

ISA

Sociology of Mental Health RC49 Newsletter Vol. 16, Issue 1: Spring 2015

FROM THE PRESIDENT OF RC-49

Dear RC-49 Members and Friends:

Welcome from your new president. I am honored and humbled to have been elected by the Board to follow in the footsteps of my predecessors. I will serve the members of RC-49 working with Vice-President Silvia Krumm, Secretary Kjeld Hogsbro, Treasurer Jeremy Dixon, and other Board members for the next four years.

Last July, we had a very inspiring and well attended group of 11 sessions at the ISA World Congress in Yokohama. Among the RC-49 presentations was a joint session hosted with RC01. Many thanks go to former Board President Bronwen Lichtenstein, Board members, and session organizers for their excellent work in planning and organizing the RC-49 program for 2014. I believe that our Research Committee 49 is a vital group and will become one of the leading RCs in the International Sociological Association. My optimism is built on the strong sociological perspective of the Sociology of Mental Health and its continuing importance for the realization of better mental health and global well-being.

During my tenure as President, we will have two international conferences. The Third ISA Forum of Sociology will be held July 10-14, 2016 in Vienna, Austria. You have responded well to the call for sessions for this upcoming meeting. The XIX ISA World Congress of Sociology will be held in Toronto, Canada in 2018.

One of the ways to increase RC-49 membership is to improve communication among members through the listing of recent publications, research projects, conferences, and job openings. Please send information on these topics directly to me. Also, if you have ideas about how the Research Committee could better serve your needs, please contact me or the Board members via email (<http://www.isa.sociology.org/rc49.htm>).

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Blaming the Mother?

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Astrid Halsas, Ph.D., University College of Lillehammer, Norway

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The family is considered a significant social factor related to mental health and illness and a number of different approaches have been developed to explain the role of the mother (or father) in this regard. Mother blaming has been the most predominant perspective in the literature whether her children develop mental distress or if a mother has mental problems herself. In this article we will at first point out some theoretical assumptions for such an understanding, and then present empirical approaches that emphasize the subject positions of family members.

Considering the understanding of schizophrenia, for example, most prominent and influencing was the concept of the “schizophrenogenic mother” (Frieda Fromm-Reichmann) – containing the image of a cold, rejective and dominating mother who generates insufficiencies and guilt in sons and daughters and thus, becomes a major causal factor in the progression of schizophrenia. Similarly, the concept of “double bind” (George Bateson) with a focus on pathogenic communication systems as an important underlying factor further promoted representations of the family - or more precisely the parents - as a central causal factor. On the one hand, against the background of a shift from biological to social explanations for mental illness during the 1950s, these concepts provided explanations for the pathogenic family psychodynamics as a basis for psychotherapeutic approaches to schizophrenia. On the other hand, they placed a tremendous burden on the family, especially to the mother as the primary care giver. The second wave of biological psychiatry as well as the growing self-helping and family movement in the 1970s initiated a discursive shift from the family as a causal factor to the (only) contributing roles of family interactions in the longer course of a family member’s mental illness. It was increasingly realized that family systems are strongly influenced and often heavily burdened by a family member’s mental illness. Families have been assessed as not only struggled by various illness symptoms, but also by insecurity about the future, isolation and stigmatisation by those who blamed solely the mother (rarely: fathers) as the source of various forms of mental illnesses. Today, such “causal approaches” have been outdated because of their short-sighted and stigmatising character. Regarding the case of schizophrenia again, rather than “blaming the victim”, concepts like “expressed emotions” or “family expressiveness” emphasised the enhancing and/or worsening impact of family members’ emotions and attitudes towards the affected family member.

At the RC49 session on “Mental Health and the Family” at the XVIII ISA World Congress of Sociology in Yokohama, Japan, three papers dealt with the interrelation between mental health issues and the given role of the mother - or father - from different perspectives.

Anne-Elise Velu from Paris Dauphine University in Paris, France, introduced results of her sociological thesis on primary school teacher’s assessment of children’s learning difficulties. She proposed that teachers assess children’s learning difficulties as a result of family dysfunctions, and educational deficiencies of the parents. Lifestyle and educational habits of families are analysed by teams of professionals, and when considered as deviant, they suggest help to the family. Rather than wider socio-economic factors or social inequalities, the parents are seen as the (only) cause for learning difficulties of the child.

The vast majority of current literature on family and mental illness is dealing with the issue of “children of mentally ill parents” and thus, with the adverse consequences of a parental mental illness for the psychosocial well-being and development of children. A large number of studies over the past decades have demonstrated that children of mentally ill parents are at high risk for the development of mental distress.

Astrid Halsa from the Department of Education and Social Work at the University College in Lillehammer, Norway, introduced the findings of her qualitative study “At home and elsewhere: How to handle daily life growing up with a “mad mother” or “drunk father”?. After considering the state of the art regarding adverse outcomes and risks, she argued that the risk and harm perspective is less suitable to study children as participating agents. Rather, she focused at the children’s own experiences on growing up with parental mental illness or substance abuse. Halsa showed that these children often have to negotiate between the often secret and shame-laden family context and arenas and situations outside the family. She concluded with the suggestion that to grasp these children and young peoples lived- experiences the research has to look outside the families front door and include children’s activities in school, leisure and community, and focus on the active and challenging identity work these young people go through in trying to keep their homes together while developing a sense of selves.

Ute Zillig, from the Faculty of Social Sciences at University of Goettingen, Germany, presented findings of biographical interviews with mothers, who are all patients of a traumaspecific psychiatric hospital and who experienced massive forms of violence in their own childhood. Zillig pointed out the women’s major difficulties of being diagnosed and treated as mentally ill and at the same time being mothers who are not supposed to be mentally tainted in any way. A strong self devaluation regarding the women’s motherhood would lead to a form of voicelessness of the women towards actors, e.g. in medicine or social work. From a sociological understanding of biographical research Zillig focused on the question to what extent the traumaspecific approach overcomes women’s voicelessness concerning issues of motherhood while at the same time this approach is somehow limiting the women’s self-understanding and self-presentations to pathologising labels of mental illness that detach their present mental symptoms from their biographical background.

Consistent with Astrid Halsa’s and Ute Zillig's arguments, a narrow focus on the situation of children has not only promoted an objective, problem-oriented perspective to children but also at the parents themselves. In conjunction with societal representations on “ideal motherhood” and the stigmatization of mental disorders, mentally ill mothers are therefore often assessed as unable to care for children. Studies of motherhood and mental illness often tend to focus primarily on mothers as instrumental in the development of their children. Several authors have argued for the importance of understanding motherhood in a broader sense, as more than just the relationship between mother and child, and much more than a mother’s psychological ability to meet their children’s needs (Feasterstone 1999, Kielty 2008). Since 1990 there have been an increasing number of studies devoted to the subjective perspectives of women with mental disorder (Dolman, 2013). However, a more contextual understanding of the life of these women has been widely neglected. To understand how women with mental illness cope with the parental role it is also necessary to pay attention to the daily life experiences of family members, as well as the institutional and cultural environment in which they live.

The further discussion within the session in Yokohama also revealed difficulties of using problem-oriented approaches towards parenthood among mentally ill persons. For example,

many papers up until today contain (latent) messages of “good preventative healthcare of schizophrenic women with the potential to become pregnant” (Robinson 2012). While the subjective perspectives of mothers (and fathers) have long been neglected, recently a considerable number of qualitative studies have placed more importance on mothers’ and fathers’ subjective perspectives including positive aspects of parenthood, parenting resources and the potential of support programs for parents.

As the three different papers as well as the following discussion have shown, there is a lack of adequate mental health care provision for families affected by different forms of mental illness, even though there is an increasing awareness of support needs of these families. In order to provide adequate mental health services for families affected by mental illness it is crucial to include the subjective perspective of both parents and non-affected partners, children as well as important others. It has also been revealed that a sociological perspective, in particular, provides theoretical and methodological measures to understand the situation of individuals, family members as well as family systems as a basis for the development of adequate support.

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Dying in Debt

Bronwen Lichtenstein, PhD
University of Alabama

The Great Recession of 2007-2011 is arguably the most significant sociological event of the twenty-first century. The effects of recession were global in scale and economies are still struggling to emerge from austerity budgets that were imposed with lightning speed. Signs of recovery are tentative at best. Employment is still sluggish, wages have stagnated, and millions of people have gone into debt or lost their homes to foreclosure. I will take this opportunity to address the mental health implications of foreclosure, with the United States as an example.

The first question to ask about the impacts of foreclosure is: “Who suffers most?” A surprising answer is “older people.” In addition to dementia, depression, and chronic illness that often afflict the elderly, foreclosure has taken a heavy toll on people aged 50 or older. Young people lose their homes after being laid off, when relationships fail, or when mortgage interest payments keep rising. Older people foreclose if they fall ill or a partner dies, or if expenses exceed fixed incomes after they retire. I am astounded at how indebtedness across all age groups has increased

since the Great Recession and how many older people carry debt until they die. Women alone and people of color are particularly vulnerable because they were targeted for predatory loans during the housing boom and were first to foreclose during the recession.

Leonard Pearlin's (1989) theory of social stress offers valuable insights into the health effects of foreclosure. His primary argument is that structural inequalities, coupled with acute life events, have a corrosive effect on health and longevity over the life course. Personal crises such as illness, divorce or loss of employment are social stressors that can have a cascading effect, especially if people live on meager incomes. For example, a homemaker who lacks an independent source of money faces increasing levels of distress and/or debt if she falls ill, squabbles with her husband over money, and forecloses after he leaves her and she cannot afford to pay the mortgage.

My analysis of 5,500 cases in Tuscaloosa County, Alabama, has identified effects of these stressors at the local-neighborhood scale. People who foreclose are typically ordinary Joes or Janes who live in modest homes and who cope financially until a crisis pushes them over the edge. Many older people are retirees or widows who were debt-free until they needed loans to cover unexpected expenses, especially medical or hospital bills. Hospitals are often the largest creditors in town and show little mercy toward debtors who are not covered by health insurance.

We need to sound the alarm about home foreclosure as a major social issue in terms of health and well being of older people. The outcomes can be tragic. I have identified cases of suicide and murder-suicide among couples who foreclosed, as well as forced evictions of widows who foreclosed after a husband's death. There are instances of financial abuse among older people whose children borrowed money in their name, financial scams that targeted older people and stripped them of their assets, and age-related illnesses such as dementia that lead to foreclosure when a homeowner forgets to pay the bills. The mental health impacts of foreclosure such as depression, loss of independence and premature death need sociological investigation, particularly in the United States where consumer protections are lacking for elderly homeowners. Pearlin's theoretical framework would be useful in refocusing attention from foreclosure as a private trouble to a major public issue in a graying world.

Status of Mental Health Services in Chile

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The Conference of Caracas, called by the Panamerican Health Organization (PAHO), in 1990, proposed the implementation of community psychiatry in mental health services in Latin America. In Chile, it was endorsed in the National Plan of Mental Health and Psychiatry in 2000. One of its main objectives was the end of mental health asylums in which the inmates are confined for life long periods. In its most radical sense was to finish with the existence of psychiatric hospitals and confine mentally ill inmates in crisis in general hospitals for brief periods. In this sense there are advances, although exist psychiatric hospitals yet, in most of them there are not inmates confined life long periods. Also it was enacted the regulation 540 that rules the non-voluntary confinements, that was expanded recently in order to guarantee the fulfillment of several human rights in mental health treatments. Also in the last years, sectors of mental

health professionals and relatives of mentally ill persons demand a Law of Mental Health that assures the fulfillment of patient rights.

But community psychiatry means more than the end of asylums. It means that psychiatric treatments be performed in the community, and that mentally ill persons be included in the community. Let us give some figures of the extent to which mental health services in Chile meet the demand.

Only 2.16% of the expenditure in health in Chile is currently earmarked for Mental Health, considering that as part of the development National Plan of Mental Health for the year 2000, it was calculated that is necessary to spend on mental health 5% of the budget of health in order to be able to meet its objectives.

To meet the standard of community mental health centers is necessary a Center by each 40,000 beneficiaries of public health , to enable a close attention to the needs of the people's lives. Today, despite a significant development from zero existing Center in 1990 to 83 centers in 2012, is still far from the raised standard (available from a Center by each 164.940 beneficiaries of public health services). It is required to increase the number of centres approximately 4 times to comply with the standard and solve the steering of the attention currently undergoing.

In year 2012, 5.3% of the beneficiaries of public health services received at least one mental health care in that year (regardless of the form of free choice). In the same year, the WHO-AIMS 2012 study showed that twice more people in private health received this type of mental health care (12.2%). These data highlight the inequity in access to mental healthcare in the country, where private insurance affiliates have an access level similar to the level in high-income countries, while public beneficiaries have a lower access to upper middle income countries average.

The evidence shows the importance of psychoeducation user and his family in adherence to treatment and evolution of mental illness and schizophrenia in particular. So as this disease of Ministry of Health guide points out that psychoeducation must be made with all people with a first episode of schizophrenia and their families. However, a study by Alvarado of the year 2006 showed that such activity was carried out only in about half of cases. In Chile, a 2009 study in the public system showed that more than two-thirds of people with a first episode of schizophrenia abandon treatment before the start of this year. This level of abandonment is much higher than the 21.3% of abandonment of psychiatric treatments found in a WHO study in countries from various regions of the world. A recent study conducted in Chile by applying the instrument QualityRights showed that 86.7% of the evaluated outpatient centers met in full the standard for psychotropic medication but only 6.7% did for access to psychosocial intervention in the social support network.

There are great differences among regions of the country in outpatient professional resources between health services, with a minimum rate for the country of 93,0 total weekly hours of mental health by 40,000 beneficiaries in Aysen of public health professionals and a maximum rate of 376,6 in the North Metropolitan health service. This shows considerable territorial differences.

In the whole country there is a rate of 1,457.5 hours/week of professional and technicians per 100,000 beneficiaries of public services for treatment of specialized outpatients in mental health, which is considered strongly insufficient.

Community psychiatry means that treatments be done in the community. To approach this end, mental health services developed several centers: daytime mental health hospitals, group homes, psychiatric rehabilitation centers, clubs of integration, sheltered workshops.

In the daytime hospitals, the patient in critical periods receives psycho-social and psychiatric treatment performed by a professional team that includes psychiatrist, psychologist, occupational therapist, and social worker; the patient stay during daytime and return to his home at every night, which intends to avoid the negative consequences of closed confinement.

The group homes pretend to give a home to patients without or with bad relations with their families, avoiding long lasting hospitalization.

The psychiatric rehabilitation centers pretend to give social, cultural and elemental work skills to patients that need them.

The clubs of integration are instances of sociability for psychically handicapped persons.

The sheltered workshops pretend to be a place for acquiring work discipline as a substitute of competitive (real) work. They receive a small monetary incentive doing craftsmanship, bakery, preparing chocolates and the like.

These strategies represent an advance to break the social isolation characteristic of mentally ill persons. But what about the intended inclusion on the real community? What is the real shift toward an empowered and autonomous patient that is the final aim of inclusion politics?

We have conducted several research projects that through light on these problems.

A feature that crosses all the spectrum is the stigmatization of mentally ill persons. A research (years 2000-2001) conducted in the principal metropolitan area of our country, arrived at the conclusion that most of persons with schizophrenia are unemployed (85%), 60-70% has working capacity, the potential employers think that they are aggressive, violent or dangerous (more than 50%) and that they will not perform adequately in simple tasks (62%). The stigma is reflected also in mental health professionals' attitudes blocking the permissions to interview them in another research project.

Another research project (2012-2013) focused in users of group homes of the second most populated region of our country, show that they do not have vital plans for the future (84%), that, because they considered themselves ill and “not normal” persons accept rigid and coercive rules without complaint, concluding that the group homes being an advancement over hospitals but preserve a noticeable degree of psychiatric institutionalization.

A third research project (2004-2006) in the metropolitan area of our country concluded that sheltered workshops are not a real solution: they pay 1/3 of the minimal legal salary, and maintain a therapeutic environment that distort real work relations in competitive world, making more difficult the transition to a full employment.

A fourth research project (2002-2003) in the same area of our country, concluded that the families of persons with schizophrenia have a distorted image of their working capacities and have an overprotective behavior that blocks the possibilities they have a “normal” work. Another handicap to get a qualified work was the effect of compulsory adaptations treatments that result on passiveness and lack of strong motivation in outpatients.

We may conclude in general that the principal aim of community psychiatry, that of social inclusion, had not been realized in our country and that the same centers that are intending to facilitate this inclusion, in many senses are blocking this inclusion, in the most important way, the possibility to have a qualified work and a family.

Asylums and After

Jeremy Dixon, Ph.D.

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What does the sociology of mental health have to say about the way in which people with mental health problems are managed now? That was the question raised by one participant at the ‘safety and mental health session’ of RC 49 at Yokohama in 2014. The question was prompted by a claim from one presenter that the sociology of mental health and illness in the US had not progressed since the publication of Goffman’s *Asylums*. This led to an observation by Dirk Richter that Goffman’s *Asylums* remains the bestselling sociological text and led to a group to discussion as to what areas of mental health care remained to be fruitfully explored by sociologists now.

Although the management of mental health problems has moved on since Goffman wrote *asylums* in 1961 it is worth reminding ourselves why the text was so influential. Goffman’s text was notable for outlining the characteristics of ‘total institutions.’ In addition, his book outlined the effects of institutionalization on the identity of the patient, examined processes of resistance by patients and studied staff views on the medical model and how they presented patients with the facts of their situation.

By some strange coincidence I am writing this article in what was once one of the largest asylums in South West England. The building is now a University library where I go when I need a quiet space to work. Sitting here reminds me that the history of asylums is a fairly recent one. I worked for many years as a mental health practitioner in this area and am aware that there are quite a number of mental health staff who were employed in this asylum who continue to work in the current mental health system. Furthermore I am aware from my time as a mental health worker that many of the patients who were housed here continue to live in the local area (often housed in supported accommodation and day centres which replicate the patterns of the asylums). So there are some clear connections between the observations that Goffman made and the current mental health system. However, the pace of change within mental health services has often been rapid and so we can also observe new ways of thinking about mental health problems that have emerged. So this brings me to a consideration of where are we now? Whilst it is not possible to offer a comprehensive review of future directions here, I offer a few of my own thoughts on how the treatment of those with a mental health problem has developed.

Goffman was concerned with the organisation of asylums. When thinking about how mental health services are organised internationally it is notable that many differences remain within jurisdictions. Whilst most countries in the West underwent a process of de-institutionalisation between the 1960s and the 1980s, this was not uniformly the case with some countries in Eastern Europe developing community care policies much more recently. In addition, the total institutions that Goffman spoke of have not been completely abolished. Whilst community care is the primary mode of delivery in the West long term institutional care remains for mentally disordered offenders.

Goffman was concerned with the 'moral career of the mental patient', or put another way the way in which the total institution acted to shape patient identity. Now that people with mental health problems are increasingly treated within the community sociologists need to find new ways to describe the processes by which identities are formed. One area of study has been the stigma that those with a mental health problem may face. Public awareness campaigns have had a limited effect and so the interaction between individuals and society merits further study. Another common theme within the literature has been the way in which those who use services may be framed by processes of medicalization. This remains a fruitful area for study and as diagnostic systems develop attention needs to be paid to the way in which the boundaries of 'normality' become defined. However, whilst diagnosis has traditionally been the realm of psychiatrists, the role of identifying and treating various disorders is increasingly devolved to a wider range of professional groups. There is, therefore, scope to examine the interactions between multi-professional groups and to study which groups maintain or gain control. In addition, as services provision is reduced in many countries the role of the wider community and the family becomes more important in understanding how those with a mental health problem are supported or managed.

'Asylums' was largely concerned with the processes through which institutions exercised control over individuals. Whilst people with mental health problems are now treated within the community, this group of people is unusual in being subject to compulsory treatment in most countries. The introduction of community treatment orders is a case in point, and sociologists of health and illness might fruitfully examine the rationale behind such approaches, their operation and processes of resistance. There is also a case for further study of the burgeoning risk industry, which increasingly claims to identify those who may pose a risk to themselves or others through standardised assessments.

Perhaps the most fruitful area of study for sociologists at the moment is the extent to which individuals with a mental health problem are able to exercise control over their own lives. Goffman recognised that individuals had power, but identified fairly limited examples of resistance within total institutions. Those with a mental health problem today face a more complex set of circumstances. Whilst they are increasingly subject to risk management strategies service users have increasingly lobbied for rights within both hospitals and communities. In addition, approaches to welfare are increasingly market driven with notions of consumer choice and competing theories of 'recovery'. So to some degree the sociology of mental health remains concerned with who is given the power to define and control mental health problems, but this landscape has become much more diffuse and arguably more interesting to study.

RC-49 Regional Meeting

A regional meeting of RC-49 will be held together with the Chronic Disease and Disability Section of the 2015 Western Social Science Association (WSSA) conference. The annual WSSA conference will be held April 8-11, 2015 in Portland Oregon at the Portland Marriott Downtown Waterfront.

Recent Book on Global Mental Health

Essentials of Global Mental Health
Edited by Samuel O. Okpaku, M.D., Ph.D.
Cambridge University Press, 2014

This book helps to define the new field of global mental health. It has a mental health and social justice perspective. The individual chapters written by researchers and clinicians provide many insights into the challenges of expanding mental health services in developing societies.

James G. Linn, Ph.D.