**lecture 14N:**

a. Bodies and Identity  
b. Deviant Careers in Mental Illness  
c. Sociology’s Central Concept

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**eating disorders (Hudson et al. 2007, Prevalence and Correlates of Eating Disorders)**

- **Varieties and Prevalence: (Hope et al. 2007)**
  - Anorexia Nervosa – purposeful starvation, high mortality (0.9% F; 0.3% M)
  - Bulimia – binge eating followed by vomiting or laxative abuse (1.5% F; 0.5% M)
  - Binge Eating Disorder – uncontrolled episodic consumption without compensatory activities (3.5% F; 2% M)
  - College surveys much higher (15%+), recent cohorts

- **Correlates: young, white, women**
  - Why the close link to gender, age, and cohort?
  - Adolescent onset
  - Why is risk of bulimia and binge eating disorder increasing with successive birth cohorts?

- **Causes: genetic, neurochemical, family/psychodevelopmental, and sociocultural**

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**Lifetime Prevalence in National face-to-face survey N=9282 (Hudson et al, 2007)**

- **Anorexia Nervosa**
  - Female: 0.90%
  - Male: 0.30%

- **Bulimia Nervosa**
  - Female: 1.50%
  - Male: 0.60%

- **Binge Eating Disorder**
  - Female: 3.50%
  - Male: 2.00%
anorexia by cohort (Hudson et al)

“White Rock Girl” (Psyche): normative body standards (?)

1893 1924

1940 and 1947

1940 1947
1970s, 2002, and 1894 (Lapini)

1970s 2002

“white rock girl” Psyche 1894-2000

but... male body ideal shifting too

• Men’s “Health”
McLorg & Taub (1987) anorexia and bulimia

- **Data** - self-help group (n=30; meeting 2 years)
- **Learning** - individual and cultural
  - Parents: emphasized nutrition and exercise
  - Appearance norms/visual objectification of women
- **Career Sequence and self-labeling**
  - CONFORMITY/POSITIVE DEVIANE: eat less, exercise
  - PRIMARY DEVIANE: “obvious solutions” to weight problem; coping mechanism for other problems
  - SECONDARY DEVIANE: norm violation in response to anorexic or bulimic label
  - Limit activities to eating/exercising
  - Bulimics “discredible”; anorexics “discredited”
  - Deviant “master status” (Hughes) and other traits
- **Changes since 1987? Desistance?**

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**lecture 14B:**

**Mental Illness**
Mental Illness/Disorders

- Medical: alterations in thinking, mood, or behavior associated with distress or impaired functioning
- Sociological: violating unspecified "residual norms;" starting as residual rule-breaking (Scheff)
  - Schizophrenia – distorted perceptions and beliefs (dropped subtypes in DSM-V)
  - Mood disorders – depression, bipolar, dysthemia (grist in DSM-V)
  - Personality disorders – e.g., antisocial, obsessive-compulsive (dimensional, not categorical in DSM-V)
  - Substance-related disorders (“Addiction” in DSM-V)
  - Sexual and gender disorders – e.g., paraphilias, low sex drive (hyposexual; gender dysphoria (not disorder) split off from sexual disorders in DSM-V)
  - Disorders diagnosed before adulthood – e.g., mental retardation (intellectual disability in DSM-V; autism)

Lifetime Prevalence (Kessler et al. 2005) [national face-to-face survey]

- Anxiety Disorders: 28.8%
  - E.g., panic, agoraphobia, social phobia, PTSD, OCD, GAD, separation
- Mood Disorders: 20.8%
  - Major depression, dysthemia, bipolar
- Impulse Control disorders: 24.8%
  - Conduct, ADHD, Oppositional-defiant
- Substance Use Disorders: 14.6%
  - Alcohol & drug, abuse v. dependence
- Any disorder: 46.4% (about half)
  - Half start by 14, % by 24

Correlates (Rand 1997), selection, and labeling

- Marital Status (clear)
  - Married have lower rates on most disorders (esp. v. divorced or separated) [selection/causation]
- Class (clear)
  - Low SES tied to higher rates on schizophrenia, cognitive impairment, panic disorder
- Age (clear)
  - Younger: schizophrenia, panic, depression
  - Older: cognitive impairment
- Gender (partly cloudy, but patterned)
  - Women: panic and depression (and help-seeking)
  - Equal: bipolar, schizophrenia, cognitive impairment
- Race/Ethnicity (cloudy – caution here)
  - Whites often higher, few differences in depression, bipolar
  - African Americans: schizophrenia, cognitive impairment
  - Latino: less panic disorder
Obstacles to Exiting Emotional Disorder Identities (Jenna Howard 2008)

- Snowball sample of “delabelers”
  - 31 women, 9 men; anxiety, eating, substance, mood disorders
  - Label “outserved its usefulness” but still an “identity void”
  - Loss of group solidarity – deserter complex and reverse stigmatization (in denial), cultural pressure to medicalize
- Recovery from recovery through bridging social capital, financial capital

David Rosenhan’s *On Being Sane in Insane Places* (1973)

- 8 “sane” people get admitted to 12 mental hospitals
  - Complained of voices (e.g., saying “thud”)
  - 7 got schizophrenia diagnosis, 1 manic-depressive
- Hospitalized average of 19 days, released “in remission”
  - Took notes, described conditions
  - Other patients quickly discovered
  - Released after taking meds, admitting
- Controversial classic
  - Evidence for labeling theory? [contexts]
  - Or biased by bad methodology?
  - Follow-up “non-existent imposter” 41 imposters, 42 suspects of 193 admitted
- Deinstitutionalization – different today

Deinstitutionalization: one of several waves of reform (NIMH)

<table>
<thead>
<tr>
<th>Reform movement</th>
<th>Era</th>
<th>Setting</th>
<th>Focus of Reform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral Treatment</td>
<td>1800-1850</td>
<td>Asylum</td>
<td>Humane, restorative treatment</td>
</tr>
<tr>
<td>Mental Hygiene</td>
<td>1890-1920</td>
<td>Mental hospital or clinic</td>
<td>Prevention, scientific orientation</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>1955-1970</td>
<td>Community mental health center</td>
<td>Deinstitutionalization, social integration</td>
</tr>
<tr>
<td>Community Support</td>
<td>1975-present</td>
<td>Community support</td>
<td>A social welfare problem (like housing)</td>
</tr>
</tbody>
</table>
Bernard Harcourt: combined rate of institutional social control

Current issues

- Contrast stigma with physical illness
  - Violence?
  - Discrimination
- Labeling and constructionist versus psychiatric accounts
- Systems of social control and deinstitutionalization
  - Homelessness
  - Incarceration (Harcourt)
  - "Parity" laws
- Medicalization of "rule-breaking"

Schnittker, Massoglia, Uggen (2012)
Incarceration and Psychiatric Disorders

- Big correlation between psychiatric disorders and incarceration, but is there a causal relationship?
  - How strong is it?
  - For what sorts of psychiatric disorders?
Figure 1. Conceptual Model Illustrating Influences in the Incarceration-Psychiatric Disorder Relationship

Table 1. Lifetime and 12-Month Prevalence of Psychiatric Disorders Among Those With and Without a History of Incarceration: NCS-R (N = 5,692)

<table>
<thead>
<tr>
<th></th>
<th>Lifetime Prevalence</th>
<th>12-Month Prevalence</th>
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<tbody>
<tr>
<td></td>
<td>Incarceration</td>
<td>No Incarceration</td>
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<tr>
<td>Anxiety Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>4.4</td>
<td>7.4*</td>
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<tr>
<td>Agoraphobia</td>
<td>2.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>12.2</td>
<td>16.8*</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>11.5</td>
<td>18.6*</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>7.6</td>
<td>8.8</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>6.3</td>
<td>10.4*</td>
</tr>
<tr>
<td>Adult Separation Anxiety</td>
<td>5.7</td>
<td>12.2*</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>16.1</td>
<td>19.8*</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>3.8</td>
<td>5.9*</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>3.6</td>
<td>8.5*</td>
</tr>
<tr>
<td>Impulse Control Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>4.5</td>
<td>2.4*</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>3.4</td>
<td>2.2*</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>3.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Intermittent Explosive Disorder</td>
<td>6.7</td>
<td>3.4</td>
</tr>
<tr>
<td>Substance Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>8.4</td>
<td>47.0*</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>3.1</td>
<td>21.3*</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>4.9</td>
<td>28.2*</td>
</tr>
<tr>
<td>Drug Dependence</td>
<td>1.7</td>
<td>12.9*</td>
</tr>
</tbody>
</table>

*p < .05 (two-tailed test of mean difference between no incarceration and incarceration)
Sociology's Central Concept?

- Writing on deviance thrives, but no longer labeling, as deviance
  - Authors avoid “deviance” in title (cite impact)
- But concepts of deviance, norms, and rule violation are core to sociology.
  - Statistical, absolutist, reactivist, normative def.s
  - Deviance is departure from norms that draw social disapproval and elicit, or are likely to elicit if detected, negative sanctions.
  - What question is more basic for sociology?
    - Sociology as the study of human social behavior -- the origins, organization, institutions, and development of human society
- We know a society by its working definition of deviance and conformity

Adlers & Goode

- Soc of deviance obituary (1994, Sumner)
  - Clinard text since 1953; Glory days of 1960s; 1980s publication peak; still popular but relabeled
  - new categories & targets (e.g., cutters)
  - “morality” and normative expectations
  - political contestation (e.g., marriage); deviance and control “battle story” (Pfohl)
- Necessity and functions of “deviance”
  - “Without deviation from the norm, progress is impossible” (Zappa)
Two Logics of Course

1. Durkheim’s “sociological realism” and social facts
   - learn the “social facts” (e.g., charts) but also critique them
2. Social constructionism
   - Focus on labels and power in rule-making
     - “The deviant is one to who that label has been successfully applied; deviance is behavior that people so label” (Howard Becker)
     - Rule creators and rule enforcers as well as “deviants” (Adler & Adler text; Best)
   - Emphasis on deviant careers
   - So, learn both social facts and big ideas about them

Course Organization

1. Basic Concepts – Deviance, Control, Careers, Subcultures
2. Theories
   - Overlap, but distinct from criminology
3. Method
4. Case Studies
   - Violence, other crime, organizational and occupational, substance use, sexuality, suicide, disability, and mental illness

second-half outline

- Outline on handout
- Exam format
  - % MC
  - % IDs
  - % Essays
- Office Hours
  - Chris:
  - TA:
- FINAL: Next week, right here
# childhood prevalence (9-17) (US Surgeon General)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence (%)</th>
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</thead>
<tbody>
<tr>
<td>Anxiety disorders</td>
<td>13.0%</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>6.2%</td>
</tr>
<tr>
<td>Disruptive disorders</td>
<td>10.3%</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>2.0%</td>
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<tr>
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