**SOC 3290: Deviance**

 **Overheads Lecture 30: Mental Disorder II**

\* Today we continue our look at mental disorder. We will consider:

 (1) Social Responses;

 (2) Theoretical Perspectives

 **(1) Social Responses to Mental Disorder:**

\* Historically:

 - in ancient Greece, mental disorder revered/ seen as divine favor

 - for most of history, however, mentally disordered treated badly

 (i.e. “Witches,” possession by “evil spirits”)

 - 1700's: confined to “poorhouses,” jails, “hospitals” & freakshows

 - 1793: Philippe Pinel: instituted humanitarian treatment

 - new “asylums” largely developed into “warehouses” until 1950's

 - after 1955: antipsychotic drugs & deinstitutionalization

\* The Public:

 - stigmatize the mentally disordered as dangerous

 - even professionals sometimes slip up

 - illustrated by popular jokes & stereotypes

\* The court:

 (1) Involuntary commitment:

 - hospitalization against one’s will

 - often perfunctory until late 1960's

 - since 1970's courts have been concerned about civil liberties &

 refused to involuntarily commit patients except in extreme cases

 (2) Denying rights:

 - courts can also deny a person the right to trial on a charge if

 mentally “incompetent” to stand trial

 - now done more carefully/reluctantly than before 1970's

 (3) Insanity defense:

 - a legal defense to a crime is that the person was “insane” at the

 time (i.e. no *mens rea*).

 - M’Naghten Rule: did the person know what they did was wrong

 at the time?

 - Durham Rule: is the act the “product” of mental illness?

\* The mental hospital:

 - mental hospitals=total institutions where inmates live enclosed,

 regimented lives, are treated as objects & often abused

 - unintended consequences include angry outbursts, hopelessness,

 “hospitalitis,” staff blindness to conventional behavior, etc

 - not all hospitals necessarily fit negative stereotype, but many do

 - extensive use of antipsychotic drugs (“therapy” or control?)

 - since 1970's, hospitals closing in favor of “community health

 centers” (deinstitutionalization)

\* The community health center:

 - mental patients can receive in/out patient care in their

 own communities: many social services linked

 - compared to professional psychiatry, “network therapy” way of

 providing social support to patients has been helpful

 **(2) Theoretical Perspectives on Mental Disorder**

**\*** Three basic approaches: medical, psychological and labelling

\* Medical model:

 - mental “illness” = a disease with biological origin

 - treated via physical means like drugs, electric shock and surgery

 - claims support from genetic studies /“successful” drug treatments

 - yet only treats symptoms/ genetic studies exaggerated

\* Psychosocial model: (e.g. psychoanalytic theory & stress theory)

(1) Psychoanalytic theory:

 - painful internal conflict between id, ego & superego repressed

 and manifested in psychiatric symptoms

 - “talking cure” suggested

 - concepts not empirically testable

 - taking cure not successful for serious disorders

 (2) Social stress theory:

 - social stress/ life crises manifest as psychological problems in

 some (a minority)

 - availability of coping resources is key to prevention

 - studies inconclusive re: causation (is stress cause or effect?)

\* Labeling model: mental “illness” as a social label imposed on disturbing behavior:

 (1) Thomas Szasz:

 - mental “illness” not objective, but a “myth” to disguise moral

 conflicts in human relations

 - sufferers experience “problems in living”

 - “treatments” benefit others more than “patients”

 - points to growth in number of DSM disorders over time

 (2) Thomas Scheff:

 - mental “illness” as “residual rule breaking” (catch-all category)

 - arises from diverse sources/ many not labeled for behavior

 - labeling can stabilize behavior into chronic mental “disorder”

 - stigma can perpetuate this, even after “treatment”

 (3) R.D. Laing:

 - patients exhibit “sane response to an insane world”

 - patients’ experiences are real to them (“inner” vs. “outer”

 conceptions of/ orientations to space and time)

- patients unhappiness stems largely from untenable social situations/ subsequent stigmatization

- focuses on letting patients “explore” inner world/ think deeply

 until their “return”

\* Criticisms of labeling theory:

 - mental “illness” appears in all cultures, past and present

 (misunderstands use of term “myth”)

 - labeling doesn’t necessarily stabilize behavior into chronic

 conditions (much debate)

\* Next class: the radical psychiatric attack on psychiatry itself