**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