Is mental illness a social construction?

Thomas Szasz challenged the very foundations of psychiatry by denying the complete existence of mental illness (Szasz, 1960) he is well known for publicly stating that “ mental illness simply functions as a way to explain away irresponsible behaviour” (cited by Gorenstein, 1992). More mainstream perspectives which lead the debate over whether mental illness is a social construction or if it is a real and tangible phenomenon are `medical naturalism’ and `social constructionism’. Social Constructionism argues that something only exists because society built it, created it or needed it for its own development or interest (Boghossian, 2001). Szasz claims that “ mental illness” was developed to control people that did not fit neatly into the current social system (as cited by Burchfield, 2008). Medical Naturalism, conversely, supports the existence of mental illness by assuming that mental abnormalities exist even before society discovers them (Pilgrim & Bentall, 1999).

Social constructionists envisage symptoms as cultural definitions rather than as properties of individuals (Horwitz, 2002). From this viewpoint it is argued that the existence of mental illness depends on the particular culture in which a definition is being attempted. Anthropological work in non-Western cultures has shown that particular behaviours which would be viewed as symptomatic of a mental disorder by Western professionals are completely normal or nonexistent in these cultures (Perring, 2005). Further support for the social constructionist perspective is how every society has its own individual beliefs about what is normal/acceptable behaviour. For example; suicide in Catholic societies goes against the teachings of Christ and is intrinsically linked to poor mental health, whereas in old Japanese tradition,

suicide was a way to atone for your sins and so was respected and honoured (Kawanishi, 2008 as cited in Luu, 2010). Kessler (n. d) states trends in mental health are almost impossible to establish because of the varied way in which mental health data is collected in different countries; data collected from Nigeria, for example, indicates a low rate of mental illness because Nigerians do not talk of mental health (as cited in Schmidt, 2007).

Despite these cultural arguments there is strong evidence which supports the existence of mental illness. In the late nineteenth century, Kraepelin applied the logic that psychological disorders are essentially illnesses or diseases of the body. If behaviour disturbances could be classified and described as diseases then the search for somatic causes and cures would be greatly facilitated. This idea that mental states and disorders are signs or symptoms of bodily processes is known as the Somatogenic hypothesis (Shontz, 1968). A number of mental illnesses demonstrate signs of biological causes or factors; for example, autistic people have been shown to have brain abnormalities. Furthermore those suffering from major depression, schizophrenia and bipolar disorder have shown biochemical imbalances in the brain (Williams, 2009).

The ongoing debate that mental illness is socially constructed is fuelled by there being no universally shared definition for mental illness. Ausubel (1961) defined mental illness as “ behaviour that is either seriously distorted or sufficiently maladaptive to prevent normal interpersonal relations and vocational functioning” (cited in Gorenstein, 1992, p. 5). This definition however simply begs the question of “ What is normal?” Factually speaking, Szasz argues “ disease” implies “ bodily disease” consequently; to speak of

mental illness is to speak metaphorically, as the mind is not a literal part of the body (cited in Perring, 2005). He further argues the term mental illness has outlived its usefulness (Szasz, 1960) and now functions simply to " conceal scientific ignorance" (cited in Gorenstein, 1992). Although Ausubel (1961) was unable to successfully define mental illnesses and refute Szasz, Widiger and Trull (1986) stated that " The failure to define mental illness does not disprove its existence" (cited in Gorenstein, 1992, p5).

Horwitz (2002) casts much doubt on the usefulness of our classification system. He claims that many mental disorders defined in the DSM are normal responses to life stresses such as divorce, job loss and family illnesses. To classify these kinds of problems as mental disorders is turning the concept of mental illness into one that is a social construction developed in response to social and economic pressure (cited by O'Connor, 2002). Kutchins & Kirk state that the use of the DSM reflects " a growing tendency in our society to medicalise problems which are not medical…" (1999, p. ix) Horwitz further argues that many of our more common disorders have been made " fashionable" by the culture of psychotherapy. " Social Phobia" has manifested from a naturally occurring temperament, shyness, into a mental disorder SSRIs (Horwitz, 2002 as cited by O'Connor, 2002). As our knowledge increases we adapt and disregard particular disorders. It is evident from historical categorisations of psychopathology that they are highly influenced by structures of power and cultural norms. Until 1973, homosexuality was universally regarded as a mental illness in Western Psychiatry (Woolfolk, 2001). Moreover in the early nineteenth century Drapetomania, the desire to escape from captivity, was also considered a Mental Illness (Cartwright,

1851/1981; Szasz, 1971; as cited by Woolfolk, 2001). Social Constructionists are at rights to argue that this changing of status brings doubt to the validity of mental illness and makes its existence as a real phenomenon vulnerable.

Support for mental illness not being a social construct comes from evidence from studies which look into whether drug treatment is effective in improving the symptoms of mental disorders. Drug treatments are used for a range of mental illnesses such as Bipolar disorder, Schizophrenia, Anxiety and Depression. Antidepressants are used to alleviate the symptoms of depression, Anxiolytic drugs for the treatment of anxiety, and antipsychotic drugs which alleviate the symptoms of schizophrenia. The most commonly prescribed medication for Bipolar disorder is Lithium, a mood stabiliser which evens out the mood swings between high and low. While lithium diminishes severe manic symptoms, it takes around 5 to 14 days to be effective, and it can take months before the condition is fully controlled (Kauffman, 1999). 10 years after initial diagnosis, approximately 50% of people diagnosed with schizophrenia are either completely recovered or improved to the point of being able to function independently. 25% are improved, but require a strong support network, and an additional 15% remain unimproved and are typically hospitalized. However, 10% of the affected population commits suicide (Nemade & Dombeck, 2009)

To further the argument that mental illness is a social construction is to consider the Postmodernist approach which states “ there are no absolute truths and instead there are only different interpretations formed in language” (Walker, 2006). Postmodernism acknowledges we create vocabularies which we use to interpret our experiences by our human

relationships and communication. Therefore, it is argued that by language we create our “ realities” (Walker, 2006). Phrases such as mental illness or classifications such as schizophrenia are argued to be abstract concepts defined by groups of symptoms. The term Schizophrenia was given to the symptoms of the disorder; hallucinations, delusions and apathy. Following this trail of thought, the various thoughts, feelings and behaviours which result from this “ disorder” exist. However the abstractions, schizophrenia and mental illness, only exist through societal consensus and only live on through convention (Walker, 2006). It can also be argued that delusions and hallucinations are not restricted to being symptoms of mental disorders; they also exist due to other factors such as a response to drug taking or starvation (Woolfolk, 2001).

Strong support in favour of mental illness comes from biological studies. Caspi & Moffitt (2003) suggest that young people who inherit a variant form of the serotonin transporter gene and go through emotionally stressful situations are more prone to depression. Weinberger (n. d) explained how brain functions change in response to the gene variant by using functional magnetic resonance imaging. Individuals with the gene variant showed hyper-activity in the amygdale, a part of the brain that processes fear and were therefore more likely to view the world as threatening meaning that stresses of daily life could be amplified to the point of inducing depression. Genetic factors have been found in Schizophrenia and Bipolar disorder. Those with immediate schizophrenic relatives are roughly 10 times more likely to develop the disorder, a child with one bipolar parent has a 27% chance of being affected and the possibility jumps to 50-75% when both

parents are affected (Meece, 2010). Twin studies report a concordance rate of 60% for Bipolar disorder in monozygotic twins compared to 15% in dizygotic twins (Barrett et al, 2003). These results are highly valuable when arguing that Mental Illness is not a social construction.

The debate over the existence of mental illness is ongoing and likely to continue. Research has provided biological insight into the causes and treatments of certain disorders; however, there are disorders past and present, which many do not view as a sign of mental instability. To say that mental illness is socially constructed is to say it would not exist had it not been socially created. However, genetics plays a major role in Schizophrenia and Bipolar disorder; therefore, essentially for some disorders, it can be said they are not socially constructed.