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An Overview of Sociological Perspectives on the Definitions, Causes, and Responses to Mental Health and Illness

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Sociological approaches regard mental health and illness as aspects of social circumstances. One type of sociological study examines the sorts of social conditions, such as negative life events, ongoing stressful circumstances, demanding social roles, levels of social support, and the strength of cultural systems of meaning, that affect levels of mental health and illness. Another type of study focuses on how social and cultural influences shape the definitions of and responses to mental health problems. These kinds of studies show how key recent trends – including the medicalization of a growing number of conditions, the increased use of prescription drugs to deal with mental health problems, and a greater willingness to identify emotional suffering as mental illnesses that require professional help – are transforming how modern societies deal with psychological problems. The sociological study of mental health and illness is both distinct from and complementary to more individualistic psychological and biological approaches to these topics. What would be an example of the difference between how a sociologist and a psychiatrist might view someone's mental health problems? What are the advantages and disadvantages of each approach? Some people think that using prescription drugs for mental health problems is a helpful way of responding to suffering, whereas others emphasize the dangers involved in growing rates of prescription drug use. Which view do you think is best supported?

Introduction

Why do some people seem to be always cheerful, whereas others are often sad? Most of us believe that our moods have to do with aspects of our personalities that make us more or less depressed, anxious, or exuberant. Others think that temperament results from biological factors such as our genes and neurochemicals. People usually also assume that engaging in therapies that change their states of mind is the natural response to mental problems. These treatments might involve psychotherapies that modify the way people view the world or drugs that alter their brain chemistry. Thus, typical approaches to the nature, causes, and cures of various states of mind emphasize individual traits, temperaments, and behaviors.

Sociological approaches to psychological well-being are fundamentally different. Unlike psychological and biological perspectives that look at personal qualities and brain characteristics, sociologists focus on the impact of social

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circumstances on mental health and illness. The distinctive emphasis of sociological approaches is on how processes such as life events, social conditions, social roles, social structures, and cultural systems of meaning affect states of mind. Social perspectives assume that different individuals who are in the same circumstances will have similar levels of mental health and illness. That is, what determines how good or bad people feel does not just depend on their own personalities or brains but also on the sorts of social conditions they face. These conditions vary tremendously across different social groups, societies, and historical eras.

Some important social influences involve how many stressful life events people confront (Holmes & Rahe, 1967). These events include such circumstances as getting divorced, losing a valued job, having a serious automobile accident, receiving a diagnosis of a serious physical illness, or having a close relative die. Especially serious stressors such as being a victim of a violent crime, natural disaster, military combat, or physical or sexual abuse during childhood are particularly powerful causes of adverse mental health outcomes (Dohrenwend, 2000). The more frequently such events occur and the more serious they are, the worse any person's mental health is likely to be.

Other social causes of poor mental health lie in persistent living conditions that do not appear at a particular time and then go away but are instead rooted in ongoing circumstances (Turner, Wheaton, & Lloyd, 1995). For example, people who live in social environments that feature high rates of poverty, neighborhood instability, crime rates, dilapidated housing, and broken families are likely to have high rates of psychological distress (Ross, 2000). Other enduring stressful circumstances are troubled marriages, oppressive working conditions, or unreasonable parents. Sociological perspectives predict that especially taxing living conditions, roles, and relationships are related to low levels of psychological well-being, over and above the qualities of the particular individuals who must deal with these situations.

Many sociologists study how social conditions affect levels of mental health. Others look at the social reactions to mental health problems. Some factors that lead people to respond to emotional difficulties in different ways involve social characteristics such as gender, ethnicity, age, and education. These traits make people more or less likely to define themselves as having some kind of psychological problem and to seek help once they have made these definitions. Other aspects involved in the reaction to mental troubles concern varying cultural values toward mental health and illness. *Culture* refers to socially shared systems of beliefs, values, and meanings. It encompasses, among many other factors, people's ethnic heritage, religious beliefs, and political principles and the tastes of their age peers. For example, responses to emotional problems in cultures that stigmatize the mentally ill will be very different from those in cultures that highly value professional treatment for these problems. Additional factors that shape the social response to psychological problems involve the accessibility, quality, type, and amount of health care that is available to people.

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Sociological approaches share the idea that mental health and illness are not just qualities of individuals but also stem from various aspects of social circumstances. What social groups people belong to, what historical periods and societies they live in, and what cultural values they hold profoundly shape how people feel about themselves, how likely they are to become mentally ill, the kinds of problems they are likely to develop, what they do if they develop mental difficulties, and the kinds of help that are available to them.

What Outcomes Do Sociologists Study?

Most sociologists examine levels of mental health and illness in the natural settings where people live. Sociological research is more likely to take place in schools, family settings, neighborhoods, and communities than in clinical settings where people seek professional mental health care. Therefore, the kinds of mental health conditions that sociologists study are usually different from those examined by other disciplines such as psychiatry or clinical psychology.

Most research that takes place in clinical settings examines particular types of mental illnesses, such as schizophrenia, bipolar disorder, major depression, and obsessive-compulsive disorder. These conditions have symptoms that are believed to indicate the presence of some underlying disease entity and that are different from the symptoms of other diseases. Diagnoses of particular mental disorders are usually dichotomous; that is, someone either has or does not have an anxiety, depressive, substance abuse, attention-deficit, or eating disorder.

In contrast, most sociologists use outcomes that reflect more generalized conditions of distress, not particular types of mental illnesses. For example, the Center for Epidemiologic Studies–Depression scale (CES-D) is the most common instrument that sociologists use to measure mental health (Radloff, 1977). It consists of 20 questions that ask people how they have felt over the past week; for example, "I enjoyed life," "My sleep was restless," or "I felt lonely." The scale is not comparable to any specific mental illness, but instead contains items relating to more global states of well-being. Many of its items (e.g., "I felt hopeful about the future," "I felt I was just as good as other people") tap general attitudes about life or personal qualities such as self-esteem. The CES-D and other scales that sociologists typically use measure global qualities of well-being rather than discrete psychiatric conditions.

The broad nature of these outcomes means that they provide good measures of general states of psychological well-being or ill health, but are not comparable to psychiatric diagnoses and do not measure mental illness. In addition, scales such as the CES-D are limited because they only measure qualities of mental health that reflect internal types of suffering. They do not contain items that ask about other possible indicators of mental health such as heavy drinking or drug taking, violent and aggressive behavior, or severe symptoms such as delusions and hallucinations.

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To adequately capture the full range of psychological symptoms, these scales need to be supplemented by a broader range of mental health outcomes.

Sociologists who examine the social response to emotional problems must use different sorts of outcomes from those used in studies that examine the social determinants of well-being and distress. They do not try to explain how symptoms develop in the first place; rather, they ask how, once symptoms emerge, sufferers themselves and others around them define, classify, and respond to experiences of mental distress. Some of these studies ask people about their attitudes toward mental illness and see how their answers reflect who does or does not enter mental health treatment. Others use official statistics that are collected about how many people with psychological problems enter different kinds of facilities such as general medical practices, outpatient psychiatric care, or inpatient mental hospitals. They then view how rates of various kinds of treatment vary across groups with divergent social characteristics such as race, socioeconomic circumstances, and immigrant status. Another type of study compares treatment rates across large geographic areas such as different states, regions of the country, or different countries to see how general aspects of the mental health system influence patterns of seeking professional help. For example, far more people with mild psychological problems are likely to enter professional mental health treatment in the United States than in other countries (Katz et al., 1997).

Sociological studies, then, are less likely than clinical studies to use small groups of people who are found in mental health treatment. Instead, they use general scales that measure mental health in samples of community members. They also rely on statistics about rates of mental health care across a wide range of facilities and regions. These studies are good at showing broad social variations in the development of and response to psychological problems, although they are unable to say much about individual experiences of mental health and illness.

What Social Factors Relate to Mental Health and Illness?

Sociological studies reveal that psychological well-being and distress are related to several general aspects of social life: the degree of social integration, inequality, and meaningful collective belief systems. In addition, the periods of time when individuals were born and the countries they live in are associated with their states of mental health. The influence of these factors means that levels of mental health diverge considerably among people in different social locations.

Social Integration

Emile Durkheim's study, *Suicide*, is generally regarded as the first explicitly sociological study of mental health (Durkheim 1897/1951). Durkheim compared the rates of suicide in different European countries at the end of the 19th century

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and correlated them with various social characteristics of the populations of these countries. His central theme was that the nature of the connections people have with each other and with social institutions shapes the likelihood that they will commit suicide. He found that people with strong social ties were least likely to commit suicide. Conversely, people who were socially isolated were more likely to commit what Durkheim called "egoistic" suicides. For example, married people had lower suicide rates than the unmarried, and married people with children were especially unlikely to commit suicide. Likewise, members of religions such as Catholicism that shared common practices and beliefs committed a smaller number of suicides than members of Protestant groups that permitted more free inquiry among individuals. In addition, Durkheim discovered that few people commit suicide during wars and revolutions because of the intensity of shared collective experiences in such periods.

Durkheim also found that a second aspect of social integration, which he termed "social regulation," affected levels of what he named "anomic" suicide. Groups that could successfully control individual expectations for constant happiness and great achievement had lower suicide rates than groups in which most people think that limitless possibilities for success exist. This was because people who always expect to be happy and believe that there are no limits on what they can achieve are bound to suffer serious disappointments. Periods of sudden economic prosperity, for example, can lead people to think they can satisfy all of their desires. Such unrealistic beliefs lead some people to become frustrated and consequently to commit suicide. Durkheim concluded that optimal mental health was found in societies that had strong systems of social integration that connected people to each other and of social regulation that moderated their desires.

Contemporary studies in the sociology of mental health confirm the importance of social integration as a fundamental cause of well-being. For example, people with more frequent contacts with family, friends, and neighbors and who are involved with voluntary organizations such as churches, civic organizations, and clubs report better mental health than those who are more isolated (Thoits & Hewitt, 2001). Married people have less distress than unmarried people because they have more supportive relationships and more ties to community institutions (Umberson & Williams, 1999). Marriage also serves the regulative functions of promoting conformity to social norms, more conventional lifestyles, and lower levels of all kinds of deviance (Umberson, 1987). Conversely, the loss of social attachments that may be caused by the death of intimates, divorce, and the breakup of romantic attachments is associated with growing levels of distress. Socially integrated people not only are less likely to develop mental health problems but they are also better able to cope with stressful experiences that they face (e.g., House, Landis, & Umberson, 1988; Turner, 1999). This is because they receive more social support, help, and sympathy from the members of their social networks.

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Residents of communities that feature more social integration also have better mental health. After taking into account the characteristics of individuals who live in them, localities that are clean and safe, feature strong and respectful relationships among residents, and have well-maintained housing foster mental health (Aneshensel & Sucoff, 1996; Ross, 2000). In contrast, areas with little cohesion and connectedness among their residents promote psychological distress. Social integration is associated with positive mental health – humans derive satisfaction from valued intimate relationships and suffer when their circumstances deprive them of these relationships.

Social Stratification

Whereas social integration involves relationships characterized by closeness, support, and friendship, social stratification involves interactions featuring differences in power, status, and resources. A considerable body of research indicates that people who are more powerful, of higher status, and wealthier also have better mental health compared with those who possess fewer resources. In addition, relationships that are relatively egalitarian promote more overall positive mental health than those that feature sharp distinctions in the amount of power and control that each member has (Mirowsky & Ross, 2003).

Inequality

Inequalities in wealth, power, knowledge, influence, and prestige, which define social class status, have powerful impacts on mental health (Link & Phelan, 1995). Poverty, which involves not only economic deprivation but also undesirable working conditions, physically hazardous environments, marital instability, and unhealthy lifestyles, is especially associated with poor mental health (McLeod & Nonnemaker, 1999). High socioeconomic status (SES) also enhances well-being, although the negative effects of impoverished circumstances on poor mental health are stronger than the positive impact of economic abundance on psychological welfare. Likewise, people who suffer declines in their economic status see their mental health deteriorate, whereas those who gain resources also achieve better mental health.

One unresolved issue is whether well-being depends on the absolute or the relative amount of resources people have. If the absolute amount of assets predicts happiness, then the wealthy will have good and the poor will have inferior states of mental health. If, however, mental health depends on how one's own resources compare to those of other people, then even the very wealthy can be unhappy when they have fewer goods than others to whom they compare themselves. For example, a professional basketball player who is a millionaire might be unhappy because he is the lowest paid member of his team. Conversely, people who don't

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make much money might be quite happy if those that they evaluate themselves with are also poor.

Work conditions also have important impacts on psychological well-being (Lennon, 1994). Jobs that are autonomous, creative, and complex and in which a person has control over others enhance mental health. Conversely, those that are tedious, routine, oppressive, and lack autonomy lead to much distress. Worst of all is having no job: unemployed people have the poorest mental health of any economic group.

Social inequality relates not only to economic and work conditions but is also an aspect of all social institutions. For example, the dominant party in a marriage reports better mental health than the less powerful spouse. Because husbands are usually more powerful than wives, they generally also report better mental health. However, this is not always the case. In the relatively few cases in which married men have fewer resources than their wives, they also have higher rates of distress than their spouses (Rosenfield, 1980). Egalitarian marriages lead to the best mental health (Mirowsky, 1985). Spouses who share child rearing and chores report better mental health than do those for whom one partner (almost always the wife) does much more of the household labor than the other.

Different social groups and societies are also marked by more or less economic inequality. Overall, societies that have low levels of inequality have high levels of mental health, whereas those that feature sharp differences in resources have worse overall well-being (Marmot & Wilkinson, 1999). In general, subordinate social positions and inequality are associated with poor mental health, dominant ones with well-being, and egalitarian relationships with the best mutual states of happiness.

Cultural Values

A third source of psychological well-being involves possessing meaningful systems of cultural values. Social groups that provide their members clear and attainable goals foster mental health. Those that create expectations that many people cannot fulfill are marked by widespread frustration and unhappiness. For example, American values traditionally have stressed that all people, regardless of their backgrounds, can achieve material success (Merton, 1938/1968). In fact, only a relatively small proportion of people will attain high-paying, prestigious, and fulfilling positions. Those who fail to realize their goals will tend to blame themselves, rather than the cultural values that emphasize success or the structural conditions that place limits on how many people can actually reach such high levels of accomplishment. High levels of distress result from the inability of people to attain the values their cultures encourage them to achieve.

Religion provides another example of the importance of cultural values. In general, religious people report less distress, especially when they undergo highly stressful life experiences, than those who are not religious (Idler, 1995). Members

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of ethnic groups that promote values emphasizing the importance of cohesion and support for fellow group members also have better mental health than members of groups with more individualistic value systems (Vega & Rumbaut, 1991). Overall, cultural values that provide group cohesion, meaning, and purpose to life are conducive to mental health. These values are not psychological characteristics of individuals, but they are socially generated and shared group properties.

Cohort Membership

Birth cohorts are another social influence that shapes mental health. A *birth cohort* is a group of people born in a particular time and place; for example, all Americans who were born in the decade of the 1980s. Each cohort shares common historical and social experiences that are different from the experiences of other cohorts. People born at different times have witnessed different historical events, different trends in marriage and divorce rates, different occupational and educational opportunities, and changes in fashion, technology, world views, and cultural patterns. To the extent that such factors are related to mental health, members of different generations have divergent rates of psychological well-being and distress because of the time period when they were born.

Differing levels of abuse of alcohol and drugs indicate the importance of cohort membership. One large study compared such abuse among 15- to 24-year-olds born between 1966 and 1975, 25- to 34-year-olds born between 1956 and 1965, 35- to 44-year-olds born between 1946 and 1955, and 45- to 54-year-olds born between 1936 and 1945 (Warner et al., 1995). Although only 2.1% of the oldest birth cohort reported a history of substance dependence by age 24, 17.3% of the youngest cohort did so. This means that there was an 800% difference in the chances of a 24-year-old having had a substance dependence disorder, depending on whether he or she was born between 1966 and 1975 or between 1936 and 1945.

Rates of many mental disorders reflect the importance of the time period when someone is born. For example, younger generations in the first decade of the 21st century report far higher levels of attention-deficit hyperactivity disorder (ADHD), eating disorders, autism, and bipolar conditions than earlier birth cohorts. Although it is not clear what factors account for the growing levels of reported mental disorders of these kinds, it is apparent that any given individual's chances of being diagnosed with many types of psychiatric conditions are related not only to individual characteristics but also to when he or she happened to be born.

Generational factors also affect general levels of well-being and distress (Yang, 2008). A sociological perspective indicates that frustration and distress from failed ambitions stem from the social structural conditions that are present in any particular time period. For example, many young people now face a growing gap between their aspirations for material achievements and the opportunities that are available to them. Cultural values still promote the possibility of high levels of financial success for everyone, but declining economic conditions allow fewer people to

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reach their goals. The result of waning opportunities for material accomplishments might be worse levels of mental health overall among current generations of young adults.

Cross-Cultural Differences

The importance of social factors such as social integration, stratification, and culture becomes especially apparent when levels of mental health and illness across different countries are examined. Rates of depression provide an example. These rates vary enormously across different societies. One set of studies showed that the amount of depression varied from a low of 3% of women in a rural area of Spain to a high of more than 30% of women in an urban township in Zimbabwe (G. W. Brown, 2002). Another summary of community surveys in 10 countries found amounts of depression that ranged from a low of 1.5% in Taiwan and 2.9% in Korea to a high of 16% in Paris and 19% in Beirut, Lebanon (Weissman et al., 1996). A third study found that rates of depression varied by a factor of 15 among primary medical care patients in 14 different countries (Simon et al., 2002).

Other mental disorders show equally steep divergences across cultures. For instance, social phobias ranged from a low of 1.7% in Puerto Rico to a high of 16% in Basel, Switzerland (Merikangas et al., 1996). Rates of alcohol and drug dependence show even larger variations across national contexts. One cross-national study of alcoholism found that the highest lifetime prevalence rate of 23% among a Native American population exceeded the lowest rate of 0.45% in Shanghai, China, by more than 46 times (Helzer & Canino, 1992)! The importance of social and cultural factors is also shown by the fact that the United States has far higher rates of many kinds of mental illnesses than the rest of the world. For example, nearly 20% of Americans reported having an anxiety disorder and almost 10% reported a depressive condition compared to only about 2% of Chinese who said they have each of these conditions (World Health Organization World Mental Health Survey Consortium, 2004).

These diverse rates could stem from differences in the rates of social stressors across cultures; disparities in social integration, stratification, and cultural systems of meaning; varied expressions of distress in each culture; or measures of mental illness that are not sensitive to cultural contexts. Although it is not clear what exact factors account for the huge differences in prevalence across cultures, these differences suggest that societal impacts on the development of emotional problems cannot be ignored in explanations of well-being and distress.

Social Responses to Mental Disorder

Another type of sociological research examines how people themselves, those around them, and their societies define and respond to psychological problems.

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Social influences profoundly affect how people and groups react to mental health troubles.

Images of mental illness have undergone radical changes in recent decades. For most of history, people associated mental illness with crazy, mad, and bizarre behaviors (Grob, 1995). These conceptions also carried a great deal of stigma so that people would resist defining themselves as mentally ill and seeking mental health treatment. Because only the most severe and disruptive conditions would come to the attention of mental health professionals, treatment often occurred in locked wards of inpatient mental hospitals.

An enormous change has occurred in recent decades in how Americans define, seek help for, and treat psychological and behavioral problems. In particular, a dramatic upsurge in the medicalization of social life occurred in the 1990s and 2000s. *Medicalization* means that conditions that previously had been defined as nonmedical difficulties are now seen as medical problems that ought to be treated through medical techniques (Conrad, 2007). Troubles that in the past were considered as spiritual, moral, or behavioral harms that were handled through prayer, counseling, or punishment or were simply tolerated are now defined as diseases and addressed through biomedical treatments. In the field of mental health, medicalization has had these effects: people are more willing to seek professional help for their emotional problems, social definitions emphasize how mental troubles are signs of diseases, and treatments primarily involve biomedical interventions, especially drugs.

The fundamental categories of mental illness themselves have undergone notable changes in recent years. For example, distressing and disruptive but not necessarily disordered childhood behaviors are increasingly being labeled as mental illnesses. Children have always behaved in ways that annoy and frustrate their parents and disturb their teachers. Only recently, however, have these behaviors been considered to be mental disorders that must be treated with medications. Just 20 years ago less than 1% of children were diagnosed and treated for ADHD (Olfson, Gameroff, Marcus, & Jensen, 2003). By 2003, ADHD had become a widely prevalent psychiatric condition among children and adolescents, with 7.8% of youth aged 4 to 17 years reporting a diagnosis of ADHD and 4.3% taking medication for the condition (Visser, Lesesne, & Perou, 2007).

The spectacular rise in rates of bipolar (or manic-depressive) disorder in youth provides another dramatic instance of a new childhood mental disorder. This disorder was traditionally thought to arise in mid-life and until recently was virtually unknown among youth. Then, in 2007 a national survey discovered an astonishing *40-fold* increase in the number of children and adolescents treated for bipolar disorder from 1994 to 2003 (Moreno et al., 2007). The common denominator among children treated for this condition seems to be that their behavior is extremely disturbing to adults, usually their parents or teachers. The rising rates of the pediatric bipolar diagnosis and resulting prescriptions for powerful drugs seem more

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due to their usefulness for pacifying disruptive behavior than to the discovery of a previously unknown disease.

Among adults, major depressive disorder (MDD) is the most common diagnosis in psychiatric treatment and one of the most common conditions reported in community surveys. Its typical symptoms are states of low mood, diminished pleasure, sleep and appetite difficulties, fatigue, and lack of concentration that persist for a 2-week period. Studies estimate that about 17% of people suffer from MDD over their lifetime (Kessler, Berglund, et al., 2005). In the past, the symptoms of MDD would often have been viewed as natural responses to some serious loss such as the breakup of a marriage or a long-term romantic relationship, the unexpected loss of a valued job, or the discovery that an intimate has a life-threatening illness. The expansion of medicalization has led American culture to define sadness as a depressive mental disorder and to treat it with medications (Horwitz & Wakefield, 2007).

Social phobia provides another example of medicalization. Social phobias are conditions that feature extreme anxiety over situations in which people are exposed to the scrutiny of others, such as when they must speak in public, have their performance evaluated, or attend social events that involve interacting with strangers. When this condition first appeared in the official psychiatric manual in 1980, it was noted that "the disorder is apparently relatively rare" (American Psychiatric Association, 1980, p. 228). Initial studies of the disorder in the early 1980s indicated that about 1% to 2% of the population reported this condition. Yet, more recent studies indicate that about 13%, or one of eight people, has had a social phobia at some point in their lives (Magee et al., 1996). Indeed, by the early 2000s, social phobias were one of the two most common mental disorders. Rising rates of conditions such as social phobia largely result from growing cultural tendencies to treat personality traits such as shyness as if they were diseases and from widespread drug advertisements that urge people to seek medical help for their distressing conditions (Lane, 2007).

It is not just conceptions of what mental disorders are that have changed in recent years. People are now far more willing to seek mental health treatment than they were just 20 years ago. The treatment of depression illustrates this change. The percentage of the population in therapy for depression in a given year increased by 76% between the early 1980s to the early 2000s (Wang et al., 2006). Although the willingness to seek professional help for mental health problems such as depression has increased among all social groups in recent years, a number of social characteristics are associated with defining oneself as in need of mental health treatment. Women, younger and middle-aged people, Whites, and highly educated individuals are considerably more likely to seek professional treatment than men, the elderly, racial and ethnic minorities, and the less educated (Pescosolido & Boyer, 1999).

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The places where people receive mental health treatment have also dramatically changed in recent years. Since the 1950s rates of inpatient treatment in mental hospitals have plunged, and few mentally ill people now enter these institutions (Grob, 1995). When people do receive inpatient treatment it is likely to be given in general hospitals or private clinics. The vast majority of people treated in the mental health system now go to outpatient facilities in the community or see general physicians for their emotional problems.

Several factors account for the dramatically rising rates of professional treatment during the recent past. The earlier emphasis of cultural conceptions of mental illness on the most serious and stigmatizing conditions has shifted toward a focus on a broad range of emotional and psychosocial problems. Younger birth cohorts, in particular, have been socialized to a therapeutic culture that emphasizes using mental health services and, especially, taking psychotropic medications to ease suffering. Various mental illnesses are common topics in television shows, movies, and popular magazines. Direct-to-consumer (DTC) advertisements of medications that treat psychological problems are another prominent reason for rising rates of treatment. These ads, which have only been allowed since the late 1990s, are now widely featured in the media.

The drug industry has had an especially important influence on the growth and evolution of mental health treatment (Barber, 2008). The most striking change in treatment is the vast increase in prescriptions for antidepressant medications. The use of antidepressants, including fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), venlafaxine (Effexor), and fluvoxamine (Luvox), nearly tripled between 1988 and 2000; in any given month, 10% of women and 4% of men use these drugs (*Health United States*, 2004). The increasing use of antidepressants is especially apparent among young adults. The period from 1994 to 2001 witnessed a 250% increase in the number of visits to physicians that resulted in a prescription for some medication that treats psychological problems among adolescents (Thomas, Conrad, Casler, & Goodman, 2006). Recent years have also seen rising rates of stimulant drugs such as Ritalin that treat ADHD. More than two million children now receive these drugs each year (Zuvekas, Vitiello, & Norquist, 2006). The numbers of persons 20 years old and younger who received a prescription for the strongest kind of medications, the antipsychotics, jumped from about 200,000 in 1993–1995 to about 1,225,000 in 2002, a more than sixfold increase in less than a decade (Olfson et al., 2006). A sharp drop in the use of psychotherapies – treatments of emotional disorders that rely on talk therapies – has accompanied the growing reliance on drugs (Olfson et al., 2002).

On the one hand, changes in the social response to mental health conditions have meant that far more people are getting professional help for their psychological problems. The stigma associated with seeking help for emotional problems and mental illness has also declined as a broader range of conditions have become

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associated with this label. However, people who suffer from more serious types of mental disorders such as schizophrenia remain highly stigmatized. The availability of effective medications is also partly responsible for why far fewer people enter mental hospitals and far more live in the community than in past decades. Psychotropic drugs allow many people to lead brighter lives and accomplish more than they would if they were not taking medications for their problems.

On the other hand, critics have emphasized how a number of problems are due to the rising use of drug therapies (Conrad, 2007; Elliott, 2003; Healy, 2004). Growing medicalization has led to the assumption that drugs are the treatment of choice for numerous psychosocial problems. Prescribing a pill can communicate the message that issues such as unfulfilling marriages, poor parenting, and inadequate finances are easily remedied through pharmaceuticals. Current health policy might be overly reliant on using medical remedies for concerns that often can be addressed through alternative social policies. For example, enhancing parenting skills, investing in childhood development programs and child care, and creating more stimulating classroom experiences might be more effective responses to childhood behavioral problems than pharmaceutical treatments. It is possible that promoting healthy lifestyles and reducing socioeconomic inequality, workplace pressures, and family demands could enhance mental health to a greater extent than telling people they have a disease and prescribing pills to remedy their conditions.

Another problem is that the benefits of medicalization are often overstated. Although these drugs do help control the worst symptoms of serious mental illnesses, their effectiveness for less severe conditions does not greatly exceed that of placebo treatments (Kirsch et al., 2008). If the benefits of drugs have been exaggerated, their risks including negative side effects such as diminished sexual desire, increased somatic symptoms, and sleep problems, withdrawal problems from ceasing use, and heightened suicidal potential might be underestimated (Healy, 2004). An additional issue is that little is known about the impact of long-term use of psychotropic medications, an especially important concern for young adults who begin using them during early stages of their life cycle. Whatever the exact balance is between the benefits and risks of the medicalized response to emotional problems, it is undoubtedly one of the most important recent trends in the field of the sociology of mental health and illness.

Conclusion

Sociological research about mental health and illness shows how the emergence of psychological well-being and distress are consequences of basic aspects of social organization (Pearlin, 1989). Dimensions of social life including integration, stratification, and cultural systems of meanings shape resulting rates of emotional problems. Even such extreme behaviors as suicide can often result from the way

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people are attached to social institutions rather than from the irrational behavior of abnormal individuals. From a sociological point of view, regular features of social life rather than abnormal processes within individuals explain how much distress will emerge among people living in any given time and place.

The response to mental problems is also rooted in essential dimensions of social life. Social processes influence how people classify what kinds of problems they have, what sort of remedies they seek, and what kind of resources are available to treat them. Cultural conceptions of what it means to be emotionally healthy or disturbed have radically altered in recent decades. A number of particular social groups including pharmaceutical companies, the mental health professions, the media, and governmental bodies encourage people to medicalize their emotional suffering. The result is that notions of mental illness are far broader than in the past, allowing many more people to view themselves as having emotional problems that require professional treatment.

Rooting the emergence and response to psychological problems in social practices rather than within individuals might seem to be counterintuitive. Most people think that their emotions are profoundly individual processes that are uniquely their own. Yet, as the various chapters in this volume will demonstrate, the kinds of societies we live in and the sorts of cultural beliefs that we share shape the seemingly most innermost aspects of our thoughts, feelings, and behaviors. They will also suggest some answers to what is possibly the most important sociological question: What sorts of social arrangements can optimize happiness and minimize distress?

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