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Source: *Journal of Health and Social Behavior*, Vol. 16, No. 4, Special Issue on "Recent Developments in the 'Sociology of Mental Illness'" (Dec., 1975), pp. 393-404

Published by: [American Sociological Association](#)

Stable URL: <http://www.jstor.org/stable/2136611>

Accessed: 04/08/2011 17:45

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Sociocultural and Social-Psychological Factors Affecting Personal Responses to Psychological Disorder*

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SOCIOLOGISTS and social psychologists have given considerable attention in recent decades to the processes leading to the identification of mental disorders in the community and to factors affecting help-seeking. Such work was given impetus almost twenty years ago with the publication of *Social Class and Mental Illness* (Hollingshead and Redlich, 1958) and its analysis of social class differences in thresholds for identifying mental disorder and pathways into care. At approximately the same time Clausen and Yarrow (1955), then at the National Institute of Mental Health, in a study of the families of schizophrenic patients, detailed the processes of denial and normalization that resulted in delays in seeking care until the patient's behavior became so bizarre and difficult to cope with that treatment was initiated. A variety of other studies examined the instrumental functioning of mental patients in the community and factors related to rehospitalization (Freeman and Simmons, 1963; Dinritz et al., 1962; Brown et al., 1966). These studies were consistent in finding that rehospitalization was related less to instrumental functioning than to the manifestation of bizarre and difficult behavior that significant others found hard to manage.

Medical sociology was then at an infant stage, and these early studies stimulated enthusiasm and interest. They illustrated that sociological methods could be applied to problems of mental illness, its iden-

tification and care, and that insights resulted through such investigation that were not apparent from clinical research. It is difficult to believe, but nevertheless true, that until the publication of Hollingshead and Redlich, psychiatrists and other mental health personnel largely ignored social class and the subcultural styles it embodies as important variables in understanding and dealing with mental illness. Although trite today, the demonstration twenty years ago that recognition of symptoms, pathways into care, and response to treatment were related to social class and subcultural patterns was of very great interest.

I have begun this article with a brief historical overview because it illustrates some of the difficulties inherent in understanding the processes of personal response today. While in the 1950's and 1960's it was useful to demonstrate the importance of social variables in explaining various processes related to mental illness and its treatment, the task is much more demanding today. It is no longer a revelation that social class, ethnicity, or household structure are correlated with dependent variables of interest. The field is presently grasping for a theoretical framework that ties together disparate studies into a more coherent whole. While the literature abounds in reports of studies illustrating that one or another social variable is associated with recognition of having a problem, with help-seeking, with retention in treatment, or whatever, these reports have a tedious similarity, giving the impression that although the effort is considerable the yield is relatively small. What clearly seems necessary is not

* Supported in part by Public Health Service Grant MH 20708, and a grant from the Robert Wood Johnson Foundation.

more studies in the same vein, but clarification of the theoretical problems, formulation of the issues that remain problematic, and review of the most adequate methodologies that facilitate their clarification. This review, thus, is not a summary of the many studies done but, in contrast, an attempt to specify where we are and where we must go if we are to advance study of personal responses and help-seeking.

Some Theoretical Issues

The areas of concern here fall most properly into an aspect of sociological theory that might be referred to as the study of social selection. Social selection is one of the most pervasive processes characteristic of human communities, and its study concerns the identification of underlying principles of sorting and resorting that continuously go on among social groups. Subareas of the study of social selection include assortative mating, geographic migration, selection related to education, life careers and achievement, and numerous other topics. Social selection ideas have become increasingly important in theoretical conceptions of deviance where attention is directed to the social processes through which particular persons are identified, processed, isolated, and are confronted with restricted opportunity structures (Lemert, 1951; Scheff, 1966b; Matza, 1969).

In making sense of processes of social selection, whatever the subarea of concern, attention is given to the particular characteristics of the individuals and groups involved that make them different in one way or another from others in the community. Attention is also given to the processes by which they interact with others exchanging information about their social characteristics, skills and disabilities, and personal inclinations. Efforts must also be made to understand the underlying opportunity structure that makes differential choice possible and that either facilitates or retards certain possibilities. In short, selection problems have personal, interactional, and structural dimensions.

Although social selection is one of the

most central processes of social activity, much of sociological investigation views it more as an irritation than as an object of inquiry. Because social selection is such a powerful process, sociologists cannot ignore it, but in order to maintain credibility they must successfully discount it. Thus, students of complex organization, comparing varying types of social structures or management styles, must make a credible case that it is the structural arrangements that are really important in contrast to the types of persons drawn to varying organizations. Investigators of education or other social programs must, in order to be taken seriously, convince us that the effects they observe are related to a specific intervention in contrast to the types of clients drawn to varying kinds of programs. Indeed, some social scientists, recognizing the power of selection, take the position that serious study without the randomization of selection effects is futile. Most curious about all of this is that, despite such widespread recognition of social selection as a powerful and pervasive social process, so few sociologists take selection itself as the object of their theory and inquiry.

It is quite possible to formulate varying hypotheses about selection that have important implications for how we construe social processes more generally and what policy implications we derive from such understanding. Take, for example, the simple instance of a patient seeking the assistance of a physician. One hypothesis about selection is that it basically reflects the magnitude, quality, and seriousness of symptoms. This "rational" concept of medical utilization would lead one to anticipate that characteristics of illness are the main determinant of use of physician services, and that exceptions flow from ignorance, misperception, or poor communication; and, of course, this is the way many physicians view the utilization process. A contrasting hypothesis would maintain that many of the problems brought to a physician resemble similar problems of considerable prevalence that only occasionally lead to care; thus, knowledge of symptoms is not sufficient to make sense of the use of physicians.

What may differentiate those who seek care from those who do not is a desire for social support, secondary gain as reflected in release from work or from other obligations, or some other social process quite unrelated to the illness or symptoms.

The perspective taken on a problem as seemingly simple as medical utilization may have important implications for the types of questions asked, as well as a variety of practical concerns. To the extent that the discrepancy between the character and magnitude of illness and utilization is seen as little more than the result of distortions that require correction, then there are few issues of intellectual concern. But the inquiry may also attempt to probe somewhat deeper to examine why people with similar symptoms behave differently, why assistance is sought during some stages in illness rather than others, and why the patient at a particular point in time comes to emphasize a given set of symptoms. The most frequent reason given for seeing a doctor is the common cold. But most people with colds do not consult doctors, and people who consult doctors because of colds on one occasion may not do so on another. An adequate theory must do more than explain a certain proportion of the variance in the dependent variable; it must provide some way of accounting for the diversity of response not only among individuals and groups but within the life history of individuals. It is conceivable, for example, that the common cold is an excuse for visiting a physician in contrast to the primary motivation, and the desire to relieve the stress of a hated job or an unhappy family situation often constitutes the primary motivation. The implication of such a hypothesis, in contrast to the rational theory referred to above, is that eliminating the prevalence of colds in the population is likely to have a less dramatic impact on utilization than might be expected. If the common cold as a justification became less viable, people would find other excuses to seek release from obligations or support.

Methodological Considerations

It is often difficult to pose interesting questions so that they are answerable. Al-

though there are extensive reports and discussions on the "hidden agenda" in medical consultations and numerous attempts to analyze people's deeper motivations for seeking care when they do so for psychological problems (see Balint, 1957), it is difficult to investigate these issues in a rigorous and replicable manner. Generally speaking, there are four methodological approaches to understanding how people respond to symptoms and choose pathways for care.

1. *Study of Care-Seeking as a Dispositional Variable:* One way of attempting to understand why people seek care from psychiatrists or some other type of helper is to attempt to isolate a dispositional trait and examine its correlates and social development. Such dispositional attributes may be measured directly through verbal reports as with a measure of the propensity to seek medical or psychiatric care, or indirectly through the fact that some individuals have sought care from a particular help source and others have not. The fact of having sought help from, for example, psychiatrists defines the disposition, and the investigator then attempts to reconstruct through depth interviews or statistical manipulation of survey or other data both the antecedents and concomitants of such dispositions. Most of the literature has not gone beyond simple sociodemographic correlates of particular help-seeking patterns, and almost no direct study has been undertaken of the social development of different dispositions.

There are a variety of interesting issues concerning the social development of help-seeking dispositions that remain highly problematic. For example, there are abundant studies indicating that women report various symptoms more frequently than men and use medical and psychiatric facilities more commonly (Gurin et al., 1960; Srole et al., 1962; Dohrenwend and Dohrenwend, 1974; Gove and Tudor, 1973; Anderson and Andersen, 1972). Many reasons are given by investigators to explain such differences: real differences in the prevalence of psychological disorder; characteristics of the measures used and judgments made of disorders that contain sex biases; women's lower threshold to perceive symptoms;

differences between men and women in the willingness to acknowledge the presence of symptoms; and psychobiological differences between men and women. Although each of these various explanations surfaces from time to time, few investigators attempt to devise studies that allow competing hypotheses to be tested. Mechanic (1964) found in a study of the socialization of attitudes toward illness that sex differences in reporting reactions to illness and pain were already apparent in children by the fourth grade, and these increased as children became older. Aggregate data on sex and utilization of medical care suggest that women have higher levels of utilization at all ages except during childhood when it is usually the mother who makes decisions for both boys and girls. However, Lewis (1975) has shown that sex differences in using a school health service exist even among young children in an experimental child-initiated help-seeking system. A better understanding of how differences by sex, as well as other important personal characteristics, emerge requires developmental inquiry. It will become clearer, however, that defining help-seeking predispositions is no easy matter and involves the same types of difficulties inherent in other predispositional investigation in developmental psychology, such as in the study of honesty, independence, etc.

2. *Study of the Interaction of Independent Variables Explaining Utilization:* One of the most common approaches to studying help-seeking is to carry out an epidemiological survey and to identify in the survey population those who have sought a particular type of care. Other data from the survey are then used to examine how the characteristics of those who seek care differ from those who do not. Such analysis allows the exploration of interactive effects and more complex models of help-seeking. Mechanic and Volkart (1961), for example, in a study of freshmen students, found that both tendency to adopt the sick role and stress were related to the use of student health services. Stress was more influential, however, among those students with a higher propensity to use medical services in af-

fecting the actual rate of medical utilization. Thus, it appeared that students had differential predispositions to cope by using health services; stress appeared to be the trigger that activated the disposition among those who were high on this variable. Stress probably led to other types of coping behavior among those who had lower dispositions to use medical services. Gurin and his associates (1960), in a national survey of definitions and reactions to personal problems, suggested that different types of factors influence varying aspects of the help-seeking process such as the identification of the problem, the decision to seek care, and the particular type of practitioner consulted.

3. *Study of the Effects of the Structure of the Health Delivery System on Utilization:* Still a third approach to studying utilization is to examine the help-giving organizations and the extent to which they either encourage care among certain groups or impose barriers to such care (McKinlay and Dutton, 1974:275-284). Barriers may result from the location of sites of care, economic or other impediments to access, bureaucratic harassment, social distance between client and professional, stigma associated with seeking care, or whatever. Such barriers may further result because of the way in which agencies and professionals define their work and organize their efforts. Beginning with the early study of Myers and Schaffer (1954), showing the varying accessibility of a psychiatric clinic to clients of different social statuses, many studies have illustrated the extent to which agencies express preferences for certain types of clients and how social dissimilarity between clients and professionals results in difficulties in communication and disruption of service.

4. *Studies of Processes of Illness Attribution:* An illuminating approach to the study of the identification and response to symptoms is the investigation of the attribution process itself, and how people come to make sense and give significance to the experiences they have. One of the most consistent findings in the illness behavior literature is that persons are more likely to take action for symptoms that in some fashion disrupt usual functioning than in other circumstances, and that con-

cepts of health are affected as much by total functioning as by the nature of the symptoms experienced (Mechanic, 1968; Hennes, 1972). Persons experiencing changes in usual physical functioning and feeling-states engage in various attempts to make sense of their experience and test various hypotheses about the seriousness of the symptoms they are experiencing and possible causes (Mechanic, 1972). The manner in which attributions are made affects the significance given to symptoms and the types of action pursued.

One of the most interesting dimensions of such attribution processes relevant to the mental disorders is how people come to attribute causality to their experiences, and more specifically the locus of causality. Under what conditions, for example, do people come to view their feelings or behavior as a consequence of a moral failure or as a consequence of an illness for which they are not responsible? Particularly in cases where definitions of mental disorder are imposed on individuals by other members of their social group, decisions must be made as to the extent to which the behavior or attitude of the patient reflects "badness" in contrast to "sickness," and these attributions are very much affected by the sociocultural context (Mechanic, 1968).

Attributions of causality have considerable implications for the care provided, for the course of disorder, and may even dramatically affect programs of rehabilitation. For example, during the Second World War soldiers who experienced "breakdown" in combat were evacuated to the back lines, and their disorganized behavior was viewed as rooted in their early childhood socialization. The soldier, wishing to avoid further combat, readily accepted the attribution that the problem was rooted in his personality, and it was difficult to return these soldiers to active duty (Glass, 1958). The military later developed a psychiatric policy that defined stress reactions in combat as transient reactions. Although soldiers were given opportunities to rest, the definition of the situation was that this was a reaction in the normal range, and that soldiers were expected to return to active duty. With this

policy, many soldiers returned to effective functioning within their units. These policies have now been translated into community care of the mentally ill, and it is apparent that many patients suffering from psychological distress do extremely well with minimal intervention. At times, however, such policies are carried too far and it is assumed that community tenure by itself, without adequate supporting care, can allow disabled persons to function adequately. The basic point, however, should be clear: the manner in which the behavior is conceptualized has an important impact not only on how the person affected sees himself and his efforts at continuing coping, but also on how he is perceived by the community in which he resides.

The study of how people come to understand and conceptualize experiential change is perhaps the area most neglected in studies of reactions and help-seeking. Although a variety of interview studies have been carried out that attempt to reconstruct the attribution process, such retrospective reports may be closer to reconstructions of what took place in light of later experience than accurate descriptions of the attribution process itself. Although such studies as those of Clausen and Yarrow (1955) provide a good intuitive sense of the processes of attribution and normalization, by focusing on patients we lose an understanding of those instances where behavior was normalized and the person concerned did not become a patient. Moreover, retrospective reports may come to emphasize the more dramatic and unusual aspects of the process, neglecting those more mundane aspects. Furthermore, to the extent that the individuals involved are coping with the problem effectively through attributions that normalize unusual feeling-states, they may not experience consciously the extent to which their frames of reference are changing. Davis (1963), in a study of adaptations to having a child with polio, followed families for several years and observed that although they changed significantly in confronting the crisis, they often failed to recognize the extent to which they had changed. Such lack of rec-

ognition may be part of the coping process. To the extent that adaptation is smooth and effective, one would anticipate that the actors themselves would not fully recognize the extent to which the situation required them to change.

A Note on Level of Analysis

It is frequently implied that reactions to mental disorder and help-seeking are in some way a unique topic deserving special attention. Although there are some unique aspects to the mental disorders area, at least from a descriptive vantage point, I do not believe that it is particularly useful to dwell on such descriptive variations. If our concern is to develop a better theoretical approach to illuminating how reactions come about and relate to help-seeking, we must not neglect the fact that reactions to physical and psychological changes are part of the same general attribution process, and that many of the same factors are operative whether it is the person himself who is interpreting his feeling-states or behavior or whether such attributions are being made by others in the group (Mechanic, 1968). From a help-seeking perspective, mental disorder is different from physical disorder in that the nature of the problem, as it becomes evident, may lead to somewhat different scores on varying dimensions of importance. Thus, any set of symptoms may be evaluated by the extent to which they disrupt normal functioning, their visibility to others, their perceived seriousness, the extent to which they elicit embarrassment, the extent to which treatment is perceived as effective, or whatever. The value on any of these criteria may be very different from one condition to another. Analytically, consideration of how a particular condition falls on relevant dimensions is more helpful than the gross distinction between psychiatric and nonpsychiatric conditions. Similarly, the underlying dimensions of the attribution process are not likely to be very different in situations where the person is defining his own problem in contrast to one where interpretations of the problem are imposed by others.

The problem of identifying mental dis-

order is further compounded by the fact that much of mental disorder is treated by primary care physicians in contrast to mental health professionals, and that such problems are often presented to helping personnel in physical and psychophysical terms (Gardner, 1970; Shepherd et al., 1966). Thus the line between physical and psychiatric illness is not easily defined and, indeed, it is often the attribution process and the factors that affect it that determine the manner in which the symptoms are organized and how they are presented to helping agencies. Certainly, the problem of understanding reactions is simplified if analysis is limited to certain well-defined instances of mental disorder such as schizophrenia. But from a sociological perspective, it is valuable to study a wider spectrum of problems, since the issue of interest is how the person comes to identify a problem, define the nature of the problem, and identify the appropriate helping source, and how he negotiates among the various agencies that play some role in providing care. The process of attribution takes place when the illness situation is still unorganized (Balint, 1957). To focus on more coherent entities tends to exclude the more ambiguous cases in which the attribution process is at work, and thus misses part of the process that is of sociological interest.

More Specific Issues

In understanding how people come to define a problem and seek appropriate assistance, it is necessary to distinguish a variety of issues in a way that no existing study has effectively achieved. In this section I wish to specify the issues that must be disentangled, the methodological requirements for pursuing them, and problems of measurement that complicate such investigation.

Most of the existing literature in the past decade demonstrates certain continuities in the characteristics of individuals drawn to psychiatric care. Existing studies generally agree that such persons are more likely to be of higher educational and income levels, of urban or suburban residence, of Jewish identification or of low religious participation, and

women (Gurin et al., 1960; Kadushin, 1969; Boyce and Barnes, 1966; Scheff, 1966a). At a more analytic level it has been argued that persons more inclined to seek psychiatric care are more likely to have developed vocabularies of distress (Bart, 1968), to have a cosmopolitan orientation (Linn, 1967), or to be part of a social circle of others who are friends and supporters of psychotherapy (Kadushin, 1969). In short, seeking care for psychiatric problems and remaining receptive to psychotherapy have been seen by a variety of students of the problem as indicative of being part of a subcultural milieu that is encouraging, supportive, and that values the nature of the service given.

To complicate the issue, however, it is necessary to take into account that types of treatment are themselves linked to social movements, and have their own rise and decline over time as the appropriate fashion for a particular subgroup facing life problems or existential dilemmas. Psychoanalysis, for example, developed its roots in urban areas, with many practitioners of urban, middle-class, Jewish origins. It is not surprising, therefore, that this form of therapy attracted persons with certain social characteristics and life inclinations. But as the psychotherapeutic movement grew and developed, it became more heterogeneous in its geographic location and the types of practitioners trained; and as these characteristics changed, so did the clients drawn into treatment. Although there is no definitive study, there is every indication that both psychotherapists and their patients are becoming more like the general population than was true twenty or thirty years ago. Thus, the social characteristics of clients drawn to such therapies are likely to change over time, becoming less distinctive. The kinds of results researchers are likely to obtain on the descriptive aspects of the selection of patients depend, in part, on what point in time they take a cross section of a continuing process through time.

At any single point in time, several interrelated issues exist in understanding the significance of sociocultural differences among patients who seek particu-

lar types of treatment (Greenley and Mechanic, 1975). First, it is necessary to distinguish the extent to which social characteristics are related to seeking treatment because these are also related to the prevalence of certain problems requiring treatment. It is not clear to what extent these social characteristics are related to the occurrence of problems or to the care-seeking process. Second, it is necessary to distinguish the extent to which certain sociocultural processes are related to the inclination to seek care (or dependency on helping sources) as compared with their effect on the use of a particular source of care. It is obvious that Jewish identification, although related in many studies to the use of psychotherapy, does not increase the propensity to use Catholic counselors. Most studies in the literature confuse the issue of generalized sociocultural selection in seeking assistance for mental disorder from the issue of selection of specific forms of help.

The requirements for carrying out a study that allows separation of sociocultural effects on symptoms as compared with seeking help, and on generalized help-seeking propensities as compared with specific inclinations to use psychiatry or some other mode of help, are extremely difficult to meet. First, the researcher must have some way of measuring unorganized psychological distress or morbidity which can be alternatively defined by members of a population. Unfortunately, there are no good measures of health levels that can be applied to community populations, and measures of generalized psychological distress pose a variety of additional difficulties. Second, the study must be so organized that the researcher has access to a variety of alternative helping sources available to the population. Some studies, such as those by Gurin et al. (1960), cover a wide variety of agencies but depend on respondent reports as compared with verified data, and use lifetime prevalence rates that are unreliable. Preferably one would like to study a population during a defined period of risk and under conditions where the help-seeking behavior is verifiable by agency records. Further-

more, to the extent that the study is concerned with issues of functioning, diagnostic assessments made by helping practitioners, and the like, it would be desirable to obtain as much data as possible on performance from sources independent of the respondent, and preferably from records.

A further comment is required on measures of psychological distress. At present, there are no adequate reliable techniques for identifying psychiatric disorders in the general population, although a great deal of progress has been made in developing a reliable clinical present-state examination with patient populations (Wing, 1974). Existing measures such as the Langner 22-item scale and the Health Opinion Survey, based on items from the Army Neuropsychiatry Inventory, confound physical and psychiatric distress and are biased by problems of social desirability response (Dohrenwend and Dohrenwend, 1969; Crandell and Dohrenwend, 1967; Seiler, 1973; Manis et al., 1963; Tousignant et al., 1974; Phillips and Clancy, 1970; Dohrenwend et al., 1970). Because of the association between age and physical morbidity, such measures are particularly deceptive when comparing subgroups of varying ages. Similarly, in populations of considerable ethnic and cultural heterogeneity, social desirability may be a source of major biases. Such measures, however, may still be relatively useful in studying populations within limited age ranges and that are not too culturally diverse. In any case, they offer better solutions than the one most sociological studies adopt — completely excluding the measurement of mental health status.

The ideal approach, although usually impossible to implement and extremely expensive, would be to follow on a panel basis a large defined population with access to a definable range of helping services. Although complete control is never fully possible, opportunities for a successful study are increased in a closed panel health care plan, particularly one in a relatively isolated community where treatment alternatives are not readily available or are easily identifiable, and thus can be

included in the study. Other alternatives include such self-contained groups as college communities, armed forces units, ships, small isolated communities, and the like. Such a study could monitor the occurrence of distress in the population, the processes by which people identify and make sense of unorganized symptoms, and types of help-seeking from alternative agencies available to the population, such as medical care, mental health practitioners, clergymen, lawyers, special clinics, etc. To the extent that such a study would monitor the help sources themselves and the course of treatment, it becomes possible to separate not only the issues already identified, but also to ascertain whether the factors that facilitate continuation in treatment are separable from those leading to the initiation of treatment in the first place (Levinger, 1960).

The cost and difficulties of implementing such a methodology require some compromises. One possibility that has been used in a variety of studies is to compare a random sample of a defined population eligible to use a particular facility with a sample of users (Scheff, 1966a; Linn, 1967; Greenley and Mechanic, 1975). Although one cannot demonstrate a causal sequence using such a methodology, a variety of interesting hypotheses can be examined. Greenley and Mechanic (1975), using such an approach, compared a random sample of a defined population with samples of users of various helping agencies which the population was eligible to use. However, in the case of the random sample, further data were obtained on the use of a wider variety of agencies including those for which special samples were obtained. If the random sample is large, the availability of reported data on help-seeking allows the replication of the analysis within the random sample that was carried out across agency samples. To the extent that comparable results appear, there is reason to have added confidence in the findings. The value of working with a variety of alternative agencies is the availability of data independent of reports by respondents and the possibility of examining sociocultural influences on help-seeking in general as

compared with inclinations to use particular types of helpers.

The State of the Literature

Most of the existing literature documents with considerable consistency systematic differences in the sociocultural characteristics of users of particular helping facilities. Only a few studies tangle with the kinds of theoretical issues I have suggested. Kadushin (1969) has perhaps done the most extensive work on attempting to describe how individuals come to perceive that they have a problem, the nature of the problem, whether care should be sought, and what type of practitioner to consult. He analyzes the propensity to use certain types of services in terms of his concept of social circles and indicates that while those of higher social status and of low religiosity tend to consult analytic clinics, lower status persons and those more religious are drawn to religious-based counseling clinics. Kadushin (1962) has further provided support for the hypothesis that patients tend to seek among alternative helpers those that minimize social distance between patient and therapist.

Although studies by both Scheff (1966a) and Linn (1967) are confined only to use of psychiatric services, they present analyses very similar to the one provided by Kadushin (1969). Scheff infers a subculture attuned to psychiatry on the basis of sociocultural characteristics differentiating users from the population from which they come. Linn (1967), studying the same clinic, more directly measures cultural attitudes and associations with others, and suggests that there is a cosmopolitan subculture characterized by introspection, interest in psychology, and the like, that predisposes individuals to use psychiatric services.

The literature is particularly confusing in differentiating sociocultural characteristics as they affect the occurrence or recognition of distress in contrast to their effect on the use of helping services. For example, epidemiological investigations find that women report more distress than men; help-seeking studies also find that women use more services than men.

These studies do not make clear whether sex is important primarily because it is related to rates of symptomatology or whether it has an independent effect on help-seeking behavior. Similarly, the high proportion of Jews found in psychotherapy has been said to result from a high level of introspection (presumably making feeling-states more salient and heightening distress) (Henry et al., 1968), or greater willingness of Jews to express distress and seek assistance (Antonovsky, 1972). Few studies differentiate these factors.

Scheff (1966a) was one among very few investigators who attempted to measure psychological problems as intervening variables, basing the measure on a problem list developed from presenting complaints of students when they sought help from a psychiatric clinic. Scheff found that, although the clients' problem levels were related to seeking help, the sociocultural differences persisted when number of problems was controlled. He found, however, that sociocultural selectivity was greater among students with fewer as compared with more problems. One of the difficulties with Scheff's measure was the absence of any indication of severity other than the number of problems reported.

Greenley and Mechanic (1975) have carried out an extensive epidemiological survey as well as a study of students using particular helping agencies in order to examine some of the issues described in this paper. Although they used a wide variety of indicators to measure level of psychological distress, and took severity into account, they find, as do other investigators (Langner et al., 1963; Gersten et al., 1974), that simple counting of symptoms or problems gives results comparable to more detailed scaling of severity. The comparability of findings is probably due to the fact that respondents who are more seriously distressed are likely to report a larger number of problems.

Using the Langner (1962) scale as a measure of psychological distress, Greenley and Mechanic could account for very little variance in rates of distress on the basis of social and cultural characteristics

of students. Only sex and age had any important effects. They found, however, considerable sociocultural selectivity in the use of psychiatric services consistent with many other studies: in the psychiatric sample there was an overrepresentation of women, older students, students with Jewish identification or no religious affiliation, those from families of high socioeconomic status, and the like. However, those students who used a student counseling service had different and sometimes opposite characteristics. Thus, students coming to counseling were younger on the average than the students in the population from which they came. Only the overrepresentation of women was consistent with selection into the psychiatric clinic. Similarly, they found considerable specific selection into a variety of formal helping sources within the random sample suggesting that much of the social selection into care depends on certain compatibilities between help-seeker and help-provider. The information on use of a variety of formal help-giving agencies, including psychiatrists, counselors, clergymen, general physicians, and the like, allowed them to compare students who sought help from a formal helper as compared with those who did not. When such an analysis is performed there is very little difference on the basis of sociocultural characteristics between these two groups, suggesting that most such characteristics have little relationship to a general readiness to seek help for personal problems.

There are a few other findings worthy of note here. The most important single factor affecting the use of psychiatry or counseling services is the level of distress. Although there is significant sociocultural selection, it operates for the most part independently of distress levels. Of the various sociocultural factors, only sex appears to be related in any significant fashion both to the reporting of levels of distress and to the use of helping services. While controlling for distress seems to account for the overrepresentation of women in the psychiatry sample, such controls did not account for the overrepresentation of women in the counseling sample or the overrepresentation of women in the ran-

dom sample reporting consulting a psychiatrist. Although Greenley and Mechanic found a slight tendency for social selection to be strongest among those least impaired, for the most part social selection appeared to operate in a comparable way at varying levels of distress. Finally, they found that distress played some role in the selection among formal help sources. In general, students seeking care from psychiatry as compared with other sources of help had higher levels of reported distress.

Where Do We Go From Here?

The discussion has ranged over a wide area, suggesting a variety of issues that remain to be clarified about how people respond to indications of mental disorder. I have neglected the literature on other-defined deviance, as in the case of involuntary hospitalization, since these issues have been amply discussed elsewhere (Mechanic, 1968; 1969), and growing emphasis in society — as well as in research studies — is being devoted to voluntary processes of care. I should emphasize that many of the considerations here are applicable to "other-defined situations," and the neglect of specific discussion should not suggest that this area offers no further provocative questions for the sociologist. The shift away from involuntary hospitalization and the emphasis on community care, as well as the new emphasis on the rights of the mentally ill, is part of a social movement that is likely to be cyclical in its development. Already there are strong indications of a community backlash to permissive mental health applications, and forces are growing to reinstate at least partially some earlier practices. The politics of the mental health sector have been very poorly studied and require vigorous sociological analysis.

In pursuing further research, the following general frame of reference appears to be a viable starting point. The occurrence of symptoms, particularly when they become visible, disruptive, or incapacitating in some fashion, set into motion a process of conceptualization in which various attributions are made. The nature of the attribution process is to some

extent shaped by the character and magnitude of the symptoms but also by the sociocultural characteristics of the persons and the social circles within which they function. The type of care selected depends on sociocultural predispositions, the assessment of the locus of causality of the problem, the immediate social context, and the character and accessibility of available helping services. In all probability, when conditions are ripe, any of a wide variety of triggering events may help bring individuals to a source of help. Such triggers may include certain crises they confront because of this problem, social influences of significant others, or public information that gives them cues as to the availability of a source of help well fitted to their difficulty. Future efforts will be required to provide data to clarify the framework and further extend it.

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