites to develop anxiety or mood disorders but *more* likely to report psychological distress, perhaps partly because of the stresses imposed by racism. Hispanic Americans are less likely than whites to develop anxiety disorders, mood disorders, and substance abuse problems, perhaps because strong extended families protect against chronic stress.
4. Perhaps because of gender socialization, men consistently display higher rates of substance abuse and personality disorders, whereas women consistently display higher rates of depression and anxiety disorders.
5. Rates of both diagnosable mental illness and psychological distress increase as social class decreases. Research suggests that occasionally mental illness can cause individuals to drift into the lower classes, but much more often the chronic stresses of lower-class life *lead* to mental illness. Chronic social stress predicts mental illness considerably better than does acute stress, such as life events.
6. Psychological distress is less common among those with more social capital: resources available to individuals through their social network.
7. According to the medical model of mental illness, (a) objectively measurable conditions define mental illness; (b) mental illness stems largely or solely from something within individual psychology or biology; (c) mental illness will worsen if left untreated but is likely to lessen if treated promptly by a medical authority; and (d) treating mental illness rarely if ever harms patients.
8. The sociological model of mental illness argues that definitions of mental illness reflect subjective social judgments regarding whether behaviors are acceptable and understandable. Behaviors are labeled mental illness when they contravene cognitive norms, performance norms, or feeling norms.
9. Research suggests that psychiatric diagnoses are neither valid nor reliable and that the psychiatric diagnostic system has developed through an overtly political process.

10. Premodern societies often could find informal ways of coping with individuals we would consider mentally ill. When they could not do so, they typically blamed the problem on supernatural forces. The development of a capitalist economy fostered a need for new formal social institutions to address mental illness. The 19th century's "moral treatment" movement aimed to improve conditions at those institutions.
11. According to Sigmund Freud, mental illness occurred when children did not respond successfully to a series of early childhood developmental issues linked to the biological body. Freudian analysis was not based in scientific research and proved too costly to implement in large hospitals.
12. By the mid-20th century, most mental hospitals were huge, depersonalizing, "total institutions" that could worsen patients' mental health. The dramatic drop in inpatient censuses at these hospitals is referred to as *deinstitutionalization*, which stemmed primarily from changes in federal funding rather than from improvements in medical treatment.
13. Managed care organizations control health care spending by closely monitoring patient care. They can improve care by promoting the best, most cost-effective treatments but can worsen care by pressing clinicians to offer only short-term, drug-based treatment.
14. Mental health is currently undergoing remedicalization through new psychiatric techniques for diagnosis and treatment and new theories that blame mental illness on individual biological abnormalities.
15. Rates of mental health treatment are highest among those who experience minor emotional problems or stress rather than significant mental illness. Persons with serious mental illness avoid seeking treatment when both they and their families define their behavior as comprehensible and can accommodate to that behavior. In contrast, mental health professionals tend to assume illness rather than health when they examine unusual individual behavior.
16. Based on research findings, some medical authorities now argue that much of what we call mental illness could be better treated by helping individuals make sense of their experiences rather than by giving them diagnoses and drugs. Similarly, the U.S. National Institute for Mental Health has declared that it will no longer fund any research based on diagnostic categories.
17. Although treatment can help, its benefits are reduced by the harm caused by the social stigma of mental illness.