Chapter 9: Who Feels OK?: The Social Problem of Mental Health

I am grateful to my friend David who has taught me a new way to live with a severe mental illness. — *Kate Burrows*

9.1 Chapter Overview

Figure 9.1 Rosalind's Story: Living with Serious Mental Illness and Alcoholism. Please watch this 5:58 minute video. As you watch, please consider how mental illness might complicate other social problems?

In this chapter, we examine the social problem of mental health, mental illness and mental well-being. Our human lives contain sadness, loss, excitement, joy, and especially in the United States, feeling like you are not enough. But what are the boundaries between having a tough day

or a tough week, and mental illness? To begin, we'll read my story about my interactions in a mental hospital.

Kate's Story

I have a SPMI (severe and persistent mental illness), and needed to be hospitalized because I couldn't differentiate between reality and fantasy. This excerpt tells part of my story. Many people* appear in the excerpt:

- *Holland* is a man in his 30s who has schizoaffective disorder. He was experiencing psychosis and mania.
- *Lise* is a woman in her 50s who has been addicted to alcohol and other drugs since her teens. She is in the hospital for detox, after which she will go to a residential addictions treatment program.
- *Music* is a man in his 40s who has schizophrenia. He often forgets his name, and as a result, he changes his name frequently.
- *Jim* is a man in his 20s who has depression. He is in the hospital because of a suicide attempt.

(*All of the names are changed to protect the anonymity of the people.)

Personal Experiences of Stigma and Out-grouping in the Psychiatric Hospital

Encounter 1: "Do you believe in UFOs?"

From my diary: Monday Day 1, South Unit

Holland and I were standing in line for dinner, and we started talking about our delusions. They are almost exactly the same! We got so excited, because finally, for once, we were talking to somebody who believed us, and who understood! Holland GETS me. He knows about the things that come over the radio. I know about the signs he gets from church. I am so excited to meet somebody who is like me!

Lise was overhearing us, and said, “What do you mean?” Holland explained that there were things going on in the universe that she doesn’t know about, and only special people can know about them. Then Christian broke in and said, “How do you know about this?” I told him I heard it on the radio. Then Jim said, in a totally rude and demeaning voice, “Do you believe in ghosts? Do you believe in UFOs? You can’t believe everything you hear on the radio!” First of all, Jim thought I was talking about FM radio, but you can’t hear anything over FM. I get the messages from Andy’s ham radio at home.

I felt like they were calling me crazy—calling me nuts. Like Lise has been sober for three days, and those other guys are all depressed and Bipolar. Like they have something over us.

Encounter 2: “I can’t believe he’s schizo!”

From my diary: Monday Day 2, South Unit

Today while I was waiting for our music group to start, Lise and Liz were talking about a conversation they had with Music last night. Lise said, “He was like a normal person! It was amazing!” Liz added, “I can’t believe he’s schizo! I mean, he talked to me totally normally. Do you know he has been married twice and has kids?” “You’d never know he had schizophrenia,” Lise said. “Until he forgets his name!” Liz said, and then they both laughed.

I didn’t know what to do to stand up for Music. I should have. I feel guilty for just letting them sit there and talk about him like that, but I didn’t know what to do. They’ve obviously never met a person with schizophrenia before. They acted like he was a freak. It was horrible.

In this story, you might notice all the things you have in common with the people who are patients. In the hospital we had to figure out how to talk to people and how to get along. Just like high school, we formed our own groups. Some people were the in-crowd, and others weren’t.

In this chapter, we use the models of social problems and social location that we have been using all along. And, we add some new sociological approaches—stigma, total institutions and in-group out group theory to understand why “who feels OK?” is a sociological issue.

You may have experienced your own challenge with mental health during COVID-19. Many of us are feeling stressed, lonely or depressed. We may have even needed to see a counselor for the first time, or we may have found that the ways we usually cope with life didn't work. But why would we consider this a social problem?

At first blush, mental health appears to be a uniquely personal phenomenon: mental health, mental well-being and mental illness seem to be intensely private experiences outside of the realm of sociological analysis. After all, who but psychologists and psychiatrists are truly equipped to understand mental health and illness? In this chapter, our aim is to not only understand the role of sociology in the study of mental health, but to gain a deeper understanding of the effects of social life on our mental well-being. You will be introduced to the major concepts and techniques of understanding mental health and illness from a sociological perspective.

This chapter is interdisciplinary. It includes material from many fields. But there is a coherent organizing theme: the need to understand mental illness in a broad social context. Too often, scientists and psychologists study people who have diseases of the mind without regard to its social origins and to the institutions of social control involved in mental illness.

The goal of this chapter is to critically examine how history, institutions, and culture shape our conceptions of mental illness and people with mental health challenges. Mental health and mental illness become a social problem because of the conflict in how people disagree about these ideas. We will consider the variety of social factors that contribute to the rates and the experiences of mental illness. By this point in our exploration, you will not find it surprising to discover that social location impacts the social problem of "who is OK?"

9.1.1 Focusing Questions

In this chapter, we examine the epidemiology of mental health and mental illness to discover how race, class gender and other social locations impact how people are diagnosed and treated. We explore how sociologists explain this difference, using concepts such as stigma. Finally, we

consider the interdependent nature of mental health and mental illness. These conditions impact individuals, but they also affect families and society. The questions that focus our curiosity are:

1. What is the difference between mental health, mental illness, and mental well-being?
2. Which social factors might impact how a person might get diagnosed and treated for mental illness?
3. How does the social construction of mental health and mental illness create a social problem?
4. How is mental health and mental illness an underlying factor in other social problems?
5. Why do people experience different mental health diagnosis based on gender, race, class, incarceration status and other social locations?
6. How has COVID-19 both increased the incidents of mental health issues and improved our capacity for providing mental health support?

Chapter Overview Licenses and Attributions

9.2 The Basics: Mental Health and Mental Illness as a Social Problem

In our everyday lives, we might say that someone is crazy. Or we might say that we feel out of it. These terms are commonly used, but social scientists have to be much more precise in their language. This section explores what we really mean when we say mental health, mental illness and mental well-being.

Once we have defined our terms, we explore why mental health and mental illness are a social problem, not just an individual one.

9.2.1 What Do We Mean, Really?

In "Kate's Story" that opens this chapter, the people used their diagnosis to sort people into groups. But what does that actually mean?

Mental health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life (American Psychological Association, n.d.). It includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.

Mental health includes subjective well-being, autonomy, and competence. It is the ability to fulfill your intellectual and emotional potential. Mental health is how you enjoy life and create a balance between activities. Cultural differences, your own evaluation of yourself, and competing professional theories all affect how one defines mental health. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

When sociologists study mental health, they look at trends across groups. They look at how mental health varies between all genders, different racial and ethnic groups, different age groups, and people with different life experiences, including socioeconomic status. In addition to this, though, they also explore the factors that maintain—or distract from—mental health, such as stress, resilience and coping factors, the social roles we hold, and the strength of our social networks as a source of support.

The term *mental health* doesn't necessarily imply *good* or *bad* mental health. At some times in your life, you are going to feel really good and have good coping skills, strong social networks, a fulfilling career and personal and family life, and you will feel good about yourself. At other times in your life, things may not be going so well for you. You may have work or family conflicts, and you find yourself engaging in poor coping skills and not reaching out to your social network to get support. Both of these are examples of mental health. In the next section, we are going to explore the concept of mental illness, which, contrary to common belief, is not the opposite of mental health. Rather, it is one type of experience a person can have with their mental health.

Over the course of your life, if you experience mental health problems, your thinking, mood, and behavior could be affected. Some early signs related to mental health problems are sleep difficulties, lack of energy, and thinking of harming yourself or others. Many factors contribute to mental health problems, including:

- biological factors, such as genes or brain chemistry
- life experiences, such as trauma or abuse
- family history of mental health problems

All of us will experience mental health challenges throughout our lives—times when we're not sleeping, eating, or socializing as well as we know we could be. We may have times when we feel mildly depressed for a matter of days, or just don't feel like doing much. These experiences are common and do not mean you have a mental illness.

Mental illness, also called mental health disorders, refers to a wide range of mental health conditions, disorders that affect your mood, thinking, and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders, and addictive behaviors. (Mayo, n.d.)

Unlike mental health, mental illness has a very specific and technical definition. Psychiatrists, psychologists, and even your primary care doctor use a manual called the **Diagnostic and Statistical Manual of Mental Disorders (DSM)** which is essentially a listing of every recognized mental illness. The DSM lays out each condition—297 in the most recent iteration—that is recognized by professionals to be a mental illness.

Each mental illness listed in the DSM has a list of diagnostic criteria that a person must meet in order to be considered to have that particular mental illness. For example, to get an official diagnosis of major depressive disorder, a person must meet five out eight symptoms, such as severe fatigue, feeling hopeless or worthless, or much less interest in activities you used to enjoy, for at least two weeks to be considered clinically depressed.

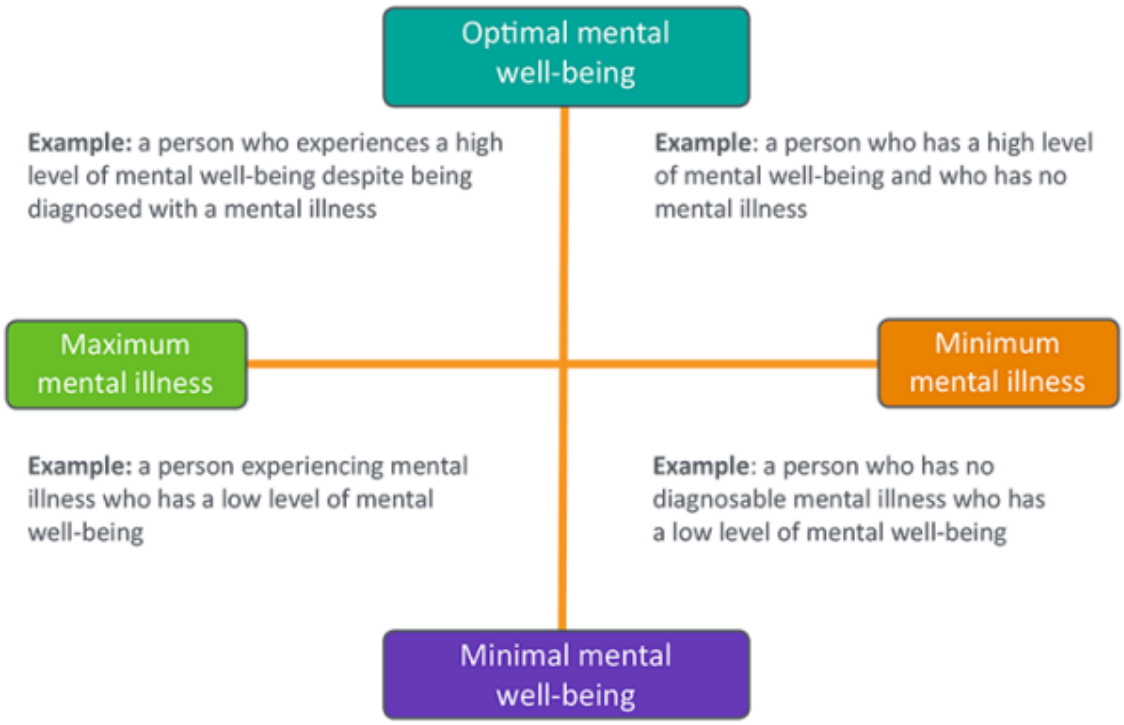

Figure 9.2 The Mental Health and Well-being Continuum. Have you ever considered that mental illness and mental well being might be different?

Image Description: The graphic displays the four stages in the Mental Health and Well-being Continuum in the form of 2 intersecting lines. At the top of the vertical line is optimal mental well-being which leads down to minimal mental well-being. The left side of the horizontal line is maximum mental illness which leads to the right and minimum mental illness. The intersection of lines creates four squares that contain examples. From top left to right, the examples are: 1) a person who experiences a high level of mental well-being despite being diagnosed with a mental illness and 2) a person who has a high level of mental well-being and who has no mental illness. From bottom left to right, 3) a person experiencing mental illness who has a low level of mental

well-being and 4) a person who has no diagnosable mental illness who has a low level of mental well-being.

In addition to the definitions of mental health and mental illness that we commonly use to talk about diagnosis or lack of them, some people are starting to use the description of mental well-being. **Mental well-being** is an internal resource that helps us think, feel, connect, and function; it is an active process that helps us to build resilience, grow, and flourish (McGroarty 2021). While people can support their own mental well-being with long walks and hot baths, the core concept is more profound. It comprises the activities and attitudes that all of us can cultivate to ensure our own resilience, whether we have a mental health diagnosis or not. Mental well-being is a state that all of us can build or work on, so that we can respond effectively to the challenges of our lives.

The community activists and researchers who created the phrase mental well-being use it for two reasons. First, by separating a mental health diagnosis from the quality of mental well-being, we have a model that helps us understand that mental illness can be similar to a chronic disease. You can see this model for yourself in figure 9.2. Some days, or weeks, or years, the illness is very well managed, and the person leads a productive, happy, and fulfilling life. Other days, the illness is not well managed, and the person needs more support. On the other axis, some people may experience a life event that makes them deeply sad or feel powerless. They don't have a mental health diagnosis, but they may need mental health treatment or support anyway. If seeing how the model works real time will help, here is a helpful video: Mental Health Continuum.

Second, some people and communities stigmatize both the people who have mental illnesses or need mental health treatment, and the words themselves. In those cases, using a word that doesn't raise the barrier of stigma can allow new conversations to happen. The National Alliance on Mental Illness (NAMI) hosts these two sites: Sharing Hope: Mental Wellness in the Black Community and Compartiendo Esperanza: Mental Wellness in the Latinx Community. Both sites have excellent videos that explore issues of mental wellness and resilience, mental health and mental illness for these specific communities.

The National Alliance on Mental Illness adds an additional perspective to the discussion by including a voice that had not been considered previously. This organization, a grassroots mental

health organization evolved from a family discussion group into a nationwide organization of mental health providers and patients provided a voice of people with direct experience with mental health issues: patients experiencing direct impact of diagnosed and undiagnosed problems. This organization operates several public health and information projects relating to mental health and supervises efforts by the U.S. Congress to address mental health treatment and policy.

9.2.2 Why Is Mental Health and Mental Illness a Social Problem

In Chapter 1, we listed the characteristics of a social problem. If you will remember:

1. A social problem goes beyond the experience of an individual.
2. A social problem results from a conflict in values.
3. A social problem arises when groups of people experience inequality.
4. A social problem is socially constructed but real in its consequences.
5. A social problem must be addressed interdependently, using both individual agency and collective action.

How might these apply to who feels OK?

Mental health and mental illness go beyond individual experience

Mental illnesses are common in the United States. Nearly one in five U.S. adults live with a mental illness (52.9 million in 2020). Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate to severe. Two broad categories can be used to describe these conditions: Any Mental Illness (AMI) and Serious Mental Illness (SMI). AMI encompasses all recognized mental illnesses. SMI is a smaller and more severe subset of AMI.

The below charts in figure 9.3 show the prevalence of AMI and SMI among adults in 2020, and the bottom chart shows the rates of any mental illness in adolescents. There are some group-level differences in this data that are important to notice. The prevalence of AMI among women is

much higher than that of men; there is a 10 percent gap between the two groups. Why might this be?

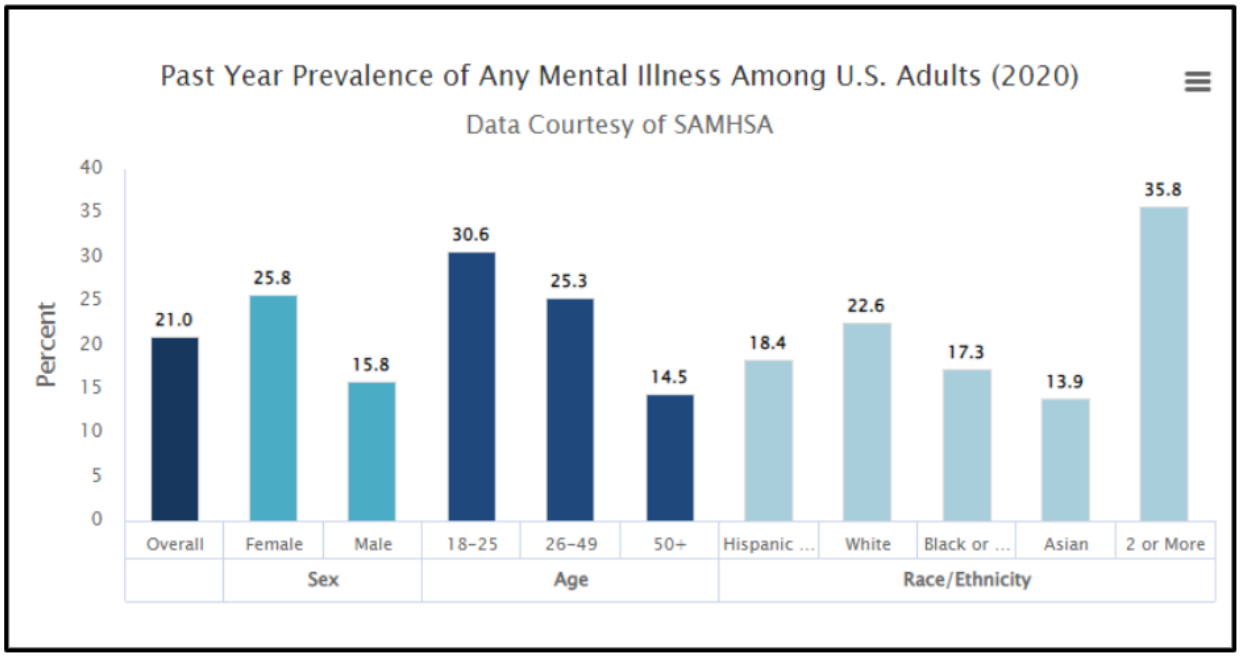

Figure 9.3 Prevalence of Any Mental Illness

Image Description:

- In 2020, there were an estimated 52.9 million adults aged 18 or older in the United States with AMI. This number represented 21 percent of all U.S. adults.
- The prevalence of AMI was higher among females (25.8 percent) than males (15.8 percent).
- Young adults aged 18–25 years had the highest prevalence of AMI (30.6 percent) compared to adults aged 26–49 years (25.3 percent) and aged 50 and older (14.5 percent).
- The prevalence of AMI was highest among the adults reporting two or more races (35.8 percent), followed by White adults (22.6 percent). The prevalence of AMI was lowest among Asian adults (13.9 percent).

For now, we will focus on just one of the bars on this graph: the 35.8 percent of people who experience any mental illness who report as two or more races. We'll look at two factors that

might influence the mental health of multiracial people: legal history and double-discrimination, although there are many more contributing factors.

Pedagogical Element: Neither One or the Other: The Social Construction of Mixed Race

Figure 9.4 President Barack Obama is a mixed-race person who identifies as Black

Figure 9.5 Vice President Kamala Harris

Former U.S. President Barack Obama and current Vice President Kamala Harris may be among the most famous U.S. people who are multiracial. Obama's mother was White from Kansas. His father was Kenyan from the Luo tribe. Although he is mixed race, he self-identifies as African American. Vice President Kamala Harris identifies as American. In most of her political work, she labels herself Black, often because mixed race wasn't a choice. Her mother was South Asian from India, and her father was Black from Jamaica. This article from Pew Research, "In Kamala Harris we can see how America has changed," describes several demographic trends of "mixing" that are occurring recently in the United States.

People from different races have always had relationships with each other. Sometimes, in the cases of slavery, these relationships have been nonconsensual. The laws against miscegenation, or the mixing of two races, were only overturned at the federal level in the United States in 1967, less than 50 years ago. (Grieg 2013). In fact, "the 2000 Census was the first time that citizens of the United States could select multiple racial categories for self-identification apart from Hispanic ethnicity in a census." (Whaley & Francis 2006). The lack of legal,

governmental, and systems recognition of multiracial identity itself is an additional stress for multiracial people. To learn more, check out this blog, Laws that Banned Mixed Marriages.

A second contributing factor to mental health risks for multiracial people is double-discrimination, the concept that you experience discrimination from both of your communities. In this popular media article about Kamala Harris quotes Diana Sanchez, a professor who studies multiracial identity:

> Sanchez says that multiracial people can face what she refers to as double discrimination, where they experience discrimination from both communities they are members of. In Harris's case, that leads to South Asians saying she's not South Asian enough and Black people saying she might not be Black enough. "So there's all these different sources of discrimination that are affecting the development of your multiracial identity and your experience with it, and that can make it hard to navigate," Sanchez said. (Chittal 2021)

If you want to learn more about the experience of mixed-race people, check out this video: Do All Multiracial People think the Same? What is your own experience?

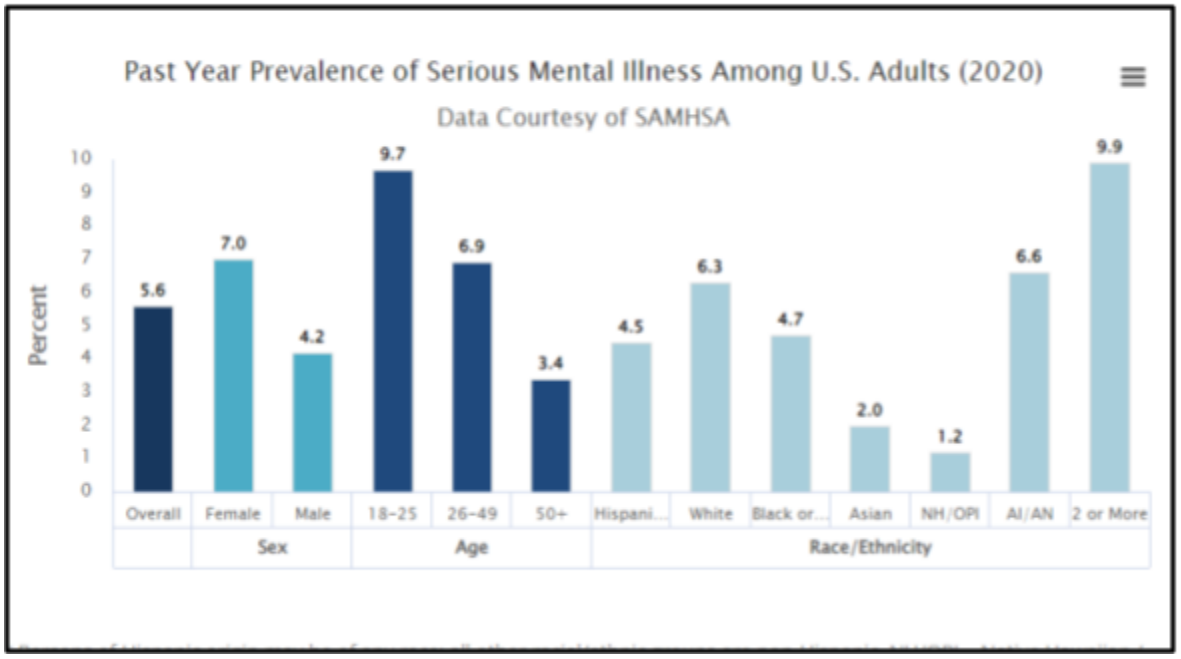

Figure 9.6 Prevalence of Serious Mental Illness 2020

Image Description:

- In 2020, there were an estimated 14.2 million adults aged 18 or older in the United States with SMI. This number represented 5.6% of all U.S. adults.
- The prevalence of SMI was higher among females (7.0%) than males (4.2%).
- Young adults aged 18-25 years had the highest prevalence of SMI (9.7%) compared to adults aged 26-49 years (6.9%) and aged 50 and older (3.4%).
- The prevalence of SMI was highest among the adults reporting two or more races (9.9%), followed by American Indian / Alaskan Native (AI/AN) adults (6.6%). The prevalence of SMI was lowest among Native Hawaiian / Other Pacific Islander (NH/OPI) adults (1.2%).

For the graph in figure 9.6, we will focus on the different prevalence of serious mental illness between women and men. Worldwide, women are more likely than men to experience mental health issues (Andermann, 2010). Before we commonly held the conclusion that women are just more emotional, however, we need to consider other factors. Women are more likely in their lives to experience violence and go hungry. In the article, Culture and the social construction of gender: Mapping the intersection with mental health, psychiatrist Lisa Andermann calls us to look beyond individual explanations of women's mental health and explore structural factors:

> Identifying the psychosocial factors in women's lives linked to mental distress, and even starting to take steps to correct them, may not be enough to reduce rates of mental illness or improve well-being of women around the world. More studies which take into account the interaction between biological and psychosocial factors are needed to explore the perpetuating factors in women's mental health, and explain why these problems continue to persist over time and suggest strategies for change. And for these changes to occur, health system inadequacies related to gender must be addressed. (Andermann 2010)

In section 9.4 of this chapter we look at the structures of patriarchy that impact all of our lives.

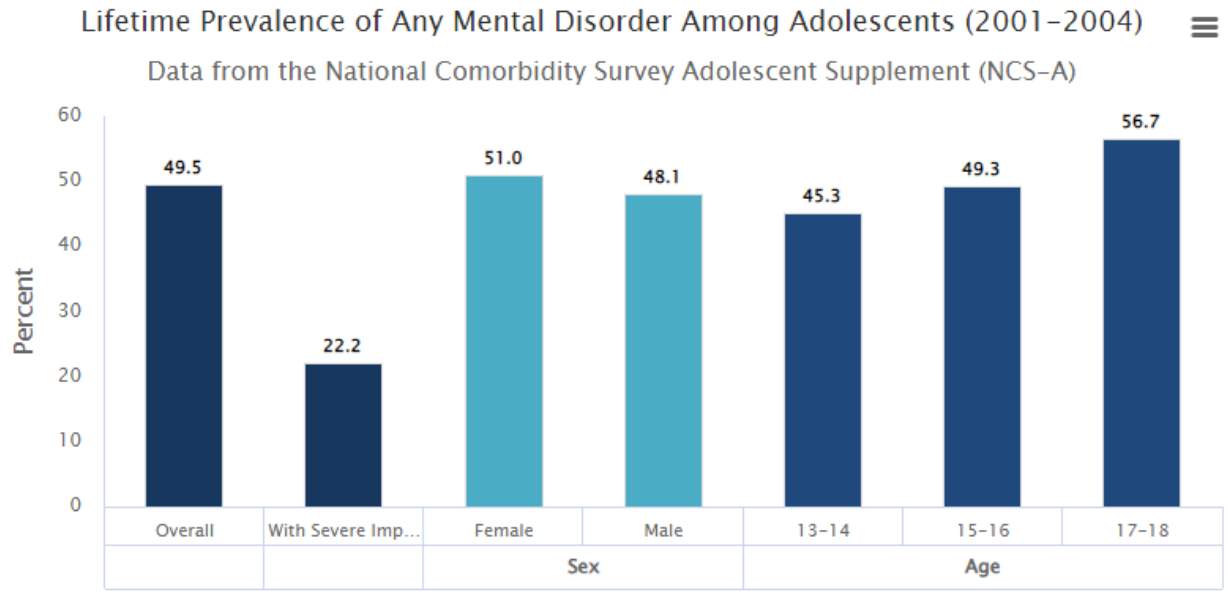

Figure 9.7 Prevalence of Any Mental Disorders Among Adolescents Almost half of all teenagers report a mental disorder. What do you think might cause such a high rate?

Image Description

- Based on diagnostic interview data from National Comorbidity Survey Adolescent Supplement (NCS-A), Figure 5 shows lifetime prevalence of any mental disorder among U.S. adolescents aged 13-18.[1]
  - An estimated 49.5% of adolescents had any mental disorder.
  - Of adolescents with any mental disorder, an estimated 22.2% had severe impairment. DSM-IV based criteria were used to determine impairment level.

When 21 percent of all adults have a mental illness and almost half of all teenagers have mental disorders, as demonstrated in figure 9.7, the condition goes beyond being a personal trouble, and

enters the realm of public issue. This video tells the story of the increase in teen suicide with the COVID-19 pandemic. Because this video recreates the experience of a parent who's child committed suicide, please skip it if you may experience harm.

Why is there such a wide difference between teenagers and adults? It's hard to say for sure, but research offer three options:

Biology: Scientists are mapping changes in the brain in much more detailed ways. During adolescence, the wiring of the brain changes significantly, adding connections, particularly connections related to executive planning and regulation. Pruning these connections is also happening, when particular pathways are not being used. Related to these changes in brain and hormones (Giedd et al., 2008). In addition, the onset for 50 percent of adult mental health disorders occurs by age 14, and for 75 percent of adults by age 24 (Kessler, 2007).

Inclusion in data: Other researchers suggest that part of the difference between the two age groups has to do with being able to contact people. Many youth are still connected with school and family, even if they are experiencing mental health issues. Most mental health surveys don't contact people in residential living, including assisted living, group homes, or prison or jail. Also, they do not contact people who are houseless. Also, young people who took their own lives would of course not be included in adult statistics. Because of this mental health issues in adult and senior populations may be significantly under reported (Kessler & Wang, 2008).

More stress, less stigma: Also, researchers are exploring whether the increase in reporting of mental health issues for teens and young adults is due to experiencing more stressors or experiencing less stigma around reporting mental health concerns. This article, Why Gen Z is More Open in Talking about Their Mental Health explores this conundrum.

What other reasons might you think the two populations would be different? Can you find any evidence?

Conflict in values

One major conflict in values we see in the social problem of mental health and mental illness is the value of community care versus the efficacy of medical care. Historically, many people with mental illnesses were institutionalized. Many state hospitals provided essential care. People were

isolated from their families and communities and significantly stigmatized. Also, because these facilities were often locked, outside oversight was often limited. In 1955 there were over half a million people who were hospitalized (Talbott 2004).

Since this high, the institutionalized population has decreased by almost 60 percent. Some of that decrease is due to a change in values. Talbott writes, "the impact of the community mental health philosophy that it is better to treat the mentally ill nearer to their families, jobs, and communities." This perspective humanizes people with this condition.

Unfortunately, government funding for community mental health services and other social supports is insufficient to meet the need. Instead of finding wrap around support, many people who were deinstitutionalized became homeless instead.

Socially constructed but real in consequences

Health consists of mental well-being as well as physical well-being, and people can suffer mental health problems in addition to physical health problems. Scholars disagree over whether mental illness is real or, instead, a social construction. The predominant view in psychiatry, of course, is that people do have actual problems in their mental and emotional functioning and that these problems are best characterized as mental illnesses or mental disorders and should be treated by medical professionals (Kring & Sloan 2010).

But other scholars, adopting a labeling approach, say that mental illness is a social construction or a "myth" (Szasz, 2008). In their view, all kinds of people sometimes act oddly, but only a few are labeled as mentally ill. If someone says she or he hears the voice of an angel, we attribute their perceptions to their religious views and consider them religious, not mentally ill. But if someone instead insists that men from Mars have been in touch, we are more apt to think there is something mentally wrong with that person. Mental illness thus is not real but rather is the reaction of others to problems they perceive in someone's behavior.

This intellectual debate notwithstanding, many people do suffer serious mental and emotional problems, such as severe mood swings and depression, that interfere with their everyday functioning and social interaction. Sociologists and other researchers have investigated the social

epidemiology of these problems. Several generalizations seem warranted from their research (Cockerham, 2011).

Unequal outcomes

First, social class affects the incidence of mental illness. To be more specific, poor people exhibit more mental health problems than richer people: they are more likely to suffer from schizophrenia, serious depression, and other problems (Mossakowski 2008). A major reason for this link is the stress of living in poverty and the many living conditions associated with it. One interesting causal question here, analogous to that discussed earlier in assessing the social class—physical health link, is whether poverty leads to mental illness or mental illness leads to poverty. Although there is evidence of both causal paths, most scholars believe that poverty contributes to mental illness more than the reverse (Warren 2009).

Figure 9.8 Jessica B – Self Portrait of Depression. Why are women more likely than men to be seriously depressed?

Women are more likely than men to be seriously depressed. Sociologists attribute this gender difference partly to gender socialization that leads women to keep problems inside themselves while encouraging men to express their problems outwardly.

Second, there is no clear connection between race/ethnicity and mental illness, as evidence on this issue is mixed: although many studies find higher rates of mental disorder among people of color, some studies find similar rates to Whites' rates (Mossakowski, 2008). These mixed results are somewhat surprising because several racial/ethnic groups are poorer than Whites and more likely to experience everyday discrimination, and for these reasons should exhibit more frequent symptoms of mental and emotional problems. Despite the mixed results, a fair conclusion from the most recent research is that African Americans and Latinos are more likely than Whites to exhibit signs of mental distress (Mossakowski 2008; Jang et al., 2008; Araujo & Borrell 2006).

Third, gender is related to mental illness but in complex ways, as the nature of this relationship depends on the type of mental disorder. Women have higher rates of bipolar disorders than men and are more likely to be seriously depressed, but men have higher rates of antisocial personality disorders that lead them to be a threat to others (Kort-Butler 2009; Mirowsky & Ross 1995). Although some medical researchers trace these differences to sex-linked biological differences, sociologists attribute them to differences in gender socialization that lead women to keep problems inside themselves while encouraging men to express their problems outwardly, as through violence. To the extent that women have higher levels of depression and other mental health problems, the factors that account for their poorer physical health, including their higher rates of poverty, stress, and rates of everyday discrimination, are thought to also account for their poorer mental health (Read & Gorman 2010).

Although people rarely take to the streets to protest mental illness, mental health is a social problem. In the next section, we'll look deeper at the inequalities related to mental health, and explore some of the causes of that inequality.

The Basics: Mental Health and Mental Illness as a Social Problem

Attributions and Licenses

9.3 Social Location and Mental Health

Figure 9.9 Equity Matters to Mental Health: Equity and Mental Health impact each other

The infographic in figure 9.9, Equity Matters to Mental Health, highlights the intersectional nature of social location and mental health. In the related report, the Canadian Mental Health Association-Ontario describes the relationship between equity, mental health, and intersectionality:

1. *Equity matters for mental health*. Due to decreased access to the social determinants of health, inequities negatively impact on the mental health of Ontarians. Marginalized groups are more likely to experience poor mental health and in some cases, mental health conditions. In addition, marginalized groups also have decreased access to the social determinants of health that are essential to recovery and positive mental health.
2. *Mental health matters for equity*. Poor mental health and mental health conditions have a negative impact on equity. And while mental health is a key resource for accessing the social determinants of health, historical and ongoing stigma has resulted in discrimination and social exclusion of people with lived experience of mental health issues or conditions (PWLE).
3. *Equity and mental health intersect*. People often experience both mental health issues and additional inequities (such as poverty, racialization, or homophobia) simultaneously. Intersectionality creates unique experiences of inequity and mental health that poses added challenges at the individual, community and health systems level. (Canadian Mental Health Association, n.d.)

Mental health status itself can influence your ability to stay in school, hold a job, or raise a family. And the reverse is also true—if you are struggling to put food on the table, keep your kids stable, or stay safe in your neighborhood, you are more likely to have poor mental health.

We introduced the concept of intersectionality in Chapter 1, as a way of identifying your own social location. Another way of understanding intersectionality though, is by looking at categories of oppression. This intersection is detailed in figure 9.10.

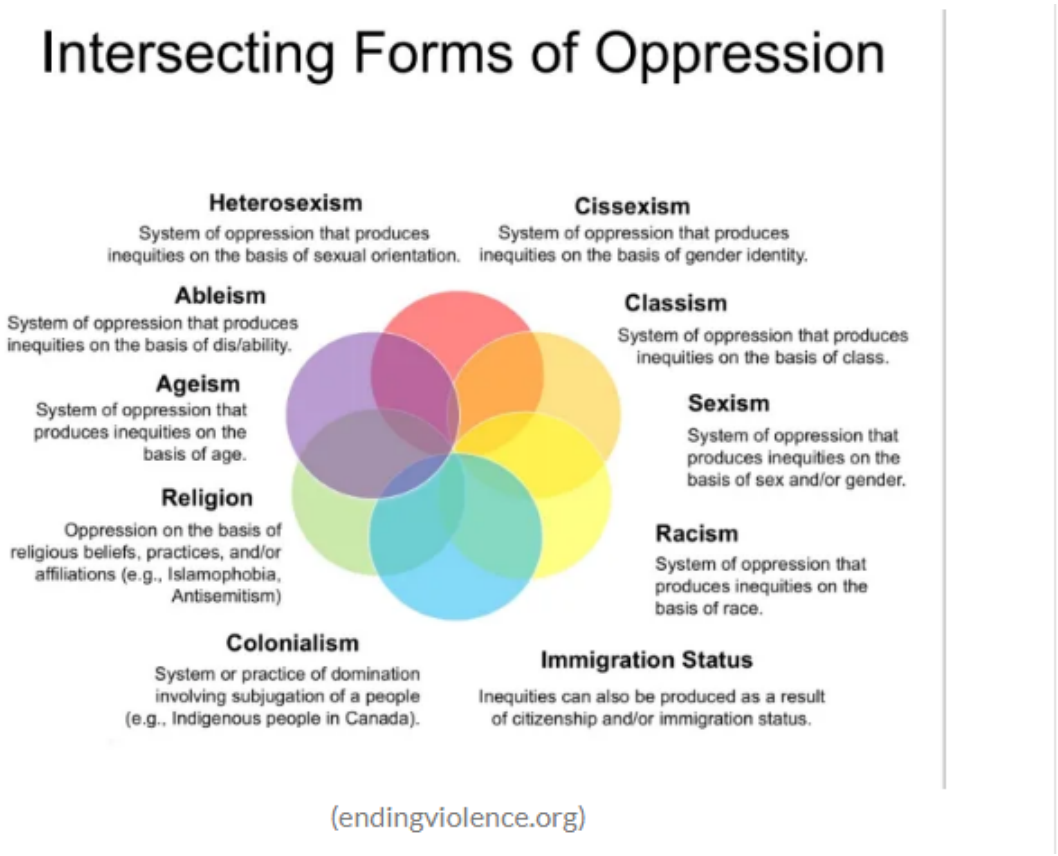

Figure 9.10 Intersecting forms of oppression: This infographic is another way to think of intersectionality and how different forms of oppression can amplify each other.

Image Description: Intersecting forms of oppression are 1) Heterosexism: system of oppression that produces inequities on the basis of sexual orientation, 2) Cissexism: system of oppression that produces inequities on the basis of ender identity, 3) Classisim: system of oppression that produces inequities on the basis of class, 4) Sexism: system of oppression that produces inequities on the basis of sex and/or gender, 5) Racism: system of oppression that produces inequities on the basis of race, 6) Immigration Status: inequities can also be produced as a result of citizenship and/or immigration status, 7) Colonialism: system or practices of domination involving subjugation of a people (e.g. Indigenous people in Canada), 8) Religion: oppression on the basis of religious beliefs, practices and/or affiliations (e.g. Islamophopia, Antisemitism), 9) Ageism: system of oppression that produces inequities on the basis of age, 10) Ableism: system of oppression that produces inequities on the basis of dis/ability.

Each of these layers of oppression connects with the other sources of oppression. Social locations such as race, ethnicity, class and socioeconomic status, sexuality, sex, and gender, all impact mental health outcomes. Kimberle Crenshaw, who popularized the concept of intersectionality, spoke recently about the urgency of intersectionality in this video: The Urgency of Intersectionality

While you're watching the video, think about how intersectionality may impact mental health. How does a White woman experience a mental health crisis differently than a Black woman, for example? One research paper examines the intersectionality of mental health, racism, sexism, and ageism. If you'd like to learn more, please read: Triple Jeopardy: Complexities of Racism, Sexism, and Ageism on the Experiences of Mental Health Stigma Among Young Canadian Black Women of Caribbean Descent

Although there are many ways to layer social location, we look more deeply at Race and Ethnicity, Class, Language, and Gender.

9.3.1 Race and Ethnicity

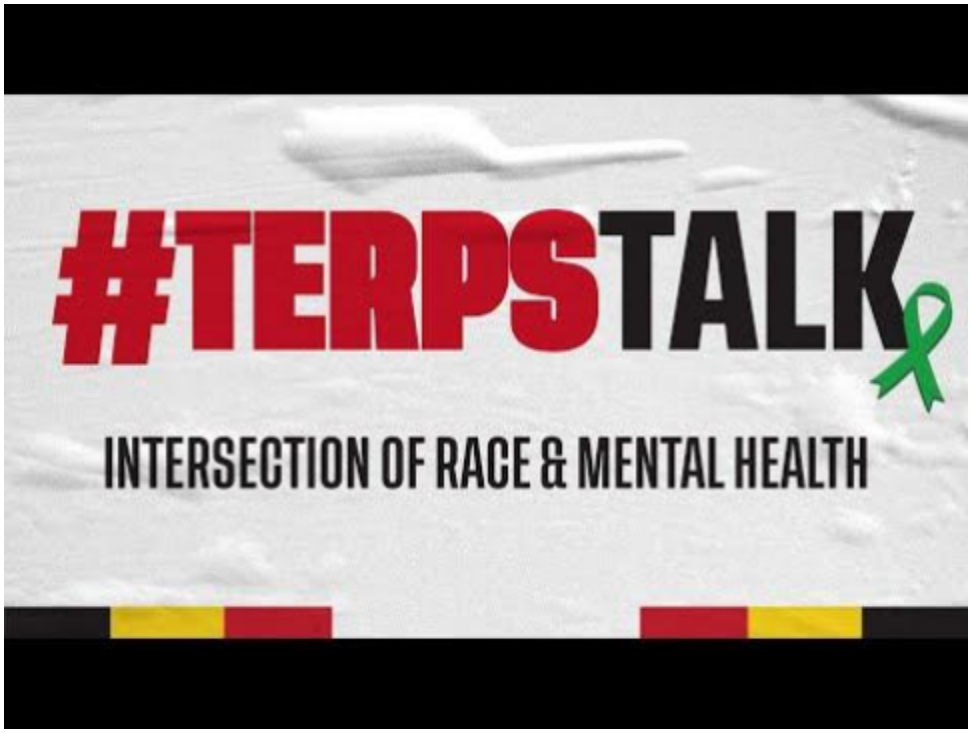

Figure 9.11 Intersection of Race and Mental Health Video. Please watch the first 10 minutes of this video discussing both the needs for mental health services and the barriers to services for BIPOC people. What issues are new as part of our discussion of social problems?

The video in figure 9.11, "The Intersection of Race and Mental Health," presents some of the newest research on race and mental health. It specifically calls out racial trauma as a cause of mental health issues. **Racial trauma** is one term used to describe the physical and psychological symptoms that people of color often experience after being exposed to stressful experiences of racism (Carter 2007). We've talked already about microaggressions in Chapter 1. We've discussed the police violence and disproportionate incarceration of people of color in Chapter 6. These experiences, and many others, contribute to racial trauma.

Making this problem worse, Black, Brown, and Indigenous people have less access to mental health services. In the chart in figure 9.12 Mental Health Service Use in the Past Year among Adults with Serious Mental Illness, by Race/Ethnicity and Age Group, we notice that White people use mental health services more than any other group.

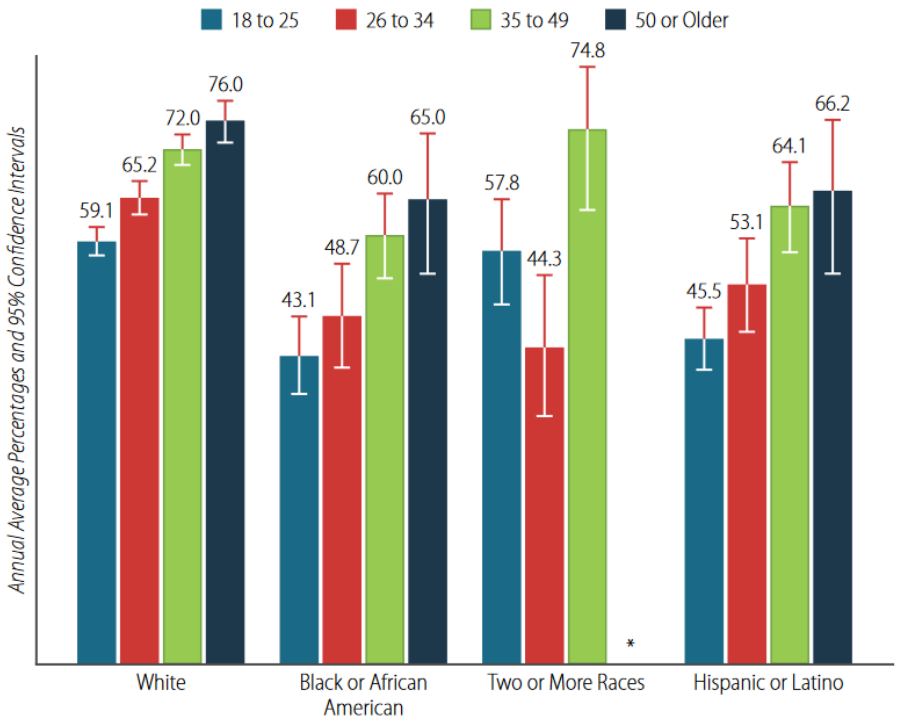

Figure 9.12 Mental Health Service Use in the Past Year among Adults with Serious Mental Illness, by Race/Ethnicity and Age Group: 2015–2019, Annual Averages

We can also examine the amount of unmet needs for mental health services according to race and ethnicity. When we do this, we see:

> Levels of unmet need (not receiving specialist or generalist care in past 12 months, with identified diagnosis in same period)
>
> - African Americans – 72 percent
> - Asian Americans – 78 percent
> - Hispanics – 70 percent
> - Non-Hispanic Whites – 61 percent

Black and Brown people have a harder time accessing quality mental health services, and when they do receive services, they are more likely to have a negative experience. Some cultures have

more stigma around mental health issues that White Americans generally have, and that can be a barrier for some immigrants and some first and second generation Americans to seek services.

For immigrants, mental health providers often lack language and cultural competency skills, which makes the treatment much less effective. Finally, racial and ethnic minorities are profoundly underrepresented in research and clinical trials for new treatments. This means that their bodies and life experiences are not considered when new treatments and medications are developed.

9.3.2 Class Issues in Mental Health Treatment

One of the most consistent findings across studies is that lower socioeconomic groups have greater amounts of mental illness. Why is this the case?

One of the earliest studies of the sociology of mental health came from the University of Chicago in the 1930s. You may remember this school from our discussion of Jane Addams in Chapter 1. Sociologists explored whether mental illness caused poverty or whether poverty caused mental illness. The two researchers who led this project—Faris & Dunham—looked at psychiatric admissions to Chicago hospitals by neighborhood. What they found was rather shocking—there was a nine times increased rate of schizophrenia from people who came from poorer neighborhoods, than from more middle-class neighborhoods. Faris and Dunham tried to figure out why.

One idea was *social selection*, the idea that lower class position is a consequence of mental illness. Mentally ill people would drift downward into lower income groups or poorer neighborhoods, because they couldn't keep jobs.In addition to considering social selection, they considered *social causation*, also. In this model, lower class position was a cause of lower class position is a cause of mental illness.

Results of this early study came back mixed. At first, Faris & Dunham said that the isolation and poverty of living in the central city created schizophrenia—cause. But then, they changed their mind, and said people with schizophrenia have downward drift, and moved to the central, poorer part of town, after developing schizophrenia—effect. Later studies have found that Faris &

Dunham's study was actually trying to tell us that it's both—cause and effect. Social selection theories and social causation theories can be used to account for schizophrenia.

As our infographic on equity and mental health shows, people with mental health issues can struggle with educational and economic stability, because sufficient social supports are not in place to support them. And, poverty itself can be a risk factor for poor mental health. This article from the Guardian, Mental Illness and Poverty: You Can't Tackle One Without The Other might help you to make more sense of this complex relationship.

9.3.3 Gender

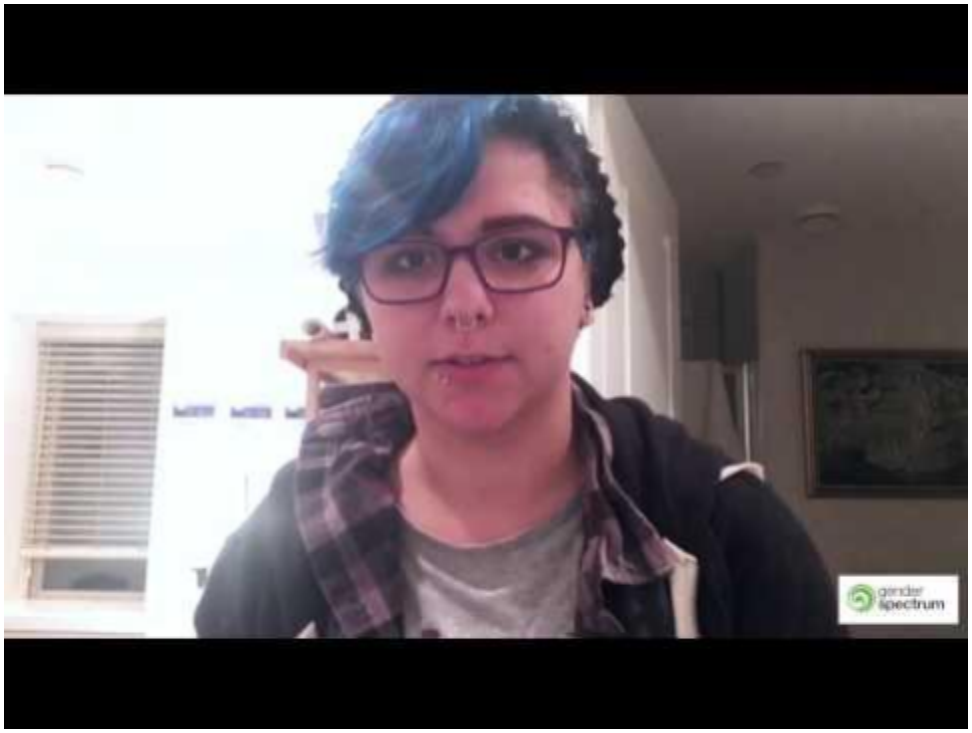

Figure 9.13 Teen Intersectionality Series: Mental Health & Gender As you watch this 4 minute video consider how gender identity and sexual orientation might impact mental health and mental well-being.

Gender has often been an explanation of the occurrence of mental health and mental illness. While traditional explanations focus on women, as explored in the previous section, newer

research is focusing on the interactions of nonbinary and gender fluid folx and their mental health. The video in 9.13 provides some detail around this experience.

But why is gender such a persistent variable in all of our social problems? To make sense of this, let's explore the social structure of patriarchy more carefully the next section

.

Social Location and Mental Health Attributions and Licenses

Figure 9.9 Equity Matters to Mental Health https://ontario.cmha.ca/equity/

Figure 9.10 Intersecting forms of oppression (ending violence.org as quoted in https://www.yoair.com/blog/anthropology-overview-of-the-concept-of-intersectionality/)

Figure 9.11 Intersection of Race and Mental Health Video.https://youtu.be/eiOv_xXsUI0

Figure 9.12 Mental Health Service Use in the Past Year among Adults with Serious Mental Illness, by Race/Ethnicity and Age Group: 2015–2019, Annual Averages

Figure 9.13 Teen Intersectionality Series: Mental Health & Gender https://youtu.be/caSr5rHnxtY

9.4 Social Location: Gender and The Persistence of Patriarchy

Figure 9.14 Gender Fluid Person People do gender in a variety of ways. Would you identify this person as male, female, fluid, androgynous or none of the above?

As early as Chapter 1, we started using the word gender in this book. We discussed sexual orientation and gender identity in Chapter 3, but as usual, we have more to say. Traditionally, sociologists defined **gender** as "The attitudes, behaviors, norms, and roles that a society or culture associated with an individual's sex, thus the social differences between female and male; the meanings attached to being feminine or masculine. " This definition is somewhat outdated, because it labels gender as only female or male, rather than seeing gender expression and gender identity as a continuum.

More new words, you say? The Human Rights Campaign Foundation (HRC) defines **gender identity** as one's innermost concept of self as male, female, a blend of both or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their **sex** assigned at birth. For example, you may know yourself as female, even if your physical body has a penis. Alternatively, you may feel like female or male gender labels don't fit you at all.

HRC further defines **gender expression** as the external appearance of one's gender identity, usually expressed through behavior, clothing, body characteristics or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine. Often your identity and your expression match. Sometimes, you may choose to wear skirts, glitter, and paint your nails, even if your gender identity is male.

Gender, then, is a complex construct. Gender develops throughout life. We may change our gender identity as we age. Paula Stone Willams, a transgender woman describes what she learned about being male and being female in this TED talk: I've lived as a man and a woman

How sociologists understand gender changes as we listen carefully to people who don't fit in traditional gender boxes. How each of us "does" gender changes as we become more authentically ourselves throughout our life.

Even though our concept of gender is fluid, our social structures consistently privilege people with a male gender and marginalize people of a femal or nonbinary gender. How can we explain the persistence of this oppression?

Figure 9.15 Alda Facio Changemaker - Publicly available bio image http://learnwhr.org/dec4/

Like our concepts of structural racism in Chapter 6, our society supports the structure of patriarchy. Alda Facio, a Costa Rican jurist, writer, teacher, and activist offers the following definition of patriarchy:

> **Patriarchy** is a form of mental, social, spiritual, economic and political organization/structuring of society produced by the gradual institutionalization of sexbased political relations created, maintained and reinforced by different institutions linked closely together to achieve consensus on the lesser value of women and their roles.

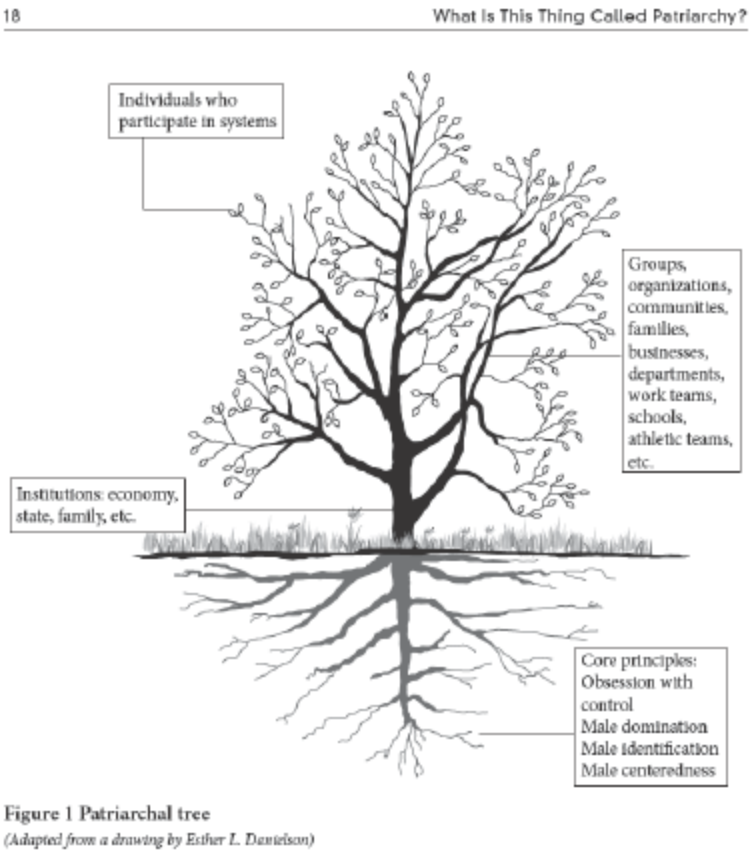

Figure 9.16 Patriarchy is like a tree - it has historical roots, structural branches, community limbs and individual leaves.
In the drawing of this tree, we notice:

Roots: The roots of the patriarchal tree are the core beliefs and practices that provide an often unconscious base of patriarchy. These underlying principles are *obsession with control*—controlling women's bodies, money, and choices. This principle also supports the idea that men should stay in control—of their emotions, lives, and other people's lives. The second principle, *male domination*, locates men in positions of authority. Leadership is a male role and a source of male power. The third principle, *male identification*, locates men at the center of what is right and good. We see this principle in action when we use words like all mankind when we actually mean all people. The fourth and final principle is *male centeredness*. In this principle we focus on and value the activities of men and boys, rather than women, girls, and nonbinary gendered people. Combining many of these principles in

action, the U.S. Soccer Federation only agreed that female and male soccer players should earn equal pay in 2022. For more on this landmark victory, feel free to read: The US National Women's Soccer Team wins $24 million in equal pay settlement.

Trunk: The trunk of this structural inequality are our institutions, our governments and our economy. Throughout this book, we have seen examples of gender inequality, often supported by our schools, businesses and governments. (We've also seen how these organizations sometimes change to become less patriarchal.)

Branches: The branches of our tree are the smaller containers of social interaction such as families, churches, clubs, work teams, or your favorite gamers discord group. At this level, group norms influence the behavior of individuals. In these smaller communities, we explore what it means to do the gender of nonbinary, female, or male. For example, in many heterosexual dual-parent families, members take on traditional gender roles; the father does the outside chores like mowing the lawn, the mother cooks, and the kids do their homework with the help of both their parents.

Leaves: Each of us is a leaf on the patriarchal tree. In our own actions we can reinforce gender norms or we can consciously choose to uproot these deep roots. Our choices matter deeply. However, by placing each of us in a system of power, we move away from shame, blame, and a bad person model. Instead, we can examine how social structures of gendered oppression may be reproduced in our own daily interactions. This knowledge empowers us to choose differently.

Because this structure is both deeply rooted and interconnected, it is resistant to change. Also, patriarchy itself becomes a reason for inequality in all of our social problems.

The Persistence of Patriarchy Licenses and Attributions

Figure 9.14 Gender Fluid Person. Photo by Mapbox on Unsplash

Figure 9.15 Alda Facio - Publicly available bio image http://learnwhr.org/dec4/
Figure 9.16 Patriarchal Tree Allan Johnson The Gender Knot p. 18 - Using temporarily for this book, will replace.

9.5 Mental Health: Models and Treatments

In this section, we explore the different models of mental health and mental illness. These models come to us from different academic disciplines—psychology, psychiatry, and sociology. All three have something to offer to help us understand mental health and mental illness. We also consider some of the main treatments for mental illness.

9.5.1 Medical and Psychological Models of Mental Health and Mental Illness

Cultural views and beliefs about mental illness have varied enormously over the course of history. For example, ancient humans once believed that mental illness was caused by the influence of evil spirits over the afflicted person. Accordingly, treatments back then involved removing part of the patient's skull to allow the demon to escape. Later, during the Middle Ages, mental illness was thought to be connected to the moon (hence the term *lunacy*). Another common belief was that a person with mental illness was being punished by God.

Fortunately, we've come a long way since then. However, scientists are still struggling to pinpoint exactly what causes mental illness. Most people, however, agree that mental illness can be influenced by a variety of things, including biological factors, personal history and upbringing, and lifestyle. To help provide a framework for understanding these potential causes, experts have developed a number of different models, which we'll explore here.

9.5.1.1 Biological model

The **biological model** of mental illness approaches mental health in much the same way an MD would approach a sick or injured patient: they look for problems or irregularities in the body that are causing the symptoms. Adherents of the medical model believe that mental illness is primarily caused by biological factors such as abnormal brain chemistry or genetic predisposition.

9.5.1.2 Medical model

The **medical model** of mental illness has proven to be true in many cases. For example, depression has long been linked to deficiencies in certain neurotransmitters, and schizophrenia has been shown to run in families. Science like this forms the basis of psychopharmacology, which seeks to treat mental illness with medication that adjusts the level of neurotransmitters present in the brain. However, critics of the medical model believe that it is too simple because it ignores important nonbiological factors in a person's life.

9.5.1.3 Psychological model

As you might expect, in the **psychological model** of mental illness, psychologists look at psychological factors to explain and treat mental illness. For example, they look at attachment theory, which is a theory that examines how you relate to other people. In fact, there are over 400 different psychological models of therapy—there is a right model for everybody, and a psychologist's or therapist's job is to figure out which of those models work for which patient. Of course, psychologists have preferences and skill sets—no psychologist can practice 400 forms of psychotherapy!

9.5.1.4 Psychosocial model

Psychologists also recognize that social factors impact mental health. This model is called the **psychosocial model** of mental illness. The psychosocial approach focuses on how an individual interacts with and adapts to their environment. Specific factors of interest might include a person's relationships, any past trauma, economic situation, and their outlook on life, including religious beliefs.

Stress—both *good* and *bad*—can affect your mental health, and psychologists pay attention to where these stressful areas are. In fact, starting a new job is in the top three stressful things—but most people are happy to start new jobs. Happiness aside, the new expectations, roles, and attitudes that you find at your new workplace, cause stress. Of course, *negative* things can also cause stress, and psychologists help people develop resilience against this sort of stress so they can successfully navigate the stressful situation.

Another thing psychologists take into account are your social roles. Having conflicting social roles—such as being a parent during Covid and having a full-time job, is a role conflict that can cause stress. There are several different kinds of **role strain**—including when one role takes up too much of the time you need to dedicate to other roles, or when two different roles compete with each other.

As the name implies, the psychosocial model focuses on the importance of psychological and social factors in informing a person's mental health. Rather than looking to a person's brain for clues, a proponent of the psychosocial model of mental illness might look to a patient's personal history, their attitude, beliefs, and life circumstances to better understand their mental illness.

9.5.1.5 Biopsychosocial model

But the psychosocial model is also limited, because it doesn't take biological or genetic factors into account. To address this, psychologists and psychiatrists have developed the **biopsychosocial model** of mental illness, which addresses the idea that mental health problems are caused by a combination of biological, sociological, and psychological features.

For example, it can be true that a patient has a biological disposition to mental illness *and* that they have experienced trauma that is causing or exacerbating their symptoms. Similarly, many patients have discovered that a combination of psychotropic medication *and* talk therapy is helpful in addressing their mental health issues. In fact, many mental health care providers integrate both approaches into a more holistic framework called the biopsychosocial model.

9.5.2 Sociological Approaches to Mental Illness

Mental illness, as the eminent historian of psychiatry Michael MacDonald once aptly remarked, "is the most solitary of afflictions to the people who experience it; but it is the most social of maladies to those who observe its effects" (MacDonald 1981:1). It is precisely the many social and cultural dimensions of mental illness, of course, that have made the subject of such compelling interest to sociologists. They have responded in a huge variety of ways to the enormously wide social ramifications of mental illness, and the inextricable ways in which the cultural and the social are implicated in what some might view as a purely intrapsychic phenomenon.

If psychiatry has typically, though far from always, focused on the individual who suffers from various forms of mental disorder, for the sociologist it is—naturally—the social aspects and implications of mental disturbance for the individual, for his or her immediate interactional circle, for the surrounding community, and for society as a whole, that have been the primary intellectual puzzles that have drawn attention.

How, for example, are we to define and draw boundaries around mental illness, and to distinguish it from eccentricity or mere idiosyncrasy, to draw the line between madness and malingering, mental disturbance and religious inspiration? Who has the social warrant to make such decisions? Why? Do such things vary temporally and cross-culturally? How have societies responded to the presence of those who do not seem to share our commonsense notions of reality? Who embrace views of reality that strike others as delusional? Who sees objects and hears voices invisible and inaudible to the rest of us? Who commits heinous offenses against law and morality with seeming indifference? Or whose mental life seems so denuded and lacking in substance as to cast doubt on their status as autonomous human actors?

Figure 9.17 Erving Goffman, Canadian born Jewish sociologist Erving Goffman researched mental health, mental illness. His book Stigma is essential in understanding the social construction of difference.

Mental illness has profoundly disruptive effects on individual lives and on the social order we all take for granted. Erving Goffman (figure 9.17), whose mid-twentieth century writings still constitute some of the most provocative and profound sociological meditations on the subject is perhaps best-known for his searing critique of mental hospitals as total institutions.

Accepting, then, that there is such a thing as mental illness (all the while acknowledging that some sociologists and even some renegade psychiatrists have questioned its reality, and still others have debated its designation as a specifically medical problem), a whole series of further questions then arise: How much of it is there, and how do we know, if indeed we do? What is its social location? Does that differ by class, by age, by gender, by race, by ethnicity, and so forth? Do these social variables have implications for the way mental illness is reacted to and socially managed? What are the costs of such episodes of mental disturbance to individuals, families, and society as a whole, and how are those costs distributed?

How have societies characteristically responded to mental illness, and what institutions have they constructed to contain and perhaps cure it? What changes in these responses have occurred over time, and what accounts for these changes? How has mental illness been conceptualized by professionals, but also by the laity? And how have these differing cultural meanings been captured, refracted, and distorted in popular culture? One could go on, but the vital importance of a sociological perspective on mental illness should by now be apparent.

From the late nineteen-sixties through the nineteen-eighties, the intellectual distance and even hostility between sociologists and psychiatrists often seemed to be growing. Within five years of the appearance of Goffman's groundbreaking book *Asylums*, the California sociologist Thomas Scheff had authored an in some ways still more radical assault on psychiatry, dismissing the medical model of mental illness and attempting to replace it with a societal reaction model, wherein mental patients were portrayed as victims—victims, most obviously, of psychiatrists (Scheff, 1966). Noting that despite centuries of effort, "there is no rigorous knowledge of the cause, cure, or even the symptoms of functional mental disorders", he argued that we would be better off adopting "a [sociological] theory of mental disorder in which psychiatric symptoms are considered to be labeled violations of social norms, and stable 'mental illness' to be a social role." And "societal reaction [not internal pathology] is usually the most important determinant of entry into that role" (Scheff 1966:pp. 25).

During the 1960s and 1970s, the societal reaction theory of deviance enjoyed a broad popularity and acceptance among many sociologists, and Scheff's was one of the principal works in that tradition. But besides attracting derision and hostility from psychiatrists (Roth 1973), where they deigned to notice his work at all, it came under increasing criticism from within sociology on both theoretical (Morgan 1975) and empirical (Gove 1970; Gove & Howell 1974) grounds. In the face of an avalanche of well-founded objections, Scheff was eventually forced to back away from many of his more extreme positions, and by the time the third edition of his book appeared (Scheff 1999), most of its bolder ideas had been quietly abandoned. Labeling and stigmatization of the mentally ill have remained important subjects for sociologists, even if few would now argue that they have the significance once attributed to them.

Though the skeptical claims of the labeling theorists have now been sharply curtailed, much of the sociological work being done on mental illness has retained its critical edge. Four major inter-related changes have occurred in the psychiatric sector in the past half century or so: the progessive abandonment of the prior commitment to hospitalization for patients for life when they have serious mental illness, and the rundown of the state hospital sector; the collapse of psychoanalysis and its replacement by a renewed emphasis on the biological basis of mental illness.

Deinstitutionalization, for example, was initially presented as a grand reform, ironically just as the mental hospital had originally been (Rothman 1971; Scull 1979/1993). From the mid-nineteen-seventies, however, a more skeptical set of perspectives emerged. Psychiatrists had assumed that the new generation of antipsychotic drugs had been the main drivers of the expulsion of state hospital patients. However, in reality it was a political and economic decision by the federal government to close mental hospitals because they were expensive and overcrowded. Also, there was a move toward community mental health, which provides a patient centered approach, but these services were not sufficiently funded. Also, there are not enough beds in current hospitals, in psychiatric wards, for the people who really need them.

In addition, the hegemony of the Diagnostic and Statistical Manual (DSM) began to attract attention, with critics examining both the processes by which the successive editions had been produced, and the intended and unintended effects of its widespread use (Kirk & Kutchins 1992; Kutchins 1997; Horwitz & Wakefield 2007). The sources and the impact of the

psychopharmacological revolution drew increased interest, with attention paid to both the role of the pharmaceutical industry and changes in the intellectual orientation of the psychiatric profession (Healy 1997/2002; Herzberg 2008).

Scholars working on the sociology of mental illness thus now confront a very different research environment than the one that prevailed a quarter century ago. The range of intellectual and policy issues thrown up by the dramatic changes that have marked the mental health sector in the same period mean, however, that there is an abundance of challenging topics for the study of which sociological perspectives are indispensable.

Mental Health: Theories Attributions and Licenses

9.6 Mental Health: Social Agency and Reasons to Hope

As usual, our explorations of social problems can make us depressed, even just by reading this chapter! However, there are several social programs out there designed to alleviate some of the problems outlined in this chapter.

To explore the idea of alternative approaches to addressing this problem, let us examine two programs addressing mental health access to treatment accessibility in nontraditional manners.

Cahoots

Figure 9.18 Cahoots: The people in this picture are working together to create solutions for mental health issues. Where do you see interdependance in their work?

The Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Eugene, Oregon is a program for addressing mental health and drug-related issues integrated into the police and 911 emergency access services system operated jointly by the White Bird Clinic and the Eugene police. To learn more, feel free to listen to the National Public Radio (NPR) audio in figure 9.18.

Its beginnings formed around an offshoot of the counterculture movement in Eugene, providing both volunteer-operated mental health services to the community and periodic role-playing seminars to the Eugene police on an informal basis on managing and defusing mental health related situations in policing. In the 1980s the police department began taking advantage of the community initiative, informally referring mental health cases to the CAHOOTS organization to reduce direct involvement of police in noncrime related scenarios. CAHOOTS volunteers offer crisis response services and access to other community services to persons experiencing mental health or drug-related issues.

Following a 2015 lawsuit against the city for excessive use of force and racial discrimination in a fatal shooting of a veteran with PTSD by the Eugene police, the incidents helped focus public attention on Eugene's response to mental health crisis, leading to the city council committing $225,000 of the city police budget to fund 24/7 availability of the CAHOOTS services and access to the 911 dispatch system.

As the CAHOOTS organization began to respond to calls, the delays in responding to issues decreased significantly, to a level about double the time required for a response by the police. CAHOOTS estimates that in 2021, roughly 17 percent of the calls to 911 in Eugene resulted in a dispatch of a CAHOOTS team—reducing the involvement of the official police significantly. Chris Skinner, the Eugene chief of police, commented before the pandemic hit that increasing the number of CAHOOTS teams is a benefit of probability—"the less time I put police officers in conflict with people, the less time those conflicts go bad".

In 2019, Eugene voters approved a payroll tax to bring in $23 million for additional community-safety positions. In the initial proposal, two-thirds of this money was intended to go to the police department for additional positions. Reacting to the Black Lives Matter protests, the city council instead opted to redirect that money to consider community organizations instead. CAHOOTS received some of that money, in addition to benefiting from county use of federal CARES Act funding to open a 250-bed homeless shelter in buildings on the Lane County Fairgrounds. The federal funding expired in June of 2021, but talks are in place to expand the use of some police funds to maintain the program, roughly $1 out of every $50 committed to the police budget.

Loveland Foundation

A different approach by the Loveland Foundation addresses resources to communities of color in a number of locations nationwide, including Texas, Georgia, California, Ohio, and New York. The Loveland Foundation was established in 2018 by Rache Cargle in response to a fundraiser for therapy support for Black women and girls.

The organization partners with organizations providing culturally-competent therapy resources for Black women and girls in the areas where they operate. The organization funds all or part of

the costs of access to therapy and operates workshops for therapy providers to educate about eating disorders in Black women and girls, in partnership with the Renfrew Center for Eating Disorders. The workshops are a six part series focusing on providing the historical context, etiology, intergenerational trauma and its impact on body image, assessment, and treatment.

One unusual feature is their approach to building future therapy support resources for specifically people of color. According to the American Psychological Association, only 17 percent of the therapists in the U.S. identify as people of color, and only 3 percent identify as Black or African American. The Loveland Foundation is investing significant scholarship funding in enabling undergraduate and graduate education for BIPOC people intending to offer therapy to the BIPOC community, including addressing the use of unpaid internships and lack of dependable mentors to provide support resources to students wishing to address this need.

9.6 Mental Health: Social Agency and Reasons to Hope Attributions and Licenses

Figure 9.18 Cahoots https://whitebirdclinic.org/cahoots-act-moves-forward/ on cahoots/whitebird website for publicity - Fair Use

9.7 Conclusion

In this section, we have explored the different explanations for mental health, mental wellness, and mental illness. We have looked at what sociologists care about when they study mental health, and we have looked at some of the leading explanations for mental challenges—including stress and social role conflict. We have seen that people of color, and people who are poor, are more likely to have mental health challenges—and we have seen that this is probably both an effect of being poor, as well as a cause. We ended the chapter by looking at innovative ways social service organizations have responded to mental illness problems in their communities.

9.7.1 Key Terms

anxiety disorders: a disorder characterized by excessive anxiety.

commodification of mental illness: the process by which people with or without mental illnesses become consumers- of therapy, medication, or lifestyle changes. Mental health becomes something you can "buy."

Diagnostic and Statistical Manual of Mental Disorders (DSM): the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders. DSM contains descriptions, symptoms and other criteria for diagnosing mental disorders.

Gender: the attitudes, behaviors, norms, and roles that a society or culture associated with an individual's sex, thus the social differences between female and male; the meanings attached to being feminine or masculine.

five models of mental illness: *biological model*: understands mental health and illness to be a combination of genetics and neurochemicals. It understands mental illness to be a defect of brain chemistry. *biopsychosocial model:* an interdisciplinary model that looks at the interconnection between biology, psychology, and socio-environmental factors *medical model:* a theory that states that psychiatric conditions are caused by an imbalance of chemicals in the brain. *psychological model:* an approach to mental illness that assumes mental health and mental illness lie within mental processes, such as beliefs, attitudes, thinking patterns, and life experiences. *sociological model:* an approach that emphasizes that a society's culture shapes its understanding of health and illness and practice of medicine"

gender identity: one's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

gender expression: the external appearance of one's gender identity, usually expressed through behavior, clothing, body characteristics or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

mental health: a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.

mental illness: a wide range of mental health conditions, disorders that affect your mood, thinking, and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders, and addictive behaviors.

mental wellbeing: an internal resource that helps us think, feel, connect, and function; it is an active process that helps us to build resilience, grow, and flourish.

mood disorders: affective disorders which refers to a number of psychological illnesses that affect mood. (affect (noun) is the outward expression of internal emotions)

patriarchy: a form of mental, social, spiritual, economic and political organization/structuring of society produced by the gradual institutionalization of sex based political relations created, maintained and reinforced by different institutions linked closely together to achieve consensus on the lesser value of women and their roles.

personality disorders: any of a class of mental disorders characterized by ongoing rigid patterns of thought and action.

psychopathology: the condition of having a psychological or psychiatric disorder that is pathologized into being an illness.

racial trauma: a term used to describe the physical and psychological symptoms that people of Color often experience after being exposed to stressful experiences of racism (Carter 2007)

role strain: a situation caused by higher-than-expected demands placed on an individual performing a specific role that leads to difficulty or stress.

self-fulfilling prophecy: the psychological phenomenon of someone "predicting" or expecting something, and this "prediction" or expectation coming true simply because the person believes or anticipates it will and the person's resulting behaviors align to fulfill the belief. This suggests that people's beliefs influence their actions.

sex: A biological categorization based on characteristics that distinguish between female and male based on primary sex characteristics present at birth.

stereotype: the characterization of a group of people as sharing the same behavior and features.

stigmatization of illness : when stigma is aimed at a person with a physical or mental illness or condition

trauma: a person (or group) response to a deeply distressing or disturbing event that overwhelms one's ability to cope, causes feelings of helplessness, diminishes self esteem and the ability to feel a full range of emotions and experiences.

9.7.2 Discussion Questions

1. What are the differences between mental health, mental illness, and mental well-being? What factors impact which label someone might receive?
2. How do different approaches define and treat mental illness?
3. Mental illness and mental health often underlie other social problems. Please explain this statement using a specific example.
4. How has COVID both increased the incidence of poor mental health and increased our capacity for providing mental health support?
5. How have the structures and practices of patriarchy contributed to gender oppression across many social problems?
6. What does it mean to practice "self care"?

7. What impact has COVID-19 had on your understanding of mental health?

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9.7 Conclusion Attributions and Licenses