

OCR examination questions

- 1 Identify and explain two ways in which patterns of ill health are influenced by social class. (17 marks)
- 2 Identify and explain two ways in which patterns of ill health are influenced by gender. (17 marks)
- 3 Outline and evaluate the view that class inequalities in health are caused by structural factors. (33 marks)
- 4 Outline and evaluate the view that ethnic inequalities in health are caused by structural factors. (33 marks)
- 5 Outline and evaluate the view that social class inequalities in health are caused by cultural factors. (33 marks)
- 6 Outline and evaluate the view that gender inequalities in health are caused by structural factors. (33 marks)

The social construction of mental illness and disability

Definitions, diagnosis and trends of mental illness

Definitions and diagnosis

Before we look at trends in mental illness and explanations for those trends, we need to think about how mental illness is defined. This is not as straightforward as it might appear because, as [Busfield \(1996\)](#) argues, 'mental disorder stands in a difficult and precarious position between' the following:

- > **physical illness** — where objective criteria can be defined and measured
- > **deviance** — where notions of what is 'acceptable' behaviour involve moral and subjective decision-making

Concepts of mental illness are, therefore, subject to a long-running dispute between health professionals and social theorists 'as to where the boundaries should be set'. In other words, mental illness is a **contested concept** — it has no clear, unequivocal, objective definition. Rather, as [Busfield \(1986\)](#) argues, different groups define, measure and treat mental illness in different ways. We can illustrate this by comparing three different types of **diagnostic model**: medical, psychological and sociological.



Identify and explain one reason why mental illness may be difficult to define.

The medical model

This model has three significant features.

The first is **objectivity**. As with its physical counterpart, mental illness is a real, objective condition.

The second feature concerns **causality**. Causes are internal to the body, the major ones being genetic and biochemical; chemical imbalances in the brain, for example, *cause* abnormal behaviours. Causes are definable by mental health practitioners — those with scientific knowledge and understanding of mental health.

The third feature concerns **treatment**. A range of methods can be successful — from surgical intervention or chemical procedures (using drugs to control or resolve biochemical imbalances) to, ultimately perhaps, gene manipulation. Treatments are **external** in that the patient plays no part in their diagnosis or cure; this is managed by health professionals, with the patient expected to play the **sick role**.

Mental illness is part of the same continuum as physical illness and can be approached in the same way. Just as the body can have a normal or abnormal state (healthy or ill), the mind can similarly be normal or abnormal (mentally healthy or ill). The objective of treatment, therefore, is the removal of the causes of an abnormal state and the restoration of a normal state of mental health.

Psychological models

These models are many and varied, but we can identify three common features, in terms of objectivity/subjectivity, causality and treatment.

Some forms of mental illness, such as schizophrenia, may have biochemical causes and can be treated **objectively**, through the use of drugs or surgical procedures. Others, however, require a more **subjective** approach, for example involving discussion and therapy. [Kinderman \(2005\)](#) suggests that one subjective approach 'examines the events of people's lives to discover how they've interpreted and reacted to these'.

Causality ranges from genetic and biochemical factors to current or childhood traumas; these causes are internal and specific to each individual, and each manifestation needs a specific form of intervention. The majority of these interventions are collaborative; the health professional and the patient work together to identify the problems that have caused the illness.

Treatment is always possible, but the patient is not always 'cured'. Some forms of psychological intervention simply help individuals cope with or manage their illness. While individual cures are desirable, this approach also focuses on the prevention of future illnesses.

Sociological models

The focus of sociological models is not the individual as such, but rather the social and material conditions under which they live. The causes of mental illness are *external* to the individual, either in the **material conditions** of the victim's life (**structural**

approaches) or the **social processes** that lead to them being labelled 'mentally ill' (**interactionist approaches**). We will describe and evaluate each approach in more detail later in the chapter.

Trends

In this section we will outline some basic trends in mental illness based on the categories of class, gender and ethnicity.

Social class

Ortega and Larson (2000) argue that the inverse relationship between class and mental disorder (the higher the class, the lower the level of disorder) 'is now so well established that it has almost acquired the status of a sociological law'. This observation is supported by a variety of statistical evidence. The Centre for Social Justice (2011), for example, found that adults from the lowest 20% of household incomes, when compared with the richest 10%, are:

- three times more likely to have a common mental disorder
- nine times more likely to have psychotic disorders (more serious forms of mental illness which may involve delusions and hallucinations)

Similarly, in terms of the long-term risk of developing a mental illness, the National Centre for Social Research (2011) found that:

- The poorest 20% in England were at greater risk than the richest 20%.
- Manual workers (both male and female) have a higher risk than non-manual workers.

These findings are supported by *longer-term* trends:

- Eaton's (1974) review of 17 mental health studies showed that those with the lowest incomes were at the highest risk of developing schizophrenia.
- Eaton and Harrison's (2001) review of 13 additional studies confirmed this relationship.
- Muntaner et al. (2004) similarly found that higher levels of schizophrenia were associated with lower-income groups.

Gender

As McManus et al. (2009) suggest, women are more likely than men to develop milder forms of mental illness. The National Centre for Social Research (2011) noted that rates of these were higher for women across all classes, income levels and age groups. The higher risk of mental illness was related to social class, with the risk for the poorest 20% of women:

- 2.5 times higher than for the richest 20%
- 2 times higher than for those on average incomes

The general trend over the past 10 years is that levels of risk have stayed fairly consistent for both men and women. In 1999, for example, around 15% of men and 19% of women were at risk of developing mental illnesses; in 2009 the figures were 15% and 17% respectively.

Social class is an important factor in mental illness: women from manual backgrounds have the highest risk. However, its influence needs to be qualified in terms of gender and inequality:

- > **Gender:** The risk of mental illness for women from *non-manual backgrounds* is equal to that of men from *manual backgrounds* — which suggests gender itself is a significant variable.
- > **Inequality:** Kahn et al.'s (2000) American study found that lower income levels correlated with a higher risk of women developing mental illness (both the relationship and the trend are fairly consistent across Western societies). However, they identified a more significant pattern: the risk of female mental illness increased in line with **income inequality**. The greater the difference in earnings between those at the top and the bottom of society, the higher the level of risk.

Ethnicity

Nazroo (1997) argues that there are higher rates of mental illness in ethnic minorities, both black and white, and particularly in Irish ethnicities. However, this has to be qualified by how we *measure* mental illness. In terms of diagnosis, 'the rate of psychosis was no greater among Caribbean men than among white men'; but in terms of treatment, 'Caribbeans, particularly young Caribbean men, are far more likely than whites to be receiving hospital treatment'.

In general, Nazroo suggests that 'ethnic minority status might increase the risk of mental illness, regardless of skin colour':

- > Caribbeans 'had the highest rates of mental illness and were more likely to suffer depression than whites'.
- > Irish and other minority whites (those born outside Britain) had similar rates to Caribbeans.
- > Caribbean women had an increased risk if they were married or cohabiting.

Nazroo's study found the same pattern as most other research: the lower the social class, as measured by occupation and income, the higher the level of mental illness.

The Centre for Social Justice (2011) reports that, despite black and minority ethnic groups having a higher risk of serious (psychotic) mental illness, black people are more likely to:

- > be turned away when they ask for help from mental health services
- > have other problems wrongly attributed to mental health
- > be admitted to hospital through a referral from the criminal justice system
- > have mental health problems which are not detected by a doctor

In terms of common mental disorders, Weich et al. (2004) found higher rates among older ethnic minorities. McManus et al. (2009) found higher rates for white, black and South Asian women — which again suggests the significance of gender, as well as class.

Hatloy (2010) reported higher levels of depressive illness among Pakistani and Indian women, and higher levels of anxiety illness among Irish men and Indian women.

These statistical relationships and trends suggest two things:

- An **inverse care law** applies in the case of ethnic minorities (and probably applies equally well to social class) whereby, as the Centre for Social Justice suggests, 'those who are in most need of support are the least likely to access the services which provide this support'.
- We need to be careful about how we interpret and explain statistical relationships since they are highly dependent on a range of complicating factors:
 - how we define mental illness
 - who defines mental illness
 - the difference between diagnosis and treatment



Briefly explain the meaning of an 'inverse care law'.

Sociological explanations for trends in mental illness

Structural approaches

Structural approaches generally accept medical definitions of mental illness. They treat it as having an **objective** existence whose causes are to be found in **social and material conditions** external to the individual. Mental illness is a **social construction** in the sense that forces outside the individual combine to push them into mental illnesses that range from the relatively mild (such as anxiety or depression) to the relatively severe (such as those involving psychotic or delusional behaviour). The particular focus is on how social and material pressures are experienced by the individual as **stress**. We can discuss this in terms of two ideas: **social resources** and **social power**.

Social resources

Social resources include such things as levels of education and income. The greater the social resources an individual possesses, the lower the likelihood of their developing a mental illness. This idea fits neatly with the statistical evidence we've outlined (the lower the class, the greater the risk of mental illness) and explains mental illness in terms of the extent to which individuals are exposed to stressful events and processes, such as unemployment and poverty. Turner et al. (1995), for example, argue that where the working class experience more stressful life events they develop higher levels of mental illness.

The relationship between social structure, stress and the individual can be explained in a variety of ways. One of the broadest is **strain theory**. This has its origins in the work of Merton (1938), who argued that every society sets goals for its members (such

as the attainment of success and wealth) and provides legitimate means (such as paid work) through which they can be achieved. However, a society may fail to provide these means for everyone: most people in our society, for example, are never going to be wealthy and successful. This creates structural tensions that make the individual react in different ways to the 'denial of success'. One possible reaction is despair — the feeling that nothing the individual does can improve their life. This, in turn, leads to what Merton calls **retreatism**: the individual withdraws from society through alcoholism, drug abuse and, in some instances, mental illness.

More specifically, we can outline some concrete ways in which structural forces stress individuals.

The [Centre for Social Justice \(2011\)](#) argues that social deprivation —involving, for example, low or no income, substandard housing and unemployment — causes 'physical health problems which greatly increase the risk of mental illness'. The risk of mental illness is much higher for those who suffer 'chronic low level stress' stemming from the problems of 'coping with daily hardship and disadvantage'.

A more focused expression of this idea is the concept of the **positive feedback loop** (Figure 11.4), involving a circular relationship between the following factors:

- > material conditions — living in a deprived neighbourhood
- > social conditions — educational failure and family breakdown
- > psychological conditions — social isolation

These conditions create poorer physical health, which increases the risk of mental illness.

Stress theory, based on the pioneering work of [Selye \(1956\)](#), argues that certain 'life events' are more stressful than others. These events can be measured and ranked, using something like [Holmes and Rahe's \(1967\)](#) 'Social Readjustment Rating Scale'. See Table 11.5 for examples of ranked life events. The ranked events can be correlated with higher or lower levels of physical and mental illness. The greater the level of 'stressful events' in an individual's life, the more likely they are to develop mental illness.

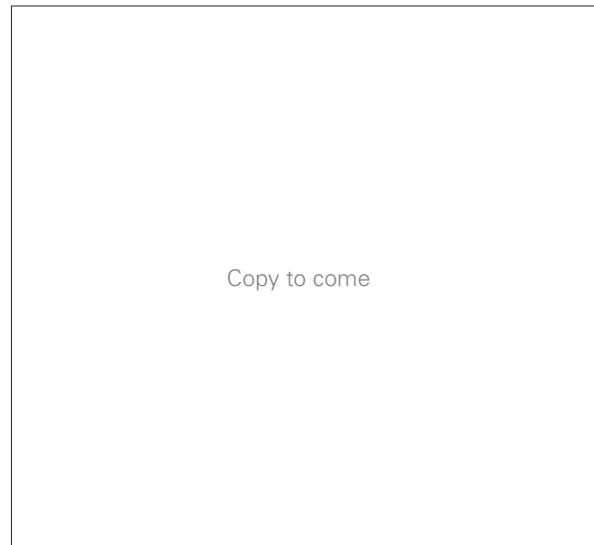


Figure 11.4: Positive feedback loop for health

Table 11.5: Examples of ranked life events

Life event	Life change score
Death of partner	100
Imprisonment	63
Dismissal from work	47
Retirement	45
Change in financial status (e.g. unemployment)	38
Change in working hours or conditions	20
Minor violation of law	11

Source: Holmes and Rahe (1967)

Those who scored 300 or more points on the complete scale of 43 life events were highly likely to develop physical or mental illnesses (Holmes and Rahe 1967). As Thoits (2010) puts it, the theory here is that ‘pile-ups of stressors’ produce high levels of psychological distress that result in the onset or recurrence of psychiatric disorders. However, she notes that only a relatively small percentage of those who scored highly on the scale actually developed mental illnesses.

McManus et al. (2009) found no real association between income and trauma; major traumas, such as death of a partner (100 points) and divorce (73), could strike equally across the class structure. However, they did find that lower-income households suffered higher levels of **post-traumatic stress disorder**, which suggests that some groups are better positioned to *resist* the effects of trauma and stress than others. This, as Thoits suggests, involves the ability to develop **buffers** that limit the effects of stressful life events. These are related to the idea of social power, discussed in the next section.

? Identify and explain one source of strain in working-class life.

Social power

Social power involves the degree of control people feel they have over their own life, their work status and so forth. This version of structural theory argues that the crucial factor in the development of mental illness is not class (or indeed gender and ethnic) differences in *exposure* to stress, but rather differences in the ability to *cope* with such exposure. Different social classes have different access to resources that limit the likelihood of mental illness developing after exposure to stress.

Pearlin and Schooler (1978) argue that, in order to deal with the negative effects of various **life strains**, people employ a range of social and psychological **coping resources** — such as the ability to draw on others (especially close friends and family) as a source of help, comfort and reassurance. Those lower down the social scale have lower levels of **social capital** — access to social networks that might effectively act as ‘buffers’ against stressful life events. They also have lower levels of **social power**: they are less able to develop an active approach to dealing with stressful events. Those

higher up the class scale are more used to solving problems in their everyday working lives and are therefore better positioned psychologically to take the steps required to preserve their mental health.

Additional consequences of differences in social power include:

- > negative attitudes towards psychiatric care
- > the stigma of 'mental illness'
- > a relative lack of access to psychiatric care

These ideas go some way towards explaining differences in diagnosis and treatment. If the lower classes, males and minority ethnic groups are more seriously mentally ill when they finally come into contact with the psychiatric services, they are more likely to be hospitalised. On this basis, [Thoits \(2010\)](#) suggests we need to refine the concept of exposure to stress, for several reasons:

- > Ethnic minority groups have greater exposure to stress created through racial discrimination.
- > Stressors are cumulative 'over the life course and across generations', and the gap between the 'advantaged and the disadvantaged' is affected by class factors. The lower classes are likely to suffer a greater accumulation of stressful life events and do not have the resources available that act as buffers against the impact of such events. For example, although both working-class and middle-class individuals could suffer unemployment, the latter are likely to have accumulated resources such as personal savings, insurance, a network of contacts and educational qualifications that make finding new work easier.
- > Class factors are significant because 'the impacts of stressors on health and well-being are reduced when people have high levels of mastery, self-esteem or social support' — something that is more likely to be the case in the middle and upper classes.



Identify and explain one way in which the middle classes have more social power than the working classes.

Evaluation

An important strength of structural approaches is the ability to explain why mental illness occurs more frequently among **disadvantaged groups**; they provide an explanation for the **non-random distribution** of mental illness:

- > **Social class**: Lower social classes experience greater strains and have a lower ability to cope with these strains.
- > **Gender**: Higher rates of female mental illness are explained by the greater levels of stress that result from a combination of paid and domestic employment — what [Muntaner et al. \(2004\)](#) term the 'double burden of home and work stress'. In basic terms, the 'pressure to cope' is much greater for women because they experience more stress through the dual action of class and patriarchy. Women not in paid

employment are also more likely to be cut off from wider social networks, as are single parents (the majority of whom are women), and this means they can muster fewer ‘coping resources’ at times of great personal stress.

- **Ethnicity:** Many ethnic minority groups in our society suffer a ‘double disadvantage’ in the sense of being more likely to experience both poverty and discrimination — both of which are significant sources of stress.

This general approach is not, however, without its critics. The **natural selection** approach (sometimes called **diathesis–stress theory**) argues that some individuals or groups have a greater predisposition towards mental illness than others. This disposition might be:

- genetic — a product of certain gene combinations
- biological — due to a chemical imbalance in the brain
- social — involving, for example, inadequate childhood socialisation or a mentally ill parent
- psychological — stemming, for instance, from an undiagnosed childhood trauma

However, the argument here is that ‘stress’ is merely the **trigger** for mental illness, not its cause— it is only when a ‘predisposed individual’ is placed under stress that their predisposition comes to the fore.

Another criticism comes from the **social selection** approach. While structural theories argue that low social class is a *cause* of mental illness, the ‘drift hypothesis’ suggests the reverse — mental illness causes individuals to ‘drift down’ the class structure because they find it impossible to retain work and earn an income.

A further criticism of structural approaches comes from interactionist approaches, discussed in the next section.

Interactionist approaches

Interactionist sociologists take a different approach to understanding mental illness from their structural counterparts (Table 11.6).

Table 11.6: Structuralist and interactionist assumptions about mental illness

Structuralist assumptions	Interactionist assumptions
Mental illness is a real, objectively defined condition.	Mental illness is a subjective condition created by the official labelling of some behaviours as ‘mentally ill’.
Mental illness can be statistically measured and quantified.	Statistical measurements are no more than the quantification of official labelling processes. What is being quantified, therefore, is not ‘mental illness’ itself, but rather how certain behaviours are socially defined.
The non-random distribution of mental illness in terms of class, gender and ethnicity is explained by the different social and material conditions that act on differently placed individuals.	The non-random distribution of mental illness is explained by a greater willingness of medical professionals to label the relatively powerless (lower social classes, women and ethnic minorities) as mentally ill.

Interactionist approaches see mental illness as socially constructed in terms of the way behaviour is so **labelled**. If the label and status 'mentally ill' did not exist, mental illness would not exist — the behaviour would be called something else and people would relate to it in a different way.

Mental illness is seen as behaviour that deviates from the norm of mental health. Following [Becker's \(1963\)](#) argument, the way to understand deviance is not to focus on what people *do*, because different people can display exactly the same behaviour but be *treated differently*. [Busfield \(1996\)](#) expresses this neatly when she argues that 'men's mental life and behaviour...are more likely to be regulated through attributions of wrongdoing, women's through attributions of mental disorder' — or, to put this more colloquially, 'Men are bad; women are mad'.

The argument here is that deviance (mental illness in this case) is not a quality of the act (what someone does) but a quality of how someone else reacts to what someone does — and the most significant 'reactors' in terms of mental illness are medical professionals, those who have the power to attach the label of mental illness to some forms of behaviour.

Interactionists are also concerned with **regulation**. If 'mental illness' is little more than a label applied to certain types of behaviour, interactionists want to understand how and why, as [Busfield \(1996\)](#) suggests, *similar* behaviours come to be regulated *differently*.

[Foucault \(1961\)](#), although by no means an interactionist, touches on these matters when he argues that 'madness', as we now think of it, is related to two ideas:

- **Reason:** The development of scientific thinking in the eighteenth century led to the idea that the natural world was ordered and rational — it obeyed certain physical laws that could be identified and explained. This led to the view that if rationality was a normal state then anything **irrational** must be **abnormal** — hence the idea of 'madness' to describe some forms of behaviour that were 'not normal'.
- **Control:** Where some forms of behaviour are seen as abnormal, they have to be controlled, and in the spirit of scientific development of the age these controls became ever more elaborate. They focused initially on controlling the **bodies** of those behaving irrationally and abnormally, **institutionalised** through confinement and separation from normal society. Prisons became the norm for criminals, mental institutions and asylums the norm for those labelled mad. A professional class developed who had a vested interest in ensuring that only they had the power to define abnormality, and that 'madness' was given a rational reading and explanation.

These notions of reason and control illustrate the interactionist idea that no behaviour is inherently deviant; what's significant is how people react to and label different forms of behaviour. The focus of interest, therefore, is explaining how behaviour comes to be defined as 'mad'. For Foucault, as for many interactionists, 'madness' is not an objective medical condition; it is a subjective social category defined by powerful vested interests.

We can explore this idea further by considering different ways in which interactionists have theorised mental illness.

The myth of mental illness?

Szasz (1961) argues that mental illness is a condition constructed by psychiatric professionals who apply an official medical label to behaviours that deviate from commonsense notions of normality. Szasz (1998) further suggests that we should see mental illness as a **metaphor** or metaphorical disease that has no biological origin or basis. Rather it is simply a convenient way to categorise 'thoughts, feelings, and behaviours' considered by some to be socially undesirable: 'Individuals with brain diseases (bad brains) or kidney diseases (bad kidneys) are literally sick. Individuals with mental diseases (bad behaviours) are metaphorically sick.'

Szasz argues that labelling certain types of 'undesirable behaviour' as mental illness provides a justification for **social control** — either physical or chemical incarceration (the latter involving the control of behaviour through the use of drugs). In this way, people whose behaviour is considered problematic for a ruling elite (the working classes, ethnic minorities) can be legally and justifiably controlled through the agency of the medical profession.

A contemporary extension of this view focuses on the **medicalisation of self and society**. This involves two broad ideas.

The first idea concerns '**problems of the self**', and the way we are encouraged to seek medical solutions to such problems (to deal with various traumas, for example). In this way a wide range of 'normal behavioural responses', from 'depression' through 'anxiety' to 'panic', are labelled 'mental illnesses'. These 'illnesses' (and the bodies to which they are attached) are then controlled through a range of treatments, from talking therapies to drugs.

The second idea concerns various behaviours labelled as '**problems for society**', from the misbehaviour of children to female crime. These are seen as medical conditions requiring treatment. Davis (2010), for example, reports the increasing use of Ritalin to treat Attention Deficit Hyperactivity Disorder (ADHD), a condition that first appeared in the mid-1980s. She notes that:

...professionals have argued over the use of such drugs. Some believe they treat a legitimate problem. Others, such as Dr Gwynedd Lloyd, refuse to acknowledge ADHD is even a medical condition. 'You can't do a blood test to check whether you've got ADHD — it's diagnosed through a behavioural checklist... Getting out of your seat and running about is an example — half the kids in a school could qualify under that criterion. I know a lot of children have genuine difficulties, and some of these are biological, but most are social and cultural.'

For interactionists, the medicalisation of self and society owes more to the power of medical professionals to label behaviour as ‘mental illness’ than to any real increase in this condition. This was demonstrated in an experiment carried out by [Rosenhan \(1973\)](#). It was designed to discover if doctors could correctly diagnose mental illness. If they could not, he argued, this would tell us something very important about the relationship between mental illness and labelling — that mental illness is not an objective but a subjective condition; that it is whatever medical professionals claim it to be.

Rosenhan and seven of his students became pseudopatients: they pretended to be suffering from some form of ‘mental illness’. They got themselves admitted to 12 hospitals on the basis that they were hearing a voice saying ‘hollow, empty, thud’. This was interpreted by the hospital staff as a symptom of schizophrenia. [Taylor \(forthcoming\)](#) writes:

Once admitted to the hospital the pseudopatients stopped faking the symptom and behaved normally. When asked by the staff how they were feeling, they said they were fine, the symptom had disappeared and could they please be released... [However,] the pseudopatients remained in hospital for between 7 and 52 days. It seemed behaving normally was not enough to get out of a mental hospital, you had to accept the diagnosis first...and they were all finally released with a diagnosis of schizophrenia in remission.

The implication of this experiment is that ‘mental illness’ only exists because we begin with a label (and a set of characteristics we associate with it) that we then apply to particular forms of behaviour. This process reverses cause and effect; rather than a cause (mental illness) coming *before* the label (the effect), the effect (labelling) comes *before* the cause. In other words, we only *know* behaviour is mental illness because that’s how medical professionals label it. Rather than an objective, quantifiable medical condition producing a specific label (‘schizophrenia’), the label defines the condition.



Suggest and explain one reason for seeing mental illness as ‘a myth’.

A contemporary example cited by the [Centre for Social Justice \(2011\)](#) is that while black Caribbeans don’t show greater levels of psychosis than any other group, the police are more likely to refer them for treatment. In addition,

...staff in mental health hospitals are more likely to perceive them as potentially dangerous and psychiatrists are more likely to consider this group as potentially dangerous to others. It is therefore possible that African Caribbean people are more likely to be diagnosed with psychosis *because of bias among those who treat them*.

Similarly, Scheff (1999) argues that we can explain class differences in mental illness not as *real* differences resulting from differential exposure to structural strains, but rather as *artefact* differences: the tendency for middle-class professionals to label as mentally ill a disproportionate number of the powerless (those who are less able to challenge medical labelling). Scheff further argues that labelling processes create a **self-fulfilling prophecy** that contributes to the confirmation of the original label. Once a label has been successfully applied:

- The individual is encouraged to acknowledge their illness in order to be 'cured'.
- The individual is rewarded for behaving as a 'good patient'. Scheff argues that we frequently learn the 'stereotypical behaviours of mental illness' from an early age, through the media and so forth.
- Once discharged, the individual has acquired a **master status** as 'mentally ill' that affects how others behave towards them.
- This reinforces the mentally ill identity — and may have real psychological consequences, stemming from feelings of rejection, social isolation, an inability to secure employment and so on.



Identify and explain one reason for believing class differences in mental illness are not *real* differences.

Evaluation

While interactionist theories have sensitised us to a range of significant ideas about how mental illness is socially constructed, these approaches are not without their criticisms:

- While it is conceivable that a range of behaviours should not be treated as mental illness, this doesn't necessarily mean mental illness doesn't exist — particularly those types that can be traced to clear genetic or biological causes. By suggesting mental illness is 'just a label', we risk denying help to those who may be suffering from a real, definable condition.
- Labelling doesn't successfully explain why some forms of mental illness (but not others) are distributed equally across class, gender and ethnic groups. If mental illness were simply an artefact, we would expect to see far higher levels among the working classes and far lower levels among the higher classes.
- The idea that labelling is itself a 'cause' of mental illness doesn't explain why people should present themselves with symptoms (some extremely serious) in the first place, prior to any labelling process. This suggests that defining mental illness is a more complex process than interactionist approaches imply.

Disability

The social construction of disability refers to the way different societies interpret the meaning of physical and mental impairments. For example, notions of disability in our society frequently carry with them the meaning of damage — 'the disabled' are not

only different but also *inferior* to those who are not disabled. In other words, through a failure to meet cultural notions of a ‘normal’ physical or mental state, disability is seen as a **damaged status**, undesirable and hence **stigmatised**.

More generally, Table 11.7 illustrates changing concepts of disability over time. It shows how the disabled have been treated in line with changing ideas about the causes of physical and mental impairment.

Table 11.7: Changing concepts of disability

Treatment	Cause
ANCIENT GREECE AND ROME (5TH CENTURY BC)	
Greece: Infanticide widely practised, sometimes obligatory for ‘imperfect children’.	Metaphysical (not explicitly linked to physical causes), e.g. disability as a punishment for sin.
Rome: Infanticide practised for the ‘sickly’ or ‘weak’. Those with no visible impairment at birth harshly treated as adults. Physically impaired (such as deaf or blind) considered objects of curiosity or ridicule and sometimes made to fight ‘for the amusement of the public’ in Roman Games.	Physiological: Wealthy Romans attempted ‘cures’ for physical and mental impairments using hydrotherapy and fitness regimes.
EARLY CHRISTIAN (2ND CENTURY AD)	
Exclusion: the physically and mentally impaired separated from ‘normal society’. Some notion of caring for the disabled, directly or indirectly, through giving alms (such as money and food).	Disability seen as ungodly and the consequence of immorality, wrongdoing and sin.
MEDIEVAL EUROPE (15TH CENTURY)	
Exclusion from society with the disabled relying on ‘Christian charity’. Some severely disabled admitted to hospitals for the ‘poor, sick and bedridden’. Some religious groups advocated infanticide.	Religious notions of the link between disability, impurity and sin. Also link between disability and the Devil (the disabled were ‘living proof’ of Satan’s power). Disability sometimes seen as punishment for mother’s involvement in witchcraft.
17TH-CENTURY EUROPE	
Introduction of some government aid for ‘deserving poor’ (such as the disabled). Impairment as source of amusement and ridicule; ‘idiots’ often kept by the wealthy. Physically disabled frequently put on show with mental asylums (such as Bedlam) open to the public.	Notions of disability still related to ideas about sin, but not as strongly as in the past. Scientific ideas start to develop about the physiological basis of disabilities.
19TH-CENTURY EUROPE	
Development of modern ideas about disability. Physically and mentally disabled excluded through institutionalisation (in hospitals and asylums). Establishment of ‘charities for the disabled’, run by the able-bodied.	Greater understanding of medical causes of disability. Initially physical, but gradual development of the idea of mental illness (through the work of Freud, for example).

Source: adapted from Barnes (1997)

We can examine contemporary ideas about disability by outlining two models developed by Oliver (1983): the individual or medical model, and the social model.

The individual or medical model

This model sees disability in terms of two ideas:

- **Individual:** Disability is 'inherent in the individual' and it is their responsibility to cope with and overcome the limitations of their condition. This also 'promotes the notion that it is the disabled individual who must adapt to the way society is constructed and organised'.
- **Medical:** The disabled are 'defined by their illness or medical condition' and are dependent on others for care and/or cure. Both of these situations are medicalised, in the sense that 'proper care' needs to follow medical guidelines and the ultimate solution to the 'disability problem' is a medical cure.

Under this model the disabled individual, rather than the way society is organised, is seen as 'the problem'. As Oliver argues, the inability of the disabled to live a 'normal life' stems from their physical and/or psychological condition, and the 'solution' to this problem is twofold:

- **Care:** In the short term at least, the disabled have to be looked after by others. The objective is to ensure that they participate as fully as possible in social relationships, albeit with limitations imposed by their condition.
- **Cure:** In the long term the aim is to find a medical cure for the disabling condition.

As Oliver notes, both solutions suggest that disability is a 'personal tragedy' and also carry with them notions of **non-culpable forms of deviance** — the disabled are different. The perception of disability as deviance is reinforced by the medical model, Oliver argues, because it gives power to medical professionals and takes it away from the disabled individual:

- It confirms the view of disability as something different and undesirable; disability is seen as a '**broken condition**' that needs to be fixed.
- It teaches the disabled to depend on others. To 'cope' with their disability, the disabled must '**learn helplessness**' — they must allow others to take control of their lives and environment if they are to be 'helped' to overcome their limitations.

In general terms, the medical model serves three specific functions:

- **Individualising deviance:** It places responsibility for disability on the individual, who must learn to both cope and submit to care.
- **Boundary setting:** By defining some people as abnormal or deviant, the model also defines the 'boundaries of normality'.
- **Normalisation:** Definitions of abnormality are reinforced because the model aims to 'normalise the disabled' through the **medicalisation** of their condition.



Identify and explain one feature of the medical model of disability.

Evaluation

- **Stereotypes and stigma:** Defining the disabled as different stigmatises this identity as something undesirable and unfortunate. As the disabled are forced to fit, as best they can, into 'normal society', this group — although defined more by their differences than their similarities — are stereotyped by notions of abnormality.
- **Discrimination:** The disabled are subject to punitive **social controls** which are not extended to the able-bodied. These controls determine where they can go, what they can do, who they can associate with — and even, on occasion, whether they're allowed to be born.
- **Self-fulfilling prophecies:** By treating the disabled as different and incapable, the medical model emphasises the negative aspects of disability. This, in turn, makes the disabled see themselves as helpless.
- **Separation:** The model sets the disabled apart from the abled, for example in special schools. This reinforces the notion of difference they aim to resolve.
- **Medicalisation:** Oliver argues that disability is not a medical condition, but a **social state**. We should view disability as an aspect of 'normality' and treat the disabled accordingly — both in interpersonal terms, for instance through the removal of stigmatising language, and in environmental terms, by finding ways to realign the environment to allow the disabled to enjoy the same rights and freedoms as the abled.

The social model

This model argues that disability is a problem for society, rather than the individual. This idea is expressed in the distinction made by **UPIAS (1976)** between impairment and disability:

- **Impairment** refers to the lack of something, such as a limb, that inhibits the normal functioning of the body (or mind).
- **Disability** refers to restrictions caused by the way societies are organised for the benefit of the able-bodied (a simple example being steps, rather than ramps, as a way of entering buildings).

This distinction changes the focus of disability away from the individual and the problems they cause society, and towards the society and the problems *it* causes the impaired.

It is also important because it changes our interpretation of 'disabled'. Rather than defining it **negatively** as 'not abled', it is possible to define it **positively** as 'differently abled' (**diffabled**). This, in turn, suggests that 'disability' and 'ability' are dimensions of the same process. Just as the 'abled-bodied' display differences in ability (some being more mobile than others, for instance), the same is true of impairment.

? Identify and explain one difference between impairment and disability.

The social model argues, therefore, that in any society where large numbers of people have physical and mental impairments, the onus is on society to adjust to this situation. If the design of the built environment makes access for people with mobility problems

an issue, the solution is not to exclude them; rather it is to change the environment to enable their inclusion. In this respect, [Oliver \(1990\)](#) suggests that the social model has a number of characteristics:

- Disability is seen as a **'failure of society'**, not the individual, when it fails 'to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account'.
- **Inclusion**, rather than exclusion, is seen as the key to engaging with disability. The social model argues that differently-abled people should be able to 'participate in activities on an equal footing'. This involves removing various barriers to inclusion:
 - **Material:** Someone in a wheelchair is only 'disabled' in an environment that does not allow full mobility and access.
 - **Non-material:** It is also important to deal with problems that stem from seeing the disabled as not just different but in some way inferior (**negative stereotyping**).
- **Discrimination** against the impaired is seen as institutionalised. Society 'disables' people, through designing everything to meet the needs of the majority of people who are not disabled'.



The built environment can be designed to maximise access and mobility for disabled people

Evaluation

- **Disabled identities:** The social model assumes that those with impairments see themselves as having a common identity as disabled — but many disabled people reject this notion. Insisting on a single 'disabled identity' simply reflects the power relationships present in the medical model, with the definitions of medical professionals replaced by those of 'society' or various interest groups.
- **Design:** [Finkelstein \(1981\)](#) argues that modifying physical environments to allow 'total inclusion' is 'an unsustainable myth' — removing barriers for one form of impairment may, for example, generate barriers to other forms. In addition, [Shakespeare and Watson \(2002\)](#) argue, 'If someone has an impairment which causes constant pain, how can the social environment be implicated?'
- **Outdated:** [Shakespeare and Watson \(2002\)](#) argue that the social model is an 'outdated ideology' for three reasons:
 - **Denial of difference:** The model denies there is any real difference (aside from that created 'by society') between the disabled and the abled — yet disabled individuals may live with pain and disability not experienced by the able-bodied.

This model, by denying difference, takes away from the disabled an important part of their identity.

- **Impairment or disability?:** The model argues that the former is a creation of bodily difference while the latter is socially created. However, by focusing on impairment the social model argues that physical and mental differences are actually *more* significant than the medical model suggests.
- **Only and always disabled?:** By arguing that society is the cause of disability, the model assumes that individuals are either disabled (and always will be) or they are not (and never will be). However, many people experience impairment in less dramatic terms, often moving through 'different states of ability' (as with gradual loss of eyesight with age).

OCR examination questions

- 1 Identify and explain two ways in which disability can be seen as socially constructed. (17 marks)
- 2 Identify and explain two ways in which mental illness is related to gender. (17 marks)
- 3 Identify and explain two ways in which mental illness is influenced by ethnicity. (17 marks)
- 4 Outline and evaluate the view that disability is socially constructed. (33 marks)
- 5 Outline and evaluate interactionist views of mental illness. (33 marks)

The role of health professionals in society

Sociological explanations

We've referred at various points to the role played by **medical professionals** in areas like the diagnosis and treatment of illness and impairment. In this section we will examine their role in more detail, from a range of sociological perspectives.

Functionalism

For functionalists society is seen as a **social system**, organised around a general **value consensus**, where the constituent parts (**institutions** such as the family, education and health) contribute to the overall maintenance and reproduction of the system. In this respect, functionalists generally consider healthcare in terms of two types of role:

- *the general role* played by the health institution in the overall social system
- *the specific individual roles* that need to be performed within the institution for it to successfully function